# There is a Better Way: Make Medicaid and Medicare More Like Social Security

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ABSTRACT

*The Medicare and Medicaid programs are not serving the needs of their target populations as well as they could. Democrats believe that Medicaid can be improved with more money and stricter federal regulation, and that Medicare can be improved by allowing it to negotiate drug prices. Republicans believe Medicaid can be improved by delegating responsibility to the states and adding work requirements, and that Medicare can be improved by moving more people into Medicare Advantage.*

*This Article proposes a very different strategy. Instead of tinkering with Medicare and Medicaid, this Article argues for remodeling both programs along the lines of Social Security, the Earned Income Tax Credit, and the Child Tax Credit. These programs do not provide housing, food, or other goods and services that beneficiaries need. They give beneficiaries money and let them decide how to spend it themselves. By using a similar approach for Medicare and Medicaid (i.e., by giving beneficiaries an insurance policy covering catastrophes plus money either in the form of cold hard cash or a restricted spending account), both programs would allow beneficiaries to purchase the goods and services that, in their judgment, will help them most. The remodeled programs would also unleash the bargain-hunting skills of more than 100 million Americans, helping to drive down costs and minimize fraud.*

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## INTRODUCTION

In *Overcharged: Why Americans Pay Too Much For Health Care*,[1] we proposed that, rather than pay providers to treat beneficiaries, Medicare and Medicaid should give beneficiaries money and let them decide how to spend it. The proposal, which would remake Medicare and Medicaid along the lines of Social Security, the Earned Income Tax Credit (EITC), and the Child Tax Credit (CTC), has a lot going for it. First, cash transfers will directly enhance beneficiaries' welfare by enabling them to buy the goods and services they value the most (which might be, but need not be, the medical treatments covered by Medicare and Medicaid). Second, consumer-directed purchasing will transform the health care sector by making providers responsible to patients rather than third-party payors. Almost instantly, the health care marketplace will become more price- and quality-transparent as providers suddenly find it in their interest to provide consumers with better information. Third, for the same reason, providers will find it advantageous to reduce prices and improve quality, and to innovate in the delivery of medical treatments by bundling goods and services in patient-friendly ways, offering convenient hours and locations, and backing up their services with warranties. Fourth, "surprise" medical bills, which approximately ten percent of the adult non-elderly population report receiving in the past year, will disappear.[2] Fifth, health care fraud will decline dramatically. At present, wrongdoers extract tens of billions of dollars a year from Medicare and Medicaid by billing for treatments that are unnecessary, over-priced, up-coded, or not even provided.[3] When patients control the money, wrongdoers will no longer be able to game the payment system.[4] The volume of services that are ineffective or unnecessary will

1. CHARLES SILVER & DAVID A. HYMAN, OVERCHARGED: WHY AMERICANS PAY TOO MUCH FOR HEALTH CARE (2018).

2. *See* Ashley Kirzinfger et al., *Kaiser Health Tracking Poll - Late Summer 2018: The Election, Pre-Existing Conditions, and Surprises on Medical Bills*, KAISER FAM. FOUND. (Sept. 5, 2018), https://www.kff.org/health-costs/poll-finding/kaiser-health-tracking-poll-late-summer-2018-the-election-pre-existing-conditions-and-surprises-on-medical-bills/ [https://perma.cc/XH2S-7QFV]. The same survey indicates that 40 percent of those polled received an "unexpected" medical bill during the prior year. *Id.* These terms are not self-defining; we think it likely that many of the "unexpected" bills were "surprise" medical bills.

3. *See generally* U.S. DEP'T OF HEALTH & HUM. SERVS. & DEP'T OF JUSTICE, HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM ANNUAL REPORT FOR FISCAL YEAR 2017 (2018), https://oig.hhs.gov/publications/docs/hcfac/FY2017-hcfac.pdf [https://perma.cc/BU6W-3WYG] (presenting examples of health care frauds).

4. *See generally* SILVER & HYMAN, *supra* note 1 (providing examples of billing-related misconduct, including up-coding, absurd prices, and charging for services that were not delivered).

decline as well, as consumers demand evidence of efficacy before spending their own money.

Although consumer-driven health care purchasing will transform the health care sector for the better, the possibility of converting Medicare and Medicaid into cash transfer programs has not been seriously considered. The idea certainly is not on Congress's radar.[5] Many people cannot imagine purchasing health care services themselves—either because they believe they cannot afford them or because they worry that providers may take advantage of them.[6] Others believe that bargaining over prices would sully their relationships with providers, who are supposed to focus on patients' well-being, not the revenues they generate by delivering treatments.[7] Some are concerned that health care is too complex for patients to make good purchasing decisions.[8] If we want the conversion of Medicare and Medicaid into cash transfer programs to be successful, policymakers must proactively address these beliefs.

Providers will vehemently oppose our proposal because Medicare and Medicaid are their cash-cows.[9] They do not want consumers to have the freedom to purchase anything other than health care with the dollars that fund these programs.[10] They will not want to forsake the myriad opportunities

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5. Dylan Matthews, *Congress Quietly Passed a Budget Outline with $1.8 Trillion in Health Care Cuts*, VOX (Oct. 26, 2017), https://www.vox.com/policy-and-politics/2017/10/26/16526458/2018-senate-budget-explained [https://perma.cc/G8YY-S9ZA] (listing various budgetary proposals for reforming Medicare and Medicaid, none of which were based on a cash-transfer strategy).

6. Bianca DiJulio et al., *Data Note: Americans' Challenges with Health Care Costs*, KAISER FAM. FOUND. (Mar. 2, 2017), https://www.kff.org/health-costs/poll-finding/data-note-americans-challenges-with-health-care-costs/ [https://perma.cc/4FBB-YBFD] ("Four in ten (43 percent) adults with health insurance say they have difficulty affording their deductible, and roughly a third say they have trouble affording their premiums and other cost sharing. . . . Three in ten (29 percent) Americans report problems paying medical bills. . . . Even for those who may not have had difficulty affording care or paying medical bills, there is still a widespread worry about being able to afford needed health care services.").

7. *See* Walecia Konrad, *A Talk with the Doctor May Help Patients Afford Care*, N.Y. TIMES (Jan. 7, 2011), https://www.nytimes.com/2011/01/08/health/policy/08patient.html [https://perma.cc/PV5H-6GBA] (providing advice to patients who wish to discuss pricing with their doctors).

8. *See, e.g.*, Austin Frakt, *Shopping for Health Care Doesn't Work. So What Might?*, N.Y. TIMES, (July 30, 2018), https://www.nytimes.com/2018/07/30/upshot/shopping-for-health-care-simply-doesnt-work-so-what-might.html [https://perma.cc/6CJN-34R7].

9. *See NHE Fact Sheet*, CTRS. FOR MEDICARE & MEDICAID SERV., https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html [https://perma.cc/3XA3-U2NB] (last updated Feb. 26, 2019) (reporting the high amount of Medicare and Medicaid spending in 2017).

10. For example, nursing home providers have long opposed reforms that would give beneficiaries greater freedom of choice. *See* Kaiser Health News, *AARP: States Lag in Keeping Medicaid Enrollees Out of Nursing Homes*, U.S. NEWS (June 14, 2017), https://www.usnews.com/news/healthcare-of-tomorrow/articles/2017-06-14/aarp-states-lag-in-keeping-medicaid-enrollees-out-of-nursing-homes [https://perma.cc/4X8P-FP4T] (attributing to Trish Riley, executive director of the National Academy for State Health Policy, the view that "states face several obstacles to expand home- and community-based options," including "a strong nursing home lobby that does not want to give up its Medicaid dollars.").

More broadly, providers have historically opposed competition-oriented reforms like the one we propose. *See, e.g.*, Jon Hawley, *Hospitals Oppose 'Need' Law's Repeal*, DAILYADVANCE.COM (May 15,

that currently exist to extract money from the government by employing crafty billing strategies and playing other games.[11] Providers also know that comprehensive third-party payment encourages consumption by making medical treatments inexpensive or even free at the point of delivery.[12] If patients had to cover the full cost of office visits instead of twenty or thirty dollar co-pays, they would see doctors less often and doctors' incomes would shrink.[13]

A sustained educational effort will be needed to overcome these obstacles. The vast majority of Americans who are alive today grew up believing that someone else is supposed to foot their medical bills.[14] They have never known a world without comprehensive private insurance, Medicaid, and Medicare. They have grown so accustomed to the Patient Protection and Affordable Care Act (ACA) that Republican efforts to repeal the (relatively unpopular) legislation went down

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2017), http://www.dailyadvance.com/News/2017/05/15/Hospitals-oppose-need-law-s-repeal.html [https://perma.cc/59DW-3UVB]; Lisa Schencker, *State Certificate-of-need Laws Weather Persistent Attacks*, MODERN HEALTHCARE (Jan. 23, 2016), https://www.modernhealthcare.com/article/20160123/MAGAZINE/301239964/state-certificate-of-need-laws-weather-persistent-attacks [https://perma.cc/P9L8-EUPP]. Instead, providers prefer to operate as they see fit rather than be forced by competition to adopt more customer-friendly business models.

11. For a discussion of organized medicine's opposition to a proposal that would have reduced the level of gaming by subjecting bills to prepayment audits, see SILVER & HYMAN, *supra* note 1, at 146–47.

12. *See* U.S. DEP'T OF HEALTH & HUM. SERVS. ET AL., REFORMING AMERICA'S HEALTHCARE SYSTEM THROUGH CHOICE AND COMPETITION 3 (2018), https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/reforming-americas-healthcare-system-through-choice-and-competition.pdf [https://perma.cc/X9U7-GV89] ("Our health care system's excessive reliance on third-party payment insulates consumers from the true price of health care and offers them little incentive to search for low-cost, high-quality care.").

13. Organized medicine regularly opposes reforms that would reduce the amount of insurance coverage available to pay for procedures. *See, e.g.*, *AMA Urges Congress to Oppose Amended Heath Care Reform Bill*, AM. MED. ASS'N (Apr. 27, 2017), https://www.ama-assn.org/press-center/press-releases/ama-urges-congress-oppose-amended-health-care-reform-bill [https://perma.cc/69QF-S5PC] (outlining a press release in which the AMA opposed the American Health Care Act on the ground that the bill did "not offer a clear long-term framework for stabilizing and strengthening the individual health insurance market"). The AMA also endorsed insurance coverage for annual mammograms for women in their forties even though the U.S Preventive Services Task Force (USPSTF) found that the scans harmed these women by producing false-positive results that led to unnecessary biopsies. *See AMA Updates Mammogram Policy, Says Screening Should Start at 40*, BREASTCANCER.ORG (June 21, 2012), https://www.breastcancer.org/research-news/20120621 [https://perma.cc/KJ6R-TEFW]; *see also Final Recommendation Statement Breast Cancer: Screening*, U.S. PREVENTIVE SERVS. TASK FORCE, https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/breast-cancer-screening1 [https://perma.cc/R6HX-8TFH] (last updated Jan. 2016). Similarly, urologists complained when the USPSTF gave PSA tests a low grade because that meant the tests would no longer be covered by the Affordable Care Act. *See* Paul Hsieh, *How Will ObamaCare Affect Prostate Cancer Screening?*, KEVINMD.COM (July 11, 2012), https://www.kevinmd.com/blog/2012/07/obamacare-affect-prostate-cancer-screening.html [https://perma.cc/45HE-3QZ3].

14. *See* Michael Roizen, *What are the Origins of Health Insurance?*, SHARECARE, https://www.sharecare.com/health/health-insurance/origins-of-health-insurance [https://perma.cc/4EAR-CNBB] (last visited Mar. 30, 2019).

to ignominious defeat.[15] It is no wonder ordinary Americans worry about losing their health insurance and having to fend for themselves.

