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MI REPORT

OVER-MEDICAID-ED

HOW MEDICAID DISTORTS AND DILUTES AMERICA'S SAFETY NET

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About the Author

Oren Cass is a senior fellow at the Manhattan Institute, where he focuses on energy, the environment, and antipoverty policy. He was domestic policy director of Mitt Romney's presidential campaign in 2011–12. In that role, Cass shaped campaign policy and communication on issues from health care to energy to trade. He spoke regularly on behalf of the campaign, including in debates at Harvard University on health care policy and at MIT on energy and environmental policy. Since then, Cass has outlined conservative policy approaches on poverty, climate change, environmental regulation, and international trade. His essays and columns have been published in the *Wall Street Journal*, *Washington Post*, *National Affairs*, *City Journal*, *National Review*, *Investor's Business Daily*, and *Washington Examiner*. In 2015, Politico named him one of the 50 "thinkers, doers and visionaries transforming American politics" for his work as "the conservative poverty crusader" on proposals to reform America's social safety net.

Before joining MI, Cass was a management consultant for Bain & Company in the firm's Boston and New Delhi offices, where he advised global companies across a range of industries on implementing growth strategies and performance-improvement programs. He holds a B.A. in political economy from Williams College and a J.D. from Harvard University, where he was an editor and vice president of volume 125 of the *Harvard Law Review*.

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Executive Summary

Since the Lyndon Johnson administration launched the War on Poverty in 1965, government social spending has increased from less than $100 billion per year to more than $1 trillion per year. The growth was initially broad-based, expanding services from education to nutrition to housing. Increased spending in recent decades, however, has gone almost entirely to health care generally and Medicaid specifically.

Does this allocation of resources most effectively help people escape poverty or prevent them from falling into poverty? Does it align with the needs or preferences of low-income Americans? This paper presents evidence that it does not. Medicaid's growth has been, in many respects, unintentional; it reflects skewed incentives built in to the program; and it does not represent the best antipoverty strategy—or even the best way to improve health in low-income households. Restructuring the safety net could reroute substantial sums from Medicaid to better meet the needs of the poor, without changing overall spending levels. This paper also suggests various reforms that could be the first step in a longer journey toward a more effective U.S. antipoverty strategy. **Key findings include:**

- **Health care dominates safety-net spending.** During 1975–2015, government social spending per person in poverty more than doubled, from $11,600 to $23,400. Rising health care expenditures accounted for more than 90 percent of that increase. For 2015–20, White House budget proposals call for 89 percent of additional social spending to target health care.
  - Notwithstanding the intense debate over the Affordable Care Act's Medicaid expansion, every state has already expanded its program far beyond the mandatory level. By 2007, more than 60 percent of all Medicaid spending represented optional expansions, including an average of 57 percent in states that subsequently declined additional expansion under the ACA.
  - By 2012, state Medicaid spending was 39 percent higher than if it had remained a constant share of state budgets since 2000. State spending on education and welfare was 9 percent and 54 percent lower, respectively.
- **This allocation is an ineffective poverty-fighting strategy.** While the majority of government social spending goes to health care, low-income households *not* enrolled in Medicaid allocate less than 10 percent of their spending to health care, compared with 40 percent for housing, 22 percent for food, and 12 percent for transportation. Only 8 percent–9 percent of marginal consumption goes to health care as such households move from $10,000 to $30,000 in total consumption.
  - Studies consistently show little to no positive impact on health outcomes from Medicaid enrollment; even evidence of a relationship between health care access and life expectancy has been elusive. States with larger optional expansions of their Medicaid programs have larger age-adjusted-mortality and infant-mortality gaps between non-Hispanic white and African-American populations.
- **Over-allocation to Medicaid may exceed $100 billion annually.** If states with above-median Medicaid enrollment rates or spending per enrollee in each recipient category (adult, child, disabled, etc.) returned to median levels, more than $100 billion could become available for other antipoverty programs.
- **How to strengthen America's safety net:**
  - The federal government should consolidate antipoverty funding streams and allow states to design programs and allocate funding to such programs as states see fit. Such a consolidation will achieve its goals only if Medicaid is included.
  - If the federal government is to retain control of disparate antipoverty programs, it should establish a "universal matching" structure for federal funds that ensures that states do not overinvest in Medicaid in pursuit of additional federal dollars.
  - As a preliminary step, the federal government could create broader program waivers that explicitly allow states to repurpose funds from one program (e.g., Medicaid) to another (e.g., a substantial expansion of the Earned Income Tax Credit). Waivers are far from ideal; but select state pilot projects may help validate the value of reallocating funds across programs.

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I. Introduction

Most policy debate about America's social safety net is about its size. The Left, concerned by entrenched poverty and rising income inequality, generates countless proposals to expand existing programs and launch new ones. The Right, concerned that a constantly expanding safety net will create perverse incentives for low-income Americans and unsustainable deficits for the government, responds with proposals to cap spending, condition it with work requirements, or cut it outright. Neither liberals nor conservatives appear likely to achieve their vision anytime soon, nor do the American people seem particularly eager to move aggressively in either direction.

Left unexamined is a potential source for a bipartisan compromise: restructuring the spending to achieve better results. If a dollar spent on program A is achieving less than it would if subtracted from A and added to program B, shouldn't we move the dollar? Current policy misallocates resources for several reasons. First, the contemporary safety net is not the result of a comprehensive antipoverty strategy. Rather, it is a tangle of programs authorized at different times by different legislation, controlled by different bureaucracies, and channeled through separate pipes, either to state agencies or to recipients directly. Each program has its own rules dictating how, and when, its funding will grow.

Second, the overwhelming majority of safety-net spending is parceled out at the federal level, where even an omniscient and all-powerful bureaucracy could not establish a single formula optimized for the needs of every community, let alone every individual. States and local governments can seek waivers from federal mandates about how they define eligibility, condition benefits, or deliver the services associated with a particular program; but they have no ability to redirect resources from one use (e.g., health care) to another (e.g., housing).

For the past 40 years, the U.S. has sunk into health care more than nine of every ten dollars in additional spending per person whose income is below the federal poverty line. If this allocation were aligned with the needs of recipients and showed impressive results, there would be no cause for complaint. But neither condition holds true.

Instead, the expansion appears to be the result of badly designed incentives. Each state sets the size of its Medicaid program and receives matching federal dollars—from $1 to $4—for every state dollar spent. States thus have a strong incentive to overinvest

in Medicaid, expanding their programs far beyond the point where a marginal dollar of their own spending produces a dollar of