These fears are understandable, but they are misplaced. Social Security is a familiar and successful program that has helped millions of people meet important needs while leaving them free to purchase the goods and services they want. The EITC and CTC are less visible, but they have had a similar impact on the working poor and moderate-income families. When Medicaid and Medicare operate the same way as Social Security, the EITC, and the CTC, people will quickly become accustomed to handling their own health care needs. They may even come to wonder why they ever let the government and providers make their choices for them.

Section I makes the case for reforming Medicare and Medicaid by showing that in-kind benefits often serve beneficiaries poorly. It also shows that the connection between third-party coverage and health is surprisingly weak.[16] Good health is the product of many factors, including housing, nutrition, education, and lifestyle choices.[17] Consequently, the value of access to medical treatments is more limited than is widely believed.[18] Section II focuses on the connection between cash transfers and health. Because factors other than medical treatments influence health, recipients can use cash to purchase goods and services that deliver more valuable benefits than medical treatments. Section III considers other advantages and disadvantages of changing Medicaid and Medicare into cash transfer programs and addresses several practical concerns, such as the fear that many recipients will squander their money and that people will be unable to pay for services they need in emergencies. Section IV addresses a few additional objections to converting Medicare and Medicaid into cash transfer programs and shows how our reform will free both programs from the many dysfunctions and pathologies that beset them.

## I. IMPACT OF MEDICAID AND SIMILAR PROGRAMS ON HEALTH

Medicaid enables impoverished Americans to obtain medical treatments they cannot purchase on their own.[19] The decision to create and maintain the program

15. *See* Rachel Roubein, *Timeline: The GOP's Failed Effort to Repeal ObamaCare*, THE HILL (Sept. 26, 2017), https://thehill.com/policy/healthcare/other/352587-timeline-the-gop-effort-to-repeal-and-replace-obamacare [https://perma.cc/Z26S-F8DK].

16. *See infra* Part II; *see also* Robin Hanson, *Cut Medicine in Half*, CATO UNBOUND (Sept. 10, 2007), https://www.cato-unbound.org/2007/09/10/robin-hanson/cut-medicine-half [https://perma.cc/E69G-ET7H] (noting the weakness of the connection between insurance coverage and health).

17. *See* Adam Felman, *Health: What Does Good Health Really Mean?*, MED. NEWS TODAY, https://www.medicalnewstoday.com/articles/150999.php [https://perma.cc/GPC2-YXPH] (last updated July 31, 2017).

18. *See* Mary Ann E. Zagaria, *Access to Health Care: Influential Factors and Cultural Competence*, U.S. PHARMACIST (Sept. 18, 2013), https://www.uspharmacist.com/article/access-to-health-care-influential-factors-and-cultural-competence-43073 [https://perma.cc/L528-VKJ4].

19. *Medicaid*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/index.html [https://perma.cc/M6ZW-XF7M] (last visited Mar. 30, 2019).

reflects a collective belief that poor people suffer from unmet medical needs and will enjoy better health when their access to providers is improved.[20]

Unfortunately, Medicaid's health-improving effects have been remarkably difficult to document. 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.[21] Although members of the recipient group reported improved mental health, "[t]he findings related to impacts on physical health were mixed."[22] The main positive effects were "increased . . . detection of diabetes and use of diabetes medication."[23] The observed improvement in mental health was likely due to the insulation from financial insecurity that Medicaid provides.[24] It should go without saying that cash transfers also alleviate financial insecurity.[25]

Studies of the ACA's Medicaid expansion 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 were improvements in self-reported mental health and general health.[26] Documented improvements in beneficiaries' physical health were few and far between.[27] One important reason for the paucity of such findings is that "health status is a function of social, behavioral, environmental, genetic, and medical factors."[28] The Medicaid expansion addressed access to health care only—rather than these other factors.

Other scholars agree that "direct evidence that Medicaid or any other type of health coverage improves not just access to care, but also health outcomes, is

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20. *See* Judith D. Moore & David G. Smith, *Legislating Medicaid: Considering Medicaid and Its Origins*, 27 HEALTH CARE FIN. REV. 45, 47 (2005–2006).

21. Julia Paradise, *Data Note: Three Findings About Access to Care and Health Outcomes in Medicaid*, KAISER FAM. FOUND. (Mar. 23, 2017), https://www.kff.org/medicaid/issue-brief/data-note-three-findings-about-access-to-care-and-health-outcomes-in-medicaid/. [https://perma.cc/NRU4-44H9]; *see also The Oregon Health Insurance Experiment*, NAT'L BUREAU ECON. RES., https://www.nber.org/oregon/1.home.html [https://perma.cc/U8H9-CR34] (last visited Nov. 12, 2019) (providing further information regarding the Oregon Health Insurance Experiment).

22. *Id*.

23. *Id*.

24. *See* Thomas Richardson et al., *The Relationship Between Personal Unsecured Debt and Mental and Physical Health: A Systematic Review and Meta-analysis*, 33 CLINICAL PSYCHOL. REV. 1148, 1154 (2013).

25. *See id*. at 1151.

26. Olena Mazurenko et al., *The Effects Of Medicaid Expansion Under The ACA: A Systematic Review*, 37 HEALTH AFF. 944, 947–48 (2018).

27. *Id*. at 950 (The main documented effects of Medicaid eligibility on physical health are reductions in infant and child mortality, and longer-term improvements in health and welfare attributable to medical treatments received during childhood.). *But see* Larisa Antonisse et al., *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review*, KAISER FAM. FOUND. (Aug. 15, 2019), https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-august-2019/ [https://perma.cc/9QVL-QMCQ] (arguing that "[a] growing body of research has found an association between Medicaid expansion and improvements in certain measures of health outcomes.").

28. Mazurenko, *supra* note 26, at 949.

limited" because health outcomes are determined by a large number of variables, from genetic factors to social supports, environmental processes, and individual behavioral choices.[29] A recent report observes that "[m]edical care determines only 20% of overall health while social, economic and environmental factors determine 50% of overall health."[30] This means that investments in health care are unlikely to result in dramatic improvements in health,[31] because the major determinants of health are social factors such as poverty, food insecurity, and substandard housing.[32]

There are also other challenges with interpreting studies of the impact of Medicaid on population health. Most studies lack control groups, making it impossible to evaluate causation.[33] Crowd-out, which occurs when Medicaid pays for treatments that beneficiaries would have received even without the program, is another complication.[34] For example, federal law forbids hospitals that receive Medicare from turning away patients with emergency medical conditions.[35] Medicare also pays hospitals billions of dollars every year to cover some

29. Paradise, *supra* note 21.

30. LexisNexis Network, *Social Determinants of Health: Turning Potential into Actual Value*, YOUTUBE (Apr. 23, 2018), https://www.youtube.com/watch?v=Z2r0Bxui1z8 [https://perma.cc/YF25-7ZHU], at 5:40; *see* Steven A. Schroeder, *We Can Do Better-Improving the Health of the American People*, 357 NEW ENGL. J. MED. 1221, 1221 (2007) (observing that "the pathways to better health do not generally depend on better health care" and reporting that social and environmental factors and individual behaviors matter far more).

31. *See* Robert M. Kaplan, *Medicine Alone Can't Lengthen US Lives. We Need to Invest Outside the Health Care System*, USA TODAY (Feb. 5, 2019), https://www.usatoday.com/story/opinion/2019/02/04/declining-life-expectancy-invest-medicine-education-social-workers-research-column/2726102002/ [https://perma.cc/82EA-BGMT].

32. *Id.*; *see also* Samantha Artiga & Elizabeth Hinton, *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity*, KAISER FAM. FOUND. (May 10, 2018), https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/ [https://perma.cc/L5Q6-2D9A] ("Though health care is essential to health, it is a relatively weak health determinant."); J. Michael McGinnis et. al., *The Case for More Active Policy Attention to Health Promotion*, 21 HEALTH AFF. 79, 79 (2002) ("The fact that medical care historically has had limited impact on the health of populations has been known for many years.").

33. *See* Julia Paradise & Rachel Garfield, *What is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care? Setting the Record Straight on the Evidence*, KAISER FAM. FOUND. (Aug. 2, 2013), https://www.kff.org/report-section/what-is-medicaids-impact-on-access-to-care-health-outcomes-and-quality-of-care-setting-the-record-straight-on-the-evidence-issue-brief/. [https://perma.cc/R3Z5-7UKM] (noting that researchers typically attempt to adjust for differences between Medicaid beneficiaries and the general population, but only the Oregon Health Insurance Experiment (OHIE) is based on a randomized controlled trial – "the gold standard in research design."); *see also* Manatt, Phelps, & Phillips, LLP, *Medicaid's Impact on Health Care Access, Outcomes and State Economies*, ROBERT WOOD JOHNSON FOUND. (Feb. 1, 2019), https://www.rwjf.org/en/library/research/2019/02/medicaid-s-impact-on-health-care-access-outcomes-and-state-economies.html [https://perma.cc/3C5X-H7R4] (noting in passing that only the OHIE has a "control group.")

34. *See* Richard Kronick & Todd Gilmer, *Insuring Low-Income Adults: Does Public Coverage Crowd Out Private?*, 21 HEALTH AFF. 225, 225 (2002).

35. David A. Hyman & David M. Studdert, *Emergency Medical Treatment and Labor Act: What Every Physician Should Know About the Federal Antidumping Law*, 147 CHEST 1691, 1691, 1693 (2015); *see also* Emergency Medical Treatment & Labor Act (EMTALA), CTRS. FOR MEDICARE & MEDICAID SERVS. (Mar. 26, 2012), https://www.cms.gov/regulations-and-guidance/legislation/emtala/ [https://perma.cc/FE28-9YDW].

of the costs of uncompensated care.[36] It is not an accident that hospitals are enthusiastic supporters of Medicaid expansion,[37] because Medicaid mainly improves hospitals' finances by providing an additional payment source for impecunious patients who would have been treated anyway.[38] It is also not surprising that one of the main arguments one hears for Medicaid expansion is that it will relieve struggling hospitals of the burden of charity care.[39]

Medicaid is also unlikely to improve population health because lots of Medicaid's budget is spent on things that are unlikely to generate quantifiable health improvements.[40] For example, a substantial fraction of Medicaid's budget is used to house, feed, and care for poor elderly beneficiaries: "Medicaid pays nearly half of nursing home costs for those who need assistance because of medical conditions like Alzheimer's or stroke. In some states, overall spending on older and disabled adults amounts to as much as three-quarters of Medicaid spending."[41] The services that nursing homes and other businesses provide for people who are elderly or disabled are certainly valuable, but their impact on health, longevity, and mortality is likely small and hard to assess.[42]

Similar difficulties beset efforts to measure the impact of Medicare on health. Because all Americans over the age of sixty-five are eligible for the program, there is no control group.[43] Crowd-out is a serious problem too. Finkelstein and McKnight studied the health impacts of Medicare, and were:

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36. *See Hospital Uncompensated Care:* Federal Action Needed to Better Align Payments with Costs, GAO-16-568 (Jun. 30, 2016), https://www.gao.gov/products/GAO-16-568.

37. Michael Ollove, *Hospitals Lobby Hard for Medicaid Expansion*, PEW STATELINE, (Apr. 17, 2013) https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2013/04/17/hospitals-lobby-hard-for-medicaid-expansion [https://perma.cc/2942-QX2B].

38. *See id*.

39. *See* Matt Broaddus, *Affordable Care Act's Medicaid Expansion Benefits Hospitals, Particularly in Rural America*, CTR. ON BUDGET & POL'Y PRIORITIES (June 23, 2017), https://www.cbpp.org/research/health/affordable-care-acts-medicaid-expansion-benefits-hospitals-particularly-in-rural [https://perma.cc/99MK-WLRQ].

40. *See* Jessica Greene & Ellen Peters, *Medicaid Consumers and Informed Decisionmaking*, 30 HEALTHCARE FIN. REV. 25, 25 (2009) (identifying several ways in which Medicaid dollars can be used more efficiently).

41. David Grabowski et al., *You're Probably Going to Need Medicaid*, N.Y. TIMES (June 13, 2017), https://www.nytimes.com/2017/06/13/opinion/youre-probably-going-to-need-medicaid.html [https://perma.cc/J6CR-CP7K].

42. The manner of calculating Quality-Adjusted Life Years (QALYs), a common way of assessing returns on health expenditures, incorporates both the quality of life and the number of years a recipient is expected to live. Because older persons tend to have shorter expected future lifespans than younger persons and to enjoy lower quality of life per year remaining, assessments based on QALYs often favor directing resources toward younger persons. *See generally* Peter J. Neumann & Joshua T. Cohen, *QALYs in 2018—Advantages and Concerns*, JAMA (June 26, 2018), https://jamanetwork.com/journals/jama/fullarticle/2682917 [https://perma.cc/MFN5-RNAF].

43. *Medicaid*, *supra* note 19. In fairness, several studies have compared the health status and medical utilization of seniors immediately before and after they qualify for Medicare. This "regression discontinuity" design offers a quasi-experimental approach with which to evaluate the "average treatment effect" of being covered by Medicare.

> unable to reject the null hypothesis that, in its first 10 years, Medicare had no effect on elderly mortality. . . . [P]art of the explanation for this finding 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.[44]

Finkelstein and McKnight did find that Medicare reduced seniors' out-of-pocket expenses and that "the welfare gains associated with this change in risk bearing . . . may [have been] sufficient to cover almost two-fifths of the social cost of Medicare."[45] Financial assistance in the form of direct cash transfers would have had this effect as well, but would almost certainly have had a higher dollar-for-dollar impact on patient well-being.[46]

Weathers and Stegman conducted one of the few controlled studies of the health- and mortality-related impacts of expanded access to insurance.[47] They studied previously uninsured applicants for Social Security Disability Insurance who were randomly assigned to three groups, one of which, the control group, was excluded from coverage, while the other two received packages that differed in richness.[48] They found evidence of improvements in mental health but no statistically significant reduction in mortality.[49] Surprisingly, the control group had a lower mortality rate than the treatment groups, a finding the researchers attributed to a chance difference in the frequency of neoplasms.[50]

Weathers and Stegman's findings indicate that there is at best a weak correlation between health and all forms of coverage (i.e., not just Medicare and Medicaid). A recent study that matched insured and uninsured persons initially aged fifty to sixty-one similarly found little evidence that the insured have lower mortality or improved health, in either the short or long run.[51] After controlling for initial health and other covariates, the uninsured did not die faster than the

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44. Amy Finkelstein & Robin McKnight, *What Did Medicare Do? The Initial Impact of Medicare on Mortality and Out of Pocket Medical Spending*, 92 J. PUB. ECONS. 1644, 1645 (2008).

45. *Id*.

46. *See* Mark V. Pauly, *Valuing Health Care in Money Terms*, *in* VALUING HEALTH CARE 99, 117 (Frank A. Sloan ed., 1995) ("If we want to provide benefit to low-income people, a more efficient approach would be to use the money that would have been spent on the program to make a direct money transfer to them, since the money will benefit low-income people more than the program would."); Lester C. Thurow, *Cash Versus In-Kind Transfers*, 64 AM. ECON. REV. 190, 195 (1974) ("while it is not axiomatically true that cash transfers always dominate restricted transfers, the general economic case for cash transfers is strong enough that the burden of proof should always lie on those who advocate restricted transfers."); *see also* Janet Currie & Firouz Gahvari, *Transfers in Cash and In-Kind: Theory Meets the Data*, 46 J. ECON. LITERATURE 333 (2008).

47. Robert R. Weathers II & Michelle Stegman, *The Effect of Expanding Access to Health Insurance On the Health and Mortality of Social Security Disability Insurance Beneficiaries*, 31 J. HEALTH ECONS. 863, 863 (2012).

48. *Id*. at 864–65.

49. *Id*. at 864, 873.

50. *Id*. at 866–67.

51. Bernard Black et al., *The Long-term Effect of Health Insurance on Near-Elderly Health and Mortality*, 3 AM. J. HEALTH ECONS. 281, 281 (2017).

insured.[52] Nor did the uninsured become less healthy over time across an array of measures.[53] The researchers were able to evaluate long-term effects because the data set assessed the subjects for twenty years.[54] When interpreting these findings, it is important to understand that many uninsured individuals receive some health care—so the study was measuring the marginal effect of insurance on health. The study's authors note that this means that "[m]uch of the additional care the [uninsured] would receive if insured could provide limited marginal benefit."[55]

Is it really possible that much of the additional care received by insured patients does relatively little to improve health and reduce mortality?[56] This may seem more plausible once one considers that intensive medical treatments—the type of treatments that third-party payers are uniquely suited to fund—tend to be delivered at disproportionate rates in the last few months of life.[57]

> Average monthly health care expenditures start to increase about [24] months before death, and increase faster in the last 6 months of life up through the last (potentially partial) calendar month of life []. This finding has been documented repeatedly in the empirical literature []. One reason for this finding is that the monthly mortality rate also rises steadily with age[]. Therefore, because people are more likely to die as they get older and because people spend more when they are close to death, aging per se is not the only reason for higher total health care expenditures for the elderly population. Instead, health care expenditures are higher on average at higher ages because a greater fraction of the population is in their last year of life.[58]

Stated more simply, "elderly persons use much more health care in the last year of life—no matter at what age they die. Closeness to death is the most important reason for higher inpatient expenditures."[59] Given the strong connection between health care consumption and proximity to death, the finding that insurance has relatively little effect on health or mortality should be less surprising.

So where does that leave us? Most of the coverage gains from the enactment of the ACA came from the Medicaid expansion. But the fixation on expanding health-insurance coverage that motivated this structure is problematic because, as we have already described, Medicaid does not seem to do all that much to reduce mortality or improve health.[60]

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52. *Id*.
53. *Id*.
54. *Id*.
55. *Id*. at 302.
56. We leave for another day the important question of whether there are material differences between being covered by commercial insurance and Medicaid, compared to being uninsured.
57. Zhou Yang et al., *Longevity and Health Care Expenditures: The Real Reasons Older People Spend More*, 58 J. GERONTOLOGY 2, 5 (2003).
58. *Id*.
59. *Id*. at 10.
60. Katherine Baicker et al., *The Oregon Experiment—Effects of Medicaid on Clinical Outcomes*, 368 NEW ENG. J. MED. 1713, 1713 (2013); *see also* Avik Roy, *Oregon Study: Medicaid 'Had No*

## II. THE IMPACT OF POVERTY ON HEALTH

Even if the connection between coverage and health were stronger than it seems to be, a discussion of the relative merits of in-kind services versus cash transfers would not end there. Cash transfers also improve health and well-being.[61] They do so in a wide variety of ways, such as by reducing financial insecurity, which enables people to improve their nutrition, live in better houses, and drive safer cars, and by helping them educate their children and themselves.[62] To assess the relative merits of in-kind benefits versus cash transfers, one must compare all the consequences of cash transfers with all the consequences of medical treatments.

Unfortunately, no study makes this comparison. But it is clear that being economically disadvantaged is bad for one's health.[63] In 2018 alone, reports showed that food insecurity is a significant problem for Medicaid recipients;[64] that low income explains the racial disparity in post-heart attack survival rates better than race does;[65] that loss of food stamps (SNAP) is associated with poor health;[66] and that "adolescents from low-income families are more likely than their affluent peers to have risk factors for cardiovascular disease like obesity, inactivity, poor

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*Significant Effect' On Health Outcomes vs. Being Uninsured*, FORBES (May 2, 2013), https://www.forbes.com/sites/theapothecary/2013/05/02/oregon-study-medicaid-had-no-significant-effect-on-health-outcomes-vs-being-uninsured/#20c5d07c6043 [https://perma.cc/W7NN-DVCK] (citing The Oregon Experiment).

61. Adriana Kugler, *Can Conditional Cash Transfers Break the Cycle of Poverty?*, ECONOFACT (Sept. 24, 2018), https://econofact.org/can-conditional-cash-transfers-break-the-cycle-of-poverty [https://perma.cc/U5NV-TCW9].

62. *Id.* (reporting that conditional cast transfer programs "increase the ability to provide for families with children while also improving their chances to raise the children's educational attainment"); *see also* Natasha Pilkauskas & Katherine Michelmore, *The Effect of Income on Housing Instability and Living Arrangements: Evidence from the Earned Income Tax Credit* 22, 27 (Poverty Solutions, U. Mich. Working Paper Series No. 1-17, 2018), https://poverty.umich.edu/files/2018/09/Pilkauskas_Michelmore_EITC_Housing_Sept2018.pdf [https://perma.cc/RUL5-KDFT] (detailing that cash transfers can reduce household crowding); FOOD. RES. & ACTION CTR., THE ROLE OF THE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM IN IMPROVING HEALTH AND WELL-BEING (2017), https://frac.org/wp-content/uploads/hunger-health-role-snap-improving-health-well-being.pdf [https://perma.cc/GAK9-TXZD] (detailing how poverty and poor nutrition are directly linked); Diane Whitmore Schanzenbach & Betsy Thorn, *Food Support Programs And Their Impacts On Very Young Children*, HEALTH AFF. (Mar. 28, 2019), https://www.healthaffairs.org/do/10.1377/hpb20190301.863688/full/ [https://perma.cc/NA2K-Y7Z].

63. Dhruv Khullar & Dave A. Chokshi, *Health, Income, and Poverty: Where We Are and What Could Help*, HEALTH AFF. (Oct. 4, 2018), https://www.healthaffairs.org/do/10.1377/hpb20180817.901935/full/ [https://perma.cc/UB95-ZAZT].

64. Thomas Beaton, *Medicaid Beneficiaries Face Significant Food Insecurity Challenges*, HEALTH PAYER INTELLIGENCE (Oct. 15, 2018), https://healthpayerintelligence.com/news/medicaid-beneficiaries-face-significant-food-insecurity-challenges [https://perma.cc/AK2D-JAQK].

65. Elizabeth Cooney, *Low Incomes Explains Poorer Survival After A Heart Attack More Than Race, Study Finds*, STAT (Nov. 2, 2018), https://www.statnews.com/2018/11/02/low-income-race-heart-attack/ [https://perma.cc/H2LF-5DW7].

66. Stephanie Ettinger de Cuba et al., *Loss of SNAP is Associated with Food Insecurity and Poor Health in Working Families with Young Children*, 38 HEALTH AFF. 765 (2019) https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.05265 [https://perma.cc/GD7E-MAHM].

nutrition and tobacco use."[67] These findings (and many more) indicate the importance of the social determinants of health (SDOH).[68]

The leading peer-reviewed research on the SDOH is listed on a webpage maintained by the United States Centers for Disease Control and Prevention (CDC).[69] One study found that children whose families received housing assistance had lower levels of lead in their blood than comparable children whose families did not receive housing assistance.[70] Another study found that food insecurity increased the likelihood that adults suffering from chronic kidney disease would develop end-stage renal disease.[71] A third study reported that "social and economic factors have the strongest association with rates of avoidable death from [cardiovascular disease]."[72] A fourth study found that very young children suffered reduced rates of abusive head trauma in states with refundable earned income tax credits.[73] As these studies reflect, income contributes to better health in a wide variety of important ways. For these reasons, wealth transfers that alleviate poverty and facilitate investments in the social determinants of health seem likely to improve population and individual health more than equivalent expenditures on medical treatments.[74]

Some of the connections between economic status and health are direct and immediate. For example, the Earned Income Tax Credit and the Child Tax Credit have been found to improve health, especially among women and children.[75]

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67. Lisa Rapaport, *Poverty Tied to Worse Heart Health Among U.S. Teens*, REUTERS (Oct. 17, 2018), https://www.reuters.com/article/us-health-teens-cardio/poverty-tied-to-worse-heart-health-among-u-s-teens-idUSKCN1MR2M4 [https://perma.cc/FD9X-FXKY].

68. *CDC Research On SDOH*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/socialdeterminants/economic-stability/index.htm [https://perma.cc/AA9B-N7AM] (last reviewed Dec. 14, 2017) (listing compiled literature including publications on economic stability and social determinants of health).

69. *Id.*

70. Katherine A. Ahrens et al., *Housing Assistance and Blood Lead Levels: Children in the United States, 2005–2012*, 106 AM. J. PUB. HEALTH 2049, 2056 (2016).

71. Tanushree Banerjee et al., *Food Insecurity, CKD, and Subsequent ESRD in US Adults*, 70 AM. J. KIDNEY DISEASE 1, 2 (2017).

72. Sophia Greer et al., *Health Factors Associated with Avoidable Deaths from Cardiovascular Disease in the United States, 2006-2010*, 131 PUB. HEALTH REP. 438, 438 (2016).

73. Joanne Klevens et al., *Effect of the Earned Income Tax Credit on Hospital Admissions for Pediatric Abusive Head Trauma, 1995-2013*, 132 PUB. HEALTH REP. 505, 505 (2017).

74. The expectation that investments in SDOHs will improve health underlies several recent initiatives to allow Medicaid programs to pay for housing, food, and education. *See* Samantha Artiga & Elizabeth Hinton, *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity*, KAISER FAM. FOUND. 4–6 (May 2018), http://files.kff.org/attachment/issue-brief-beyond-health-care [https://perma.cc/2A8J-FXC7].

75. William N. Evans & Craig L. Garthwaite, *Giving Mom a Break: The Impact of Higher EITC Payments on Maternal Health*, 6 AM. ECON. J. 258, 286 (2014) (noting that "expansion of the EITC decreased the number of reported bad mental health days for mothers with a high school degree or lower and with two or more children compared to a similar woman with only one child. Suggestive evidence was also found that the increase in [EITC] payments increased the probability of reporting excellent or very good health status. [Strong evidence was also found] that the expansion of the EITC lowered the counts of the total number of risky biomarkers for women with two or more children and a high school degree or less compared to similar women with only one child."); *see also* David Simon et al.,

They also improve infants' health by reducing the incidence of low birth weight and increasing the mean birth weight—effects that will have long-term benefits.[76] Other effects are more roundabout. For example, the EITC may enhance children's long-term earning power, and thereby their health, by improving their scores on academic tests.[77] The EITC also increases mothers' incomes by encouraging them to participate in the workforce, leading to higher wage growth and larger Social Security retirement benefits.[78] EITC transfers also improve recipients' housing by reducing crowding and enabling them to move to better neighborhoods.[79] The EITC also means that housing consumes a smaller fraction of total income—freeing up resources for spending on other things and reducing the overall pressure on recipient's finances (i.e., being "one paycheck away from homelessness"[80]).

Healthy People 2020 is a federal initiative aimed at improving the health of all Americans through science-based 10-year national objectives.[81] The Healthy People 2020 website notes that "[h]ealth starts in our homes, schools, workplaces, neighborhoods, and communities" and groups the SODH under five headings: Economic Stability, Education, Social and Community Context, Health and Health Care, and Neighborhood and Built Environment.[82] The Healthy People

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*The Earned Income Tax Credit, Poverty, and Health*, HEALTH AFF. 1 (Oct. 4, 2018), https://www.healthaffairs.org/do/10.1377/hpb20180817.769687/full/ [https://perma.cc/439T-SRKD] (reporting on a growing body of studies finding that the EITC improves health for single mothers and children).

76. Hilary Hoynes et al., *Income, the Earned Income Tax Credit, and Infant Health*, 7 AM. ECON. J. 172, 172 (2015) (finding "that the EITC reduces the incidence of low birth weight and increases mean birth weight").

77. Raj Chetty et al., *New Evidence on the Long-Term Impacts of Tax Credits*, 104TH ANN. CONF. ON TAX'N 116, 122 (2011), https://www.ntanet.org/wp-content/uploads/proceedings/2011/018-chetty-new-evidence-longterm-2011-nta-proceedings.pdf [https://perma.cc/C8AM-UWYA] (suggesting that tax credits to families with young children generate significant lifetime earnings gains by improving students' test scores); *see also Social Determinants of Health: Know What Affects Health*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/socialdeterminants/index.htm [https://perma.cc/7D2L-J6GH] (last reviewed Jan. 29, 2018) (explaining that poverty affects overall health).

78. Chuck Marr et al., *EITC and Child Tax Credit Promote Work, Reduce Poverty, and Support Children's Development, Research Finds*, CTR. ON BUDGET & POL'Y PRIORITIES 1 (Oct. 1, 2015), https://www.cbpp.org/research/federal-tax/eitc-and-child-tax-credit-promote-work-reduce-poverty-and-support-childrens#_ftnref3 [https://perma.cc/2Y4Z-R3RF] (explaining that EITC was one of the most important factors in explaining why female family heads increased their employment over 1993–1999, which had a larger effect in increasing employment among single mothers than the 1996 welfare law and that because the EITC boosted employment earnings, it also increased Social Security retirement benefits).

79. Pilkauskas & Michelmore, *supra* note 62, at 22–23, 27.

80. *Id*. at 25.

81. *About Healthy People*, HEALTHYPEOPLE.GOV, https://www.healthypeople.gov/2020/About-Healthy-People [https://perma.cc/R73Z-P7NR] (last visited Aug. 8, 2019).

82. *Social Determinants of Health: Overview*, HEALTHYPEOPLE.GOV, https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health [https://perma.cc/EL9Z-8JD8] (last visited May 13, 2019).

2020 website lists an enormous number of readings in each of these five areas.[83] Its recommendations also cover the waterfront of the SODH.[84]

The recognition that health and well-being depend primarily on factors other than medical treatments poses a challenge for Americans who are accustomed to thinking about poverty relief programs in siloed ways. 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 ordinances 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.[85] 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.

## III. THE IMPACT OF SOCIAL WELFARE PROGRAMS ON POVERTY

Social Security is our nation's largest social welfare program.[86] In 2018, the program doled out approximately $988 billion to nearly sixty-three million beneficiaries.[87] But unlike Medicaid and Medicare, Social Security does not pay for

83. *Social Determinants of Health: Interventions & Resources*, HEALTHYPEOPLE.GOV, https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources [https://perma.cc/CB9M-XGRF] (last visited May 13, 2019).

84. *Social Determinants of Health: Objectives*, HEALTHYPEOPLE.GOV, https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health/objectives [https://perma.cc/HQ6G-TAVA] (last visited May 13, 2019).

85. Khullar & Chokshi, *supra* note 63 (demonstrating that low-income negatively impacts an individual's overall health); *see also Social Determinants of Health*, MENTAL HEALTH AM., http://www.mentalhealthamerica.net/conditions/social-determinants-health [https://perma.cc/D6WA-XRU9] (last visited Feb. 27, 2019) ("In the United States the data consistently show that people living in poverty, and particularly those who are minorities, bear a disproportionate burden of exposure to unhealthy environments and are at greater risk for mental and behavioral health-related conditions."); Paul Prettitore, *Future Development: Does Legal Aid Reduce Poverty?*, BROOKINGS INST. (June 23, 2015), https://www.brookings.edu/blog/future-development/2015/06/23/does-legal-aid-reduce-poverty/ [https://perma.cc/3KHF-8S2T] (detailing that families in the bottom half of expenditure distribution account for nearly 80% of reported legal problems related to family law, 68% of problems for civil law, and 65% of problems for criminal law).

86. *See, e.g.*, Terence P. Jeffrey, *Social Security Administration Spending Tops $1 Trillion for First Time*, CNS NEWS (Oct. 25, 2017), https://www.cnsnews.com/news/article/terence-p-jeffrey/social-security-administration-spending-tops-1-trillion-first-time [https://perma.cc/TL74-VPVX].

87. Christopher Chantrill, *Social Security*, U.S. GOV'T SPENDING, https://www.usgovernmentspending.com/social_security_spending_by_year [https://perma.cc/7TR9-PYY4] (last visited Mar. 9, 2019);

goods or services after they have already been delivered.[88] Instead, it gives cash to program beneficiaries and lets them decide what they want and how much they are willing to pay for it.[89]

Medicare and Medicaid rival Social Security in size.[90] In 2018, Medicare paid out $731 billion in benefits[91] on behalf of approximately forty-three million beneficiaries.[92] In 2017, combined federal and state spending on Medicaid was $553 billion, which covered over sixty-five million people.[93] There is some overlap between the beneficiary populations covered by these two programs, but about ninety-nine million Americans are covered by at least one of them.[94] By comparison, all other spending on other welfare programs equaled only about $350 billion—about one-fourth as much.[95]

By common consensus, Social Security is our country's most successful anti-poverty program.[96] The conventional wisdom, which is undoubtedly

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*see also Social Security Beneficiary Statistics*, SOC. SECURITY ADMIN., https://www.ssa.gov/oact/STATS/OASDIbenies.html [https://perma.cc/U7UQ-CSRU] (last visited Feb. 28, 2019) (explaining that social security benefits are divided between several categories of beneficiaries including those that are disabled (10.1 million), survivors (5.9 million), and retired workers (46.8 million)).

88. *What is the Difference Between Medicaid and Social Security?*, IND. LEGAL SERVS., https://www.indianalegalservices.org/node/119/what-difference-between-medicaid-and-social-security [https://perma.cc/SG9G-XZZ3] (last visited Feb. 28, 2019).

89. *Id.*

90. Jeffrey, *supra* note 86 ("[T]he only major spending category that absorbed more money than the Social Security Administration in the fiscal 2017 was the Department of Health and Human Services, which spent $1,116,764,000,000.").

91. Juliette Cubanski et al., *The Facts on Medicare Spending and Financing*, KAISER FAM. FOUND. (Aug. 20, 2019), https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/ [https://perma.cc/63KU-AR85]. *But see* Press Release, CTRS. FOR MEDICARE & MEDICAID SERVS., CMS Office of the Actuary Releases 2016 National Health Expenditures (Dec. 6, 2017), https://www.cms.gov/newsroom/press-releases/cms-office-actuary-releases-2016-national-health-expenditures [https://perma.cc/3LHB-GNRR] (reporting that Medicare spending was $672 billion in 2016).

92. *Health Insurance Coverage of the Total Population*, KAISER FAM. FOUND., https://www.kff.org/other/state-indicator/total-population/?dataView=1&currentTimeframe=0&selectedDistributions=medicaid-medicare&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D [https://perma.cc/BC5S-D5ZQ] (last visited Feb. 28, 2019).

93. Robin Rudowitz & Allison Valentine, *Medicaid Enrollment & Spending Growth: FY 2017 & 2018*, KAISER FAM. FOUND. (Oct. 19, 2017), https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-spending-growth-fy-2017-2018/ [https://perma.cc/NW8K-WA9V]. *But see* Press Release, *supra* note 91 (reporting that Medicaid spending was $565.5 billion in 2016); *Total Medicaid Spending*, KAISER FAM. FOUND., https://www.kff.org/medicaid/state-indicator/total-medicaid-spending/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D [https://perma.cc/KG7R-BFRM] (last visited Feb. 27, 2019) (reporting Medicaid spending of $576 billion in FY 2017).

94. There are approximately 9 million "dual eligible" Americans covered by both programs. *Dual Eligible*, KAISER FAM. FOUND., www.kff.org/tag/dual-eligible [https://perma.cc/8UMQ-R2BY]. Our math is simple: 43 million Medicare beneficiaries + 65 million Medicaid beneficiaries – 9 million dual eligible = 99 million combined beneficiaries of these two programs.

95. *Policy Basics: Where Do Our Federal Tax Dollars Go*, CTR. ON BUDGET & POL'Y PRIORITIES (updated Jan. 29, 2019), https://www.cbpp.org/research/federal-budget/policy-basics-where-do-our-federal-tax-dollars-go [https://perma.cc/HMJ2-7YXV].

96. Elise Gould, *Social Security is the Most Effective Anti-Poverty Program in the U.S., In One Chart*, ECON. POL'Y INST.: WORKING ECON. BLOG (July 30, 2013, 12:05 P.M.), https://www.epi.org/blog/social-security-effective-anti-poverty-program/ [https://perma.cc/D3RP-YA3P].

exaggerated,[97] is that Social Security raises more than 20 million people above the federal poverty level each year.[98]

Though Medicaid and Medicare do help ameliorate poverty, in comparison to cash transfer programs, their effects are small.[99] Over the past fifty years, tax policy (including reduced rates at the lowest income levels, the EITC, and the Child Tax Credit) and Social Security benefits have substantially decreased the number of Americans living in poverty.[100] By contrast, "other cash and noncash government transfer programs," a category that includes Medicare and Medicaid, "have had only a small impact" on poverty.[101]

In fairness, official poverty measures do not recognize health care coverage as a need nor treat coverage as income when it is provided to those who are unable to pay for it.[102] These omissions make it more challenging to measure the impact of Medicare and Medicaid on poverty.[103] A group of researchers recently sought to address this problem by developing a health-inclusive poverty measure, which incorporates health insurance as a "basic need."[104] This effort is certain to be controversial, but if we accept the authors' estimates at face value, public health insurance programs of all types "reduced the health-inclusive poverty rate by 4.6 percentage points," and adding all other public benefits "reduced it by a further 10.4 percentage points."[105]

If Medicare and Medicaid gave beneficiaries money, the impact on poverty would be even greater. In 2014, Medicare spent nearly $11,000 per beneficiary.[106] 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.[107] Had the Medicare benefit been distributed in cash rather than services, even if we assume beneficiaries had

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97. The estimate is too high because it ignores the effect of eliminating Social Security taxes on income and the incentive to work. *See* Andrew Biggs, *How Much Does Social Security Really Reduce Poverty*, FORBES (Nov. 2, 2016), https://www.forbes.com/sites/andrewbiggs/2016/11/02/how-much-does-social-security-really-reduce-poverty/#8a342a7332c3 [https://perma.cc/88D9-AB5T].

98. *See, e.g.*, Kathleen Romig, *Social Security Lifts More Americans Above Poverty Than Any Other Program*, CTR. ON BUDGET & POL'Y PRIORITIES (Nov. 5, 2018), https://www.cbpp.org/research/social-security/social-security-lifts-more-americans-above-poverty-than-any-other-program [https://perma.cc/7R96-ZRHU]; *The Role of Benefits in Income and Poverty*, NAT'L ACAD. SOC. INS., https://www.nasi.org/learn/socialsecurity/benefits-role. [https://perma.cc/GFA4-SU4K] (last visited Nov. 13, 2019).

99. *See generally* Bruce D. Meyer & James X. Sullivan, *Winning the War: Poverty from the Great Society to the Great Recession*, 45 BROOKINGS INST. 133, 176 (2012) (contrasting the effects of noncash transfer programs, like Medicaid, with changes in tax policy, including cash transfer programs).

100. *Id.* at 136. In fairness, increases in Social Security benefits have played a role as well. *Id.*

101. *Id.*

102. Dahlia K. Remler et al., *Estimating the Effects of Health Insurance and Other Social Programs on Poverty Under the Affordable Care Act*, 36 HEALTH AFF. 1828, 1828 (2017).

103. *Id.*

104. *Id.*

105. *Id.* at 1833.

106. *State Health Facts: Medicare Spending Per Enrollee, by State*, KAISER FAM. FOUND., https://www.kff.org/state-category/medicare/medicare-spending/ [https://perma.cc/HUV6-G6Z5] (last visited Feb. 28, 2019).

107. *2014 Federal Poverty Line (FPL) Guidelines*, PEOPLE KEEP (Jan. 27, 2014), https://www.peoplekeep.com/blog/federal-poverty-line-fpl-guidelines-2014 [https://perma.cc/X728-NWVC].

no other income, the benefit would have brought all single seniors to within $1,000 of the poverty line and elevated all senior couples more than $6,000 above it. Stated differently, converting Medicare into a cash transfer plan would almost entirely eliminate the problem of poverty among senior citizens.

The United States spends less on Medicaid than on Medicare, averaging about $5,700 per beneficiary in 2014.[108] For that reason, converting Medicaid into a cash transfer program will do less to reduce the poverty rate, but the impact would still be substantial. 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.[109]

Focusing on the population below the federal poverty level dramatically magnifies Medicaid's potential poverty-reducing impact. In 2016, Medicaid spending totaled roughly $565 billion.[110] Dividing that amount by 39.7 million—the number of Americans who lived below the official poverty level in 2017[111]—yields a payment of $14,244 per person, considerably more than the $12,488 poverty cutoff for a single person that year.[112] If Medicaid just distributed money, its budget alone would be large enough to reduce the official poverty rate to zero.

Poverty is a money problem. Economically disadvantaged people have too little of it. The most direct solution is to give them more. Medicare and Medicaid 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.

Remarkably enough, the rhetoric of the policy debate over Medicaid has changed in ways that make it easier to argue for the superiority of cash transfers. As multiple studies have failed to document a positive impact of Medicaid on the health of the impoverished population, the program's defenders have increasingly

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108. *State Health Facts*, *supra* note 105.

109. In fairness, our reliance on an average per-beneficiary figure obscures the reality that elderly and disabled beneficiaries receive far more than the moms and kids who make up a substantial majority of the program's beneficiaries. Ann C. Foster & William R. Hawk, *Spending Patterns of Families Receiving Means-Tested Government Assistance*, 2 U.S. BUREAU LAB. STAT. 1, 2 (2013), https://www.bls.gov/opub/btn/volume-2/pdf/spending-patterns-of-families-receiving-means-tested-government-assistance.pdf [https://perma.cc/VAT7-8SUB]. If funds were distributed on a per capita basis, the investment in younger citizens would be far higher than if funds were distributed based on current patterns of consumption.

110. *See* Press Release, *supra* note 91.

111. Kayla Fontenot et al., *Income and Poverty in the United States: 2017*, U.S. CENSUS BUREAU (Sept. 12, 2018), https://www.census.gov/library/publications/2018/demo/p60-263.html [https://perma.cc/2VA6-C7W5].

112. U.S. CENSUS BUREAU, POVERTY THRESHOLDS: 2017 (2017), https://www.census.gov/data/tables/2018/demo/income-poverty/p60-263.html [https://perma.cc/U6KH-BTST].

focused on its poverty-reducing effects.[113] After studies of Oregon's Medicaid experiment produced little evidence of significant improvements in recipients' physical health, commentators emphasized that Medicaid improved recipients' psychological health by relieving their concerns about financial insecurity.[114] The National Center for Health Care for the Homeless Counsel even posited that "the primary purpose of insurance" is not to improve health but "to protect against financial ruin."[115] This focus on the financial benefits of Medicaid helps prove our point. Wanting to help poor people provides no basis for preferring in-kind benefits (like Medicaid) to cash. To the contrary, the desire to help people financially justifies cash transfers more than it does anything else.

The superiority of cash becomes even clearer when one considers that Medicaid only protects beneficiaries from health care costs.[116] Other losses, including wages lost from illness, are not covered.[117] 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 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. Now, consider which group is likely to be larger? If you said the group whose members would prefer the cash, you are in good company. Three prominent advocates for Medicaid concede that "*many or most*" Medicaid

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113. *See, e.g.*, Heidi L. Allen et al., *Can Medicaid Expansion Prevent Housing Evictions?*, 38 HEALTH AFF. 1451 (2019); Emily A. Gallagher et al., *The Effect of Health Insurance on Home Payment Delinquency: Evidence from ACA Marketplace Subsidies*, 172 J. PUB. ECON. 67 (2019); Richard Fording & William Berry, *The Historical Impact of Welfare Programs on Poverty Rates, Evidence from the American States*, 35 POL'Y STUD. J. 37, 56 (2007).

114. Stacey McMorrow et al., *Medicaid Expansion Increased Coverage, Improved Affordability, And Reduced Psychological Distress For Low-Income Parents*, 36 HEALTH AFF. 808, 812 (2017), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.1650 [https://perma.cc/JG3A-Q4GY] (finding that study results suggest that the improvements in mental health status may be driven by reduced stress associated with improved financial security from insurance coverage); *see also* Rachel Garfield & Karen Young, *How Does Gaining Coverage Affect People's Lives? Access, Utilization, and Financial Security among Newly Insured Adults*, KAISER FAM. FOUND. (June 19, 2015), https://www.kff.org/health-reform/issue-brief/how-does-gaining-coverage-affect-peoples-lives-access-utilization-and-financial-security-among-newly-insured-adults/ [https://perma.cc/9MCC-GU46] (finding that "[w]hile many newly insured adults report difficulty affording their monthly premium, they also report lower rates of problems with medical bills and lower rates of worry about future medical bills than their uninsured counterparts.").

115. *Oregon Study Shows Obtaining Medicaid Improves Financial Security*, NAT'L HEALTH CARE FOR HOMELESS COUNCIL, http://www.nhchc.org/2013/05/oregon-study-shows-obtaining-medicaid-improves-financial-security/ [https://perma.cc/E3PQ-6X5E ] (last visited Mar. 1, 2019).

116. *Non-Covered Services*, N.D. DEP'T HUM. SERVS., https://www.nd.gov/dhs/services/medicalserv/medicaid/noncovered.html [https://perma.cc/FK22-8F8Q] (last visited Mar. 1, 2019) (illustrating items and services that are not covered by Medicaid).

117. *Mandatory & Optional Medicaid Benefits*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.medicaid.gov/medicaid/benefits/list-of-benefits/index.html [https://perma.cc/X7LW-Z7MQ ] (last visited Mar. 1, 2019).

beneficiaries would rather have the money.[118] Oregon's Medicaid Experiment supports this position too.[119] When researchers measured the financial value of the services Oregon supplied, all of their "estimates indicate[d] a welfare benefit from Medicaid to recipients that [was] below the government's cost of providing Medicaid"—at most forty cents on the dollar.[120]

Health policy experts prefer to ignore the reality that Medicaid recipients value other goods and services more highly than health care coverage.[121] Consider the conclusion reached by researchers who studied the financial strain that out-of-pocket health care costs place on people with high-deductible insurance plans.[122] After finding that almost 47% of covered poor adults with two or more chronic conditions incurred out-of-pocket health care costs exceeding twenty percent of their family's disposable income, the authors wrote: "high out-of-pocket costs for low-income adults with employer-sponsored insurance may create a barrier to achieving effective treatment to manage multiple chronic conditions."[123] This observation implicitly assumes that medical treatments are more important and more valuable than other things that poor adults may need.

To see the point more clearly, ask why the authors did not write that high out-of-pocket costs may cause poor people to be evicted from their residences, to have their utilities cut off, to go hungry, to drive old cars that are unsafe and prone to fail, to let their children's needs go unmet, or to suffer any of a thousand other deprivations. After all, health care costs are just costs—and the strains these costs place on families' budgets affect the entire range of purchasing decisions.[124] If the literature on health-care-induced bankruptcies makes any point persuasively,

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118. Harold Pollack et al., *Valuing Medicaid*, AM. PROSPECT (July 26, 2015), http://prospect.org/article/valuing-medicaid [https://perma.cc/5BGL-ZADN] ("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.").

119. Amy Finkelstein et al., *The Value of Medicaid: Interpreting Results from the Oregon Health Insurance Experiment* (Nat'l Bureau of Econ. Res., Working Paper No. 21308, June 2015), https://www.nber.org/papers/w21308.pdf [https://perma.cc/YR5S-M9LG] (stating that research estimations indicate that the financial value of Medicaid benefits received by enrollees was less than the government's cost of providing Medicaid by twenty to forty cents on the dollar).

120. *Id.* at 4. *See also* Ethan Lieber & Lee Lockwood, Targeting with In-Kind Transfers: Evidence from Medicaid Home Care (Jan. 22, 2018) (unpublished manuscript), https://economics.harvard.edu/files/economics/files/lieber.pdf [https://perma.cc/CM3S-CVPR], (finding that recipients value in-kind transfers below their cost of provision, but showing that in-kind transfers produce a targeting benefit by increasing the likelihood that people who need particular services will receive them.)

121. Pollack et al., *supra* note 117.

122. Salam Abdus & Patricia S. Keenan, *Financial Burden of Employer-Sponsored High-Deductible Health Plans for Low-Income Adults with Chronic Health Conditions*, 178 JAMA 1706, 1707–08 (2018).

123. *Id.*

124. Jeanette Settembre, *Millions of Senior Citizens Can't Afford Food—and They're Not All Living in Poverty*, MARKETWATCH (May 19, 2019), https://www.marketwatch.com/story/millions-of-senior-citizens-cant-afford-food-and-theyre-not-all-living-in-poverty-2019-05-16 [https://perma.cc/7DGN-BJ2R] ("Some seniors end up skipping meals due to the high cost of health care, housing, utilities and transportation, the study suggests.").

it is that one.[125] There is no principled reason to treat health care consumption decisions as entitled to superior moral weight.

The unstated belief that health care is always more important than other goods and services also pushes public policy in unwarranted directions. In Abdus & Keenan's article, the predictable conclusion is that policymakers should assign top priority to lowering out-of-pocket costs, thereby removing the financial barrier to effective treatment. But even if one concedes that the barrier exists, it hardly follows that it is more important to remove that barrier than it is to help poor people in other ways. People who cannot afford the out-of-pocket costs associated with medical treatments are likely to have difficulty meeting other needs too—including needs that, at least to those people, are more urgent.[126] To best help poor people, policymakers should give them resources they can use as they see fit. The stubborn insistence on giving medical services to people who would rather have cash may make the public feel more virtuous, but doing so will prevent beneficiaries from improving their lot in life as much as they could.[127]

The problem is real. Consider the recent proposal to allow Medicare Advantage plans to cover non-medical services that elderly people need, "such as help with chores, safety devices and respite for caregivers."[128] If Medicare doled out cash, this reform would not be needed. The elderly would be able to purchase any non-medical services they desired. As this simple example demonstrates, the rules under which Medicare operates prevent it from satisfying recipients' preferences.[129] Recognizing the failure to meet beneficiaries' needs, Medicaid is also diversifying the range of services it offers; "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."[130] Some plans

125. Donald D. Hackney et al., *What is the Actual Prevalence of Medical Bankruptcies?*, 43 INT'L J. SOC. ECON. 1284, 1295 (2016); *see also* Dan Mangan, *Medical Bills are the Biggest Cause of US Bankruptcies: Study*, CNBC (June 25, 2013, 11:01 AM), https://www.cnbc.com/id/100840148 [https://perma.cc/G4E3-98UZ] (reporting that 15 million people in the United States will deplete their savings to cover medical bills and up to 10 million will be unable to pay for necessities such as rent, food, and utilities because of those bills).

126. The point that people, including those with low levels of income or wealth, often derive less marginal value from medical treatments than from goods and services of other types cannot seriously be disputed. Were it not true, a rational person would spend all of his or her money on health care, which no real person does. The incessant claims that health care is "special" ignore this basic reality.

127. *See supra* note 46 and accompanying text.

128. *Medicare Expands to Cover In-home Services Like Chores, Safety Devices*, CBS NEWS (Nov. 9, 2018), https://www.cbsnews.com/news/medicare-some-advantage-plans-will-cover-in-home-chores-safety-devices/ [https://perma.cc/VSD3-HM5C].

129. *Id*. (claiming that Medicare's online plan finder to search for plans with expanded benefits, like home care services, is difficult to use); *see also Enrollment in Medicare Advantage*, HEALTH NETWORK GROUP (Oct. 2017), https://medicare.net/medicare-advantage/ [https://perma.cc/B6LA-Vwww] (noting that under Medicare Advantage participants are limited to visiting the doctors or facilities that are within the network, unless the participant chooses to pay a charge for going out of the network).

130. Phil Galewitz, *Medicaid Plans Cover Doctors' Visits, Hospital Care – And Now Your GED*, KAISER HEALTH NEWS (Jan. 7, 2019), https://khn.org/news/medicaid-plans-cover-doctors-visits-

will even help high school dropouts earn their GEDs.[131]

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.[132] It is highly likely that most (if not all) beneficiaries are saddled with suboptimal arrangements. Medicare and Medicaid's rules also force persistent mismatches for many beneficiaries.[133] For example, home- and community-based options, which cost much less, may better serve many elderly nursing home residents. Medicaid can "pay for housing-related services that promote health and community integration such as assistance in finding and securing housing, and home modifications when individuals transition from an institution to the community."[134] However, Medicaid regulations prohibit the program from paying recipients' rent or room and board, which can frustrate beneficiaries' ability to move to more suitable accommodations.[135]

Beneficiaries are not likely to gain greater freedom of movement anytime soon. As noted previously, the nursing home industry, which seeks to maximize the number of residents living in nursing homes, will oppose efforts to loosen existing restrictions.[136] If Medicaid delivered cash instead of services, elderly people would be free to move out—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 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.[137] Other significant but smaller expenditure

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hospital-care-and-now-your-ged/ [https://perma.cc/6XRP-CD6Q]; Brian Rinker, *Finding Shelter And Support Along The Road To Better Health*, 38 HEALTH AFF. 1252 (2019), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2019.00840 [https://perma.cc/RJ2E-ESJX].

131. *Id.* ("AmeriHealth Caritas, a Philadelphia-based insurer with 2 million Medicaid members in Pennsylvania and five other states, helps connect members with nonprofit groups providing GED test preparation classes, offers telephone coaching to keep members on track and pays the testing fees . . . AmeriHealth Caritas is one of just a handful of Medicaid health plans that offer a GED benefit.").

132. *Id.* (discussing that even though Medicaid beneficiaries are provided health insurance, many continue to struggle in maintaining access to safe housing, food, and work-related transportation); *see also* Harriet L. Komisar et al., *Unmet Long-Term Care Needs: An Analysis of Medicare-Medicaid Dual Eligibles*, 42 INQUIRY 171, 176 (2005) (reporting that even beneficiaries that are dual-enrolled in Medicare and Medicaid still have unmet needs).

133. Komisar, *supra* note 131.

134. *Medicaid's Role in Housing*, MACPAC 1 (Oct. 2018), https://www.macpac.gov/wp-content/uploads/2018/10/Medicaid%E2%80%99s-Role-in-Housing-.pdf. [https://perma.cc/UJ2K-42PX].

135. *Id.*

136. See sources cited *supra* note 10.

137. Foster & Hawk, *supra* note 108, at 2 ("For families receiving assistance, food, housing, and transportation accounted for 77.0 percent of the family budget, compared with 65.5 percent of the budget of families not receiving assistance.").

categories include clothing, healthcare, personal insurance, and pensions.[138] A report focusing on the uses workers made of their EITCs found "that recipients allocate their refunds carefully, meeting essential needs that they may have difficulty addressing with regular income."[139]

It is also easy for upper middle class policy wonks and academics to exaggerate the government's ability to allocate resources more appropriately than welfare recipients.[140] The government's priorities reflect the interests of the providers who dominate the political process.[141] 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.[142]

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.[143] For example, instead of buying insurance coverage for catastrophic health risks, some beneficiaries may purchase lavish vacations, lottery tickets, or illicit substances. Then, after being injured in accidents or stricken by serious illnesses, they may show up at hospitals' emergency rooms and demand treatments for which they cannot pay. Even sensible spenders may 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 works perfectly. Medicare and Medicaid certainly do not. The touchstone for program evaluation should be the least worst institutional arrangement—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. The major selling point of the ACA was that too many people were showing up empty-handed at hospital emergency departments, and extending them coverage would allow them to receive

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138. *Id*. at 7 (reporting that clothing, healthcare, personal insurance, and pensions account for approximately 28 percent of expenditures, with healthcare accounting for 5.2 percent of that).

139. Mathieu R. Despard et al., *Do EITC Recipients Use Their Tax Refunds to Get Ahead? New Evidence from Refund to Savings* (Wash. U. in St. Louis Ctr. for Soc. Dev., CSD Research Brief No. 15-38, July 2015), https://openscholarship.wustl.edu/cgi/viewcontent.cgi?article=1589&context=csd_research [https://perma.cc/6N44-4LHS].

140. See SILVER & HYMAN, *supra* note 1, at ch. 22.

141. *Id*. at ch. 7.

142. *Id*. at ch. 5.

143. Although studies show that most people with low incomes spend money wisely, it is obviously true that some do not. Robert M. Sapolsky, *Rich Brain, Poor Brain*, L.A. TIMES (Oct. 18, 2013, 12:00 A.M.), https://www.latimes.com/opinion/la-xpm-2013-oct-18-la-oe-sapolsky-cognitive-load-poverty-20131018-story.html [https://perma.cc/PGT7-XRK4] ("An extensive literature search shows that lower socioeconomic status is associated with a range of self-defeating behaviors, including . . . poorer financial management (impulse buying, for example, or buying on credit, which adds considerably to an item's cost).").

care more cheaply at physicians' offices.[144] According to the American Hospital Association, community hospitals provided $38.3 billion in uncompensated care in 2016.[145]

What about imprudent spending? Singapore's experience with mandatory savings accounts suggests one strategy for dealing with this problem.[146] Funds placed in Singapore's restricted-use accounts can be used to pay for health care, housing, and retirement needs.[147] Our Medicaid program could similarly implement restricted-use accounts. Instead of distributing money without limitations, the government could deposit funds into Health Savings Accounts (HSAs) and Flexible Spending Accounts (FSAs), both of which already exist.[148] Of course, this approach would entail a non-trivial administrative burden because expenditures would have to be monitored and approved, as they already are with HSAs and FSAs today.

A different approach would 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 treatments from beneficiaries' 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

144. Sara Collins et al., *How the Affordable Care Act Has Improved Americans' Ability to Buy Health Insurance on Their Own*, COMMONWEALTH FUND (Feb. 1, 2017), https://www.commonwealthfund.org/publications/issue-briefs/2017/feb/how-affordable-care-act-has-improved-americans-ability-buy1 [https://perma.cc/Y7CX-KWEN]; *see also* Jessica Schubel & Matt Broaddus, *Uncompensated Care Costs Fell in Nearly Every State as ACA's Major Coverage Provisions Took Effect*, CTR. ON BUDGET AND POL'Y PRIORITIES (May 23, 2018), https://www.cbpp.org/research/health/uncompensated-care-costs-fell-in-nearly-every-state-as-acas-major-coverage [https://perma.cc/SBX7-CDEP].

145. AM. HOSP. ASS'N, UNCOMPENSATED HOSPITAL CARE COST FACT SHEET 3 (Dec. 2017), https://www.aha.org/system/files/2018-01/2017-uncompensated-care-factsheet.pdf [https://perma.cc/VW5W-MTFH].

146. Ezra Klein, *Is Singapore's "Miracle" Health Care System the Answer for America?*, VOX (Apr. 25, 2017), https://www.vox.com/policy-and-politics/2017/4/25/15356118/singapore-health-care-system-explained [https://perma.cc/EF6L-U83P]. We discuss Singapore's mandatory savings program in SILVER & HYMAN, *supra* note 1, at ch. 22.

147. Chanh Liu & William Haseltine, *The Singaporean Health Care System*, COMMONWEALTH FUND, https://international.commonwealthfund.org/countries/singapore/ [https://perma.cc/HTX9-4KCV] ("The Central Provident Fund is the umbrella account under which Singaporeans save for retirement, housing costs, and medical care. . . .").

148. Richard L. Kaplan, *Who's Afraid of Personal Responsibility—Health Savings Accounts and the Future of American Health Care*, 36 MCGEORGE L. REV. 535, 548, 561 (2005).

common among the homeless.[149] A cash-oriented Medicaid program might give homeless persons vouchers to be used 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.[150]

Unsophisticated shopping will also be a problem. Because patients know less about medical treatments than providers, providers may try to sell them services that are overpriced, ineffective, or unnecessary.[151] Again, these are serious problems already, and a cash transfer program will make them less severe.[152] As the retail market develops, providers will feel pressure to demonstrate the value of their services and the reasonableness of their prices. Advising services will also develop and will 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. Converting Medicaid into a cash transfer program does not prevent government agencies from certifying or monitoring nursing homes, assisted living centers, or home health agencies. If government involvement adds value, it can continue. Second, because many poor people shop intelligently, less savvy 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 beneficiaries can also secure good value for their money.

Finally, markets have distinctive advantages over direct government regulation in ensuring that providers respond to consumer preferences. A dissatisfied nursing home resident 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.[153]

## IV. OTHER ADVANTAGES AND DISADVANTAGES OF CASH TRANSFERS

The idea of converting Medicaid and Medicare into cash transfer programs may seem radical, but the required changes would be modest. Instead of paying claims,

149. NAT'L COALITION FOR THE HOMELESS, SUBSTANCE ABUSE AND HOMELESSNESS 1 (July 2009), https://www.nationalhomeless.org/factsheets/addiction.pdf [https://perma.cc/7RU5-VT4V].

150. In general, vouchers are inferior alternatives to cash because recipients who want cash sell them at a discount on the black market. This necessitates monitoring of the use of vouchers, which entails its own costs and problems. C. Eugene Steuerle, *Common Issues for Voucher Programs*, *in* VOUCHERS AND THE PROVISION OF PUBLIC SERVICES 3, 15 (C. Eugene Steuerle et al., 2000).

151. On informational asymmetries between doctors and patients and the potential of markets to address them, see Steven Shmanske, *Information Asymmetries in Health Services: The Market Can Cope*, 1 INDEP. REV. 191, 197–99 (1996), http://www.independent.org/pdf/tir/tir_01_2_shmanske.pdf [https://perma.cc/TZS6-KWB9].

152. *Id.*

153. ALBERT O. HIRSCHMAN, EXIT, VOICE, AND LOYALTY (1970).

both programs would periodically make electronic deposits into beneficiaries' accounts. The deposits could be the same for all beneficiaries, or they could vary based on age, income, or other characteristics. As long as the average payment per beneficiary equaled the average amount currently spent per beneficiary, the proposal would leave the programs' finances unchanged. And compared to the status quo, Congress could more easily fix the rates at which Medicaid and Medicare would grow.

At the same time, our proposal would dramatically improve the efficiency of the health care sector by forcing providers to compete for the business of customers whose own dollars were on the line. The cost savings and quality improvements would be considerable, as providers scrambled 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 will quickly disappear.[154] These price reductions will 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.[155] 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 will 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 will no longer be needed.[156] The process of determining eligibility and distributing money could be turned over to the Social Security Administration, which already handles Medicare enrollment.[157]

The main concerns raised by the proposal to convert Medicare and Medicaid into cash transfer programs are eligibility fraud, cost escalation attributable to the "woodwork effect," and work disincentives.[158] Fraud will be a problem because

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154. Shmanske, *supra* note 150, at 197 ("[T]he market will reward doctors who can verify that they honestly convey their private information; it will punish those seen to exploit their patients.")

155. *See generally* Donald M. Berwick & Andrew D. Hackbarth, *Eliminating Waste in US Health Care*, 307 JAMA 1513 (2012).

156. For a discussion of the connection between first-party payment and fraud reduction, see OVERCHARGED, *supra* note 1, at 383–86.

157. *Medicare Benefits: How To Apply Online For Just Medicare*, SOC. SECURITY ADMIN., https://www.ssa.gov/benefits/medicare/ [https://perma.cc/U92N-WU6W] (last visited Mar. 28, 2019).

158. *The Woodwork Effect*, OFF. POL'Y DEV. & RES., U.S. DEP'T. HOUSING & URB. DEV. (2013), https://www.huduser.gov/portal/periodicals/em/fall13/highlight2_sidebar1.html [https://perma.cc/KV6H-L2AV] (writing that the woodwork effect encourages eligible participants to "come out of the woodwork" and enroll in programs after they are expanded or changed); *see also* John Howley, *What is Medicaid Eligibility Fraud?*, JOHN HOWLEY, ESQ. (July 11, 2013), http://www.john-howley.com/john-howleys-medicaid-fraud-blog/what-is-medicaid-eligibility-fraud [https://perma.cc/7PMD-MMH8] (writing about the most common types of Medicaid eligibility fraud); Andy Schneider, *Medicaid and Work: How the CMS Administrator Has it Completely Upside Down*, GEO. U. HEALTH POL'Y INST. (Dec. 4, 2017), https://ccf.georgetown.edu/2017/12/04/medicaid-and-work-how-the-cms-administrator-has-it-completely-upside-down/ [https://perma.cc/2BPJ-BUYF] (discussing that because Medicaid has limits on the amount of income an individual can make and still qualify for Medicaid, there are some work disincentives).

both programs restrict eligibility— Medicare on the basis of age and Medicaid on the basis of income and wealth.[159] 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. Costs may also rise because of the "woodwork effect," which "describes the increase in enrollment that can occur after programs are expanded or changed, encouraging eligible participants to 'come out of the woodwork' to enroll in them."[160] If cash were available instead of medical services, people who are eligible for Medicaid but who do not bother to apply might change their minds. Work disincentives may be a problem for the familiar reason that some people would rather live on the dole than hold productive jobs.

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 that the amount of fraud in the program is fairly small.[161] Both improper payments and fraud could be further reduced, though not eliminated, by increasing the Internal Revenue Service's (IRS) budget, which, in real dollars, has declined markedly since 2010.[162] If it is given more resources, the IRS could use improved technology and artificial intelligence to audit all returns. The government could also require tax preparers whose clients apply for the EITC to be trained, licensed, and bonded.

For Social Security, estimates of mistaken payments are remarkably low. "According to the Social Security Administration, all improper payments . . . [we]re estimated at $3 billion per year," which is approximately 0.4 percent of total spending.[163] Unofficial estimates are higher.[164] One can easily find assertions that Social Security's disability insurance program is rife with fraud committed

159. *Medicaid Eligibility*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/eligibility/index.html [https://perma.cc/XN66-D6X6] (last visited Feb. 27, 2019) (discussing that Medicaid restricts eligibility based on financial requirements); *see also* Patricia Barry, *Do You Qualify for Medicare?*, AARP (Sep. 25, 2019), https://www.aarp.org/health/medicare-insurance/info-04-2011/medicare-eligibility.html [https://perma.cc/M63J-JPWY] (discussing that Medicare restricts eligibility to those who are at least 65 years old).

160. *The Woodwork Effect*, *supra* note 157. The phenomenon is also known as the "welcome-mat effect." *Id.*

161. Robert Greenstein et al., *Reducing Overpayments in the Earned Income Tax Credit*, CTR. ON BUDGET & POL'Y PRIORITIES, https://www.cbpp.org/research/federal-tax/reducing-overpayments-in-the-earned-income-tax-credit [https://perma.cc/R5VC-DZMK] (last updated Jan. 31, 2019).

162. Colleen Murphy, *IRS's Budget Likely 'Miserable' for 2017 and Beyond*, BLOOMBERG NEWS (Dec. 13, 2016), https://efilegroup.com/irss-budget-likely-miserable-for-2017-and-beyond/ [https://perma.cc/FLV5-3TJJ] (discussing that the IRS funding has reduced by $900 billion since 2010).

163. *Fact Sheet: How Much Waste, Fraud, and Abuse is there in Social Security?*, COMMITTEE FOR A RESPONSIBLE FED. BUDGET (Mar. 15, 2016), http://www.crfb.org/press-releases/fact-sheet-how-much-waste-fraud-and-abuse-there-social-security [https://perma.cc/U28L-P4KE].

164. Jim Probasco, *Social Security Fraud: What Is It Costing Taxpayers?*, INVESTOPEDIA, https://www.investopedia.com/articles/retirement/120516/social-security-fraud-what-it-costing-taxpayers.asp [https://perma.cc/VG4K-DEYP] (last updated Oct. 20, 2019) (writing that improper SSA payments totaled $1.3 trillion between 2004 and 2017).

by applicants who feign maladies and by beneficiaries who remain on the dole long after recovering.[165] Whether these charges are accurate is less clear. Relying on a report by the Center on Budget and Policy Priorities, the *New York Times* reported that "[t]here is fraud [in the SSDI program], no doubt. But there is no evidence it is rampant."[166] Other sources agree.[167]

Whatever the truth may be, the only prudent course is to expect fraud to happen and to prepare for it. Any plan to convert Medicaid and Medicare into transfer programs should include a significant anti-fraud 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.[168] A cash-transfer program would not have to police providers at all. Because providers (and those fraudulently posing as providers) are responsible for most fraud losses, this is a sizeable advantage.

Turning to the woodwork effect, we begin by assuming that the effect could be substantial. Many people value money more highly than medical treatments, so it stands to reason that many people who would not take the trouble to apply for Medicaid will apply for cash benefits. That said, the magnitude of the effect is hard to gauge, and its consequences may be good rather than bad. Experience with the EITC sheds light on both matters. As explained previously, the EITC transfers cash to working people with low incomes.[169] A high participation rate should therefore be expected, so it is not surprising that the current take-up rate is around eighty percent of the eligible population.[170] Participation increased when "the EITC expanded to include richer families, who could have larger

165. Richard Finger, *Fraud And Disability Equal A Multibillion Dollar Black Hole For Taxpayers*, FORBES (Jan.14, 2013), https://www.forbes.com/sites/richardfinger/2013/01/14/fraud-and-disability-equal-a-multibillion-dollar-balck-hole-for-taxpayers/#4ed54e8f3369 [https://perma.cc/AXB9-E7ZV]; *see also* Eric Pianin & Josh Boak, *New Evidence that Disability Fraud Costs Billions*, FISCAL TIMES (Oct. 7, 2013), http://www.thefiscaltimes.com/Articles/2013/10/07/New-Evidence-Disability-Fraud-Costs-Billions [https://perma.cc/EYX4-V8TV]; James M. Taylor, *Facilitating Fraud: How SSDI Gives Benefits to the Able-Bodied*, CATO INST. 2 (Aug. 15, 2000), https://www.cato.org/sites/cato.org/files/pubs/pdf/pa377.pdf [https://perma.cc/AU8B-JYE3].

166. Teresa Tritch, *Busting the Myths about Disability Fraud*, N.Y. TIMES (Sept. 8, 2015), https://takingnote.blogs.nytimes.com/2015/09/08/busting-the-myths-about-disability-fraud/ [https://perma.cc/ZUW5-EGAT] (citing CTR. ON BUDGET & POL'Y PRIORITIES, CHART BOOK: SOCIAL SECURITY DISABILITY INSURANCE, https://www.cbpp.org/sites/default/files/atoms/files/7-21-14socsec-chartbook.pdf [https://perma.cc/T2JS-FZUF] (last updated Sept. 6, 2019)).

167. Katy Neas, *Social Security Disability Fraud is Rare*, THE HILL (Jan. 16, 2014), https://thehill.com/blogs/congress-blog/economy-budget/195559-social-secuity-disability-fraud-is-rare [https://perma.cc/EUQ8-VXGP].

168. Finger, *supra* note 164; *see also* Pianin & Boak, *supra* note 164; Taylor, *supra* note 164, at 24.

169. Chris Edwards & Veronique de Rugy, *Earned Income Tax Credit: Small Benefits, Large Costs*, CATO INST. (Oct. 14, 2015), https://www.cato.org/publications/tax-budget-bulletin/earned-income-tax-credit-small-benefits-large-costs [https://perma.cc/N7G6-RTDW].

170. *About EITC*, INTERNAL REVENUE SERV., https://www.eitc.irs.gov/eitc-central/about-eitc/about-eitc [https://perma.cc/4ZZ4-YLBL] (last updated Mar. 11, 2019). *See also EITC Participation Rate by States*, INTERNAL REVENUE SERV., https://www.eitc.irs.gov/eitc-central/participation-rate/eitc-participation-rate-by-states [https://perma.cc/35AM-H456] (last updated Oct. 8, 2019), (showing that, between 2008 and 2015, EITC participation increased or remained the same in thirty-nine states).

participation rates," and when local governments and public interest groups started outreach programs that helped recipients prepare tax returns.[171] If Medicaid and Medicare were converted into transfer programs and administered like the EITC, it seems reasonable to expect a comparable take-up rate as service providers expand their operations and the application process is streamlined.

Whether an eighty percent participation rate constitutes a woodwork effect depends in part on how the eligible population is defined. According to the Census Bureau, 39.7 million Americans lived below the federal poverty level in 2017.[172] If only these people were eligible for cash transfers, an eighty percent participation rate would yield a beneficiary population of less than 32 million individuals. Because Medicaid and CHIP covered about 72 million people in 2019,[173] the beneficiary population would actually shrink dramatically—increasing the amount of money that each beneficiary could be given while still remaining budget neutral.

The woodwork effect could also be dealt with by regulating eligibility so as to keep the amount of money distributed at or below a specified level. In 2017, spending on Medicaid totaled $553 billion, including both federal and state contributions.[174] If a cash transfer program was designed to pay out an average of $10,000 per beneficiary, a population of 55.3 million could be covered. Assuming an eighty percent take up rate, the income ceiling for eligibility would be set so that about 70 million people fell beneath it.

Finally, it is important to understand that the consequences of a woodwork effect, should one occur, would not be entirely bad. The point of wealth transfers is, or should be, to increase social welfare by moving assets from wealthy people to those who are poor. An increase in the take-up rate that generates desirable reductions in poverty should not be a cause for concern.

Another potential pitfall of this program is work disincentives. It is certainly true that a cash transfer system should be designed to encourage recipients to hold productive jobs. The EITC does this because it is available only to families headed by persons who are employed.[175] It also helps that the tax credits are too small to be a person's sole source of income.[176] The average claimant received

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171. Wojciech Kopczuk & Cristian Pop-Eleches, *Electronic Filing, Tax Preparers, and Participation in the Earned Income Tax Credit*, 91 J. PUB. ECON. 1351, 1353, 1366 (2007).

172. Kayla Fontenot et al., *Income and Poverty in the United States: 2017*, U.S. CENSUS BUREAU 15 (Sept. 2018), https://www.census.gov/content/dam/Census/library/publications/2018/demo/p60-263.pdf [https://perma.cc/F4LV-MLNA].

173. *September 2019 Medicaid & CHIP Enrollment Data Highlights*, MEDICAID.GOV (Feb. 7, 2019), https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html [https://perma.cc/AN3H-BJBG].

174. *See supra* note 93 and accompanying text.

175. *Earned Income Tax Credit (EITC)*, INTERNAL REVENUE SERV., https://www.irs.gov/credits-deductions/individuals/earned-income-tax-credit [https://perma.cc/Z3J2-NPGG] (last updated July 10, 2019).

176. *Policy Basics: The Earned Income Tax Credit*, CTR. ON BUDGET & POL'Y PRIORITIES, https://www.cbpp.org/research/federal-tax/policy-basics-the-earned-income-tax-credit [https://perma.cc/FH3J-CNHH] (reporting that "families mostly use the EITC to pay for necessities, repair homes, maintain

about $2,500 in 2019.[177]

Tying access to benefits to a work requirement makes sense for everyone except persons who are otherwise eligible but who are disabled or elderly. The Treasury Department, which runs the Social Security Disability Insurance program, already has procedures in place for identifying such people.[178] How well the procedures screen out applicants who are trying to game the system, however, is a subject of considerable disagreement.

Encouraging people to work is plainly a matter of great importance. Therefore, it may make sense to have two benefit systems: one that gives cash assistance to people who are employed, and one that gives in-kind services to people who are not. The desire for more cash benefits, which are more valuable than services, should encourage beneficiaries to work, while the in-kind program enables the smaller population of disabled individuals to maintain an adequate standard of living.

Two problems remain to be addressed: catastrophes and long-term care. In any given year, a small percentage of the population needs expensive medical treatments. The prevailing wisdom is that ten percent of the population accounts for fifty percent of total health expenditures.[179] The number of people in need of long-term care is also large and growing quickly, as the Baby Boom generation ages.[180] In the short-run, converting Medicare and Medicaid into cash-transfer programs will leave many people in these groups short of funds. These transitional problems will be wrenching—but our current approach is unsustainable. The longer we postpone taking steps to address the deficiencies in our current approach, the worse these problems will become.[181]

## CONCLUSION

The United States has medicalized poverty since the mid-1960s—when the government chose to give eligible persons Medicaid and Medicare instead of cash.[182] Since then, trillions of dollars have been spent helping the beneficiaries

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vehicles that are needed to commute to work, and in some cases obtain additional education or training to boost their employability and earning power.") (last updated June 21, 2019).

177. *Statistics for Tax Returns with EITC*, INTERNAL REVENUE SERV., https://www.eitc.irs.gov/eitc-central/statistics-for-tax-returns-with-eitc/statistics-for-tax-returns-with-eitc (last updated Nov. 17, 2019).

178. *Benefits Planner: Disability, How You Qualify*, SOC. SECURITY ADMIN., https://www.ssa.gov/planners/disability/qualify.html [https://perma.cc/DT9C-K6GY] (last visited Feb. 28, 2019).

179. Bradley Sawyer & Gary Claxton, *How Do Health Expenditures Vary Across the Population?*, PETERSON-KAISER HEATH SYSTEM TRACKER (Jan. 16, 2019), https://www.healthsystemtracker.org/chart-collection/health-expenditures-vary-across-population/#item-start [https://perma.cc/CV2C-2DBE].

180. *See* Paula Span, *The New Old Age: Many Americans Will Need Long-Term Care. Most Won't Be Able to Afford It*, N.Y. TIMES (May 10, 2019), https://www.nytimes.com/2019/05/10/health/assisted-living-costs-elderly.html [https://perma.cc/5M6U-DE37].

181. *Trustees Reports (current and prior)*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/TrusteesReports.html [https://perma.cc/KZ3L-U246] (last updated Aug. 7, 2019).

182. *See CMS' Program History*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/About-CMS/Agency-information/History/ [https://perma.cc/XDV2-CYSS] (last updated June 20,

on terms dictated by the health care sector—with decidedly unimpressive results.[183] Our proposal to convert Medicaid and Medicare into cash transfer programs modeled on Social Security and the EITC recognizes that people know how to help themselves better than health care providers do. We should give the beneficiaries money and let them decide how to spend it.

Even though cash transfers will 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—but they are beyond the scope of this article.

When thinking about implementation, it is advisable to draw upon approaches that have been used successfully in this country and elsewhere. Experience with Social Security and the EITC weighs in favor of using unrestricted cash transfers,[184] rather than restricted vouchers—although experience with retirement accounts, health savings accounts, and flexible spending accounts suggests that there may be a role for restricted savings accounts.[185] It may be desirable to divide payments between restricted and unrestricted accounts so as to help recipients provide for their future needs without unduly hampering their ability to make choices. Social Security already does this implicitly, by doling out benefits on a monthly basis instead of giving recipients much larger lump sums.[186] Taxpayers can elect to receive their EITCs on a similar basis, although most prefer a lump sum payment. As always, the devil is in the details.

Health care providers, who profit from existing arrangements, will vigorously oppose our proposed reform. They will likely 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 object too. This coalition of "Bootleggers and Baptists" will continue to support Medicaid and Medicare in their current forms even though these programs serve the interests of their beneficiaries poorly.[187] After more than half a century of spiraling costs and mediocre service, it is time to make these programs work for their enrollees.

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2018); *see also* David A. Hyman, *The Medicalization of Poverty: A Dose of Theory*, 46 J.L. MED. & ETHICS 582 (2018).

183. *NHE Fact Sheet*, *supra* note 9.

184. Edwards & de Rugy, *supra* note 168; *see also Policy Basics*, *supra* note 176.

185. Klein, *supra* note 145; *see also* Kaplan, *supra* note 147.

186. *See* SOCIAL SECURITY ADMINISTRATION, WHAT YOU NEED TO KNOW WHEN YOU GET RETIREMENT OR SURVIVORS BENEFITS 1 (2019), https://www.ssa.gov/pubs/EN-05-10077.pdf [https://perma.cc/TRV7-94AR].

187. *See* Bruce Yandle, *Bootleggers and Baptists in Retrospect*, REGULATION, 5 (Jan. 1999) (describing bootleggers as those who tolerate regulation to ensure limited competition and are "simply

Finally, changing Medicaid and Medicare into cash transfer programs will require Congressional action—as will ongoing funding of the transformed programs. The politics of that process are daunting, to say the least.[188] But the fact that we are willing to fund cash-transfer programs like Social Security, the EITC, and the CTC indicates that there is a better way of structuring Medicaid and Medicare.[189] We should take it.

in it for the money" and Baptists as those who "point to the moral high ground and give vital and vocal endorsement of laudable public benefits promised by a desired regulation.").

188. *See* Uwe Reinhardt, *Provide Cash, or Benefits in Kind*, N.Y. TIMES: ECONOMIX (Jan. 21, 2011), https://economix.blogs.nytimes.com/2011/01/21/provide-cash-or-benefits-in-kind/? [https://perma.cc/74QH-5RXV] (suggesting that in-kind benefit programs may reflect the preferences of median voters); *see also* Uwe E. Reinhardt, *On the Economics of Benefits in Kind*, ECON 100 (2014), https://scholar.princeton.edu/sites/default/files/reinhardt/files/100-2014_benefits_in_kind.pdf [https://perma.cc/VSU9-HFP3] (suggesting that in-kind benefit programs may reflect the preferences of median voters); Thurow, *supra* note 46, at 192–95 (arguing that use of in-kind benefits reflects societal preference for an equal distribution of access to health care).

189. To put the issue in numerical terms, because Medicaid beneficiaries appear to value their benefits at 20% to 40% of their on-budget cost, changing that program to look more like Social Security will increase the welfare of those beneficiaries by 150–400%. *See supra* note 120 and accompanying text. For Medicare, "the direct insurance benefits cover between forty-five and seventy-five percent of the costs of the program." *See* Finkelstein & McKnight, *supra* note 44, at 22. For this population, changing the program to look more like Social Security will increase the welfare of those beneficiaries by 133-222%.

These findings make it clear that in health care "the low-hanging fruit isn't just low-hanging fruit; the fruit is lying on the ground, and we have to be careful not to trip over it." J.K. Wall, *The Low Hanging Fruit is Lying on the Ground*, HEALTH ADVICE & MORE (July 29, 2015), https://healthadviceandmore.wordpress.com/2015/07/29/the-low-hanging-fruit-is-lying-on-the-ground/ [https://perma.cc/ZCJ7-8SPK] (quoting Indiana University management professor Mohan Tatikonda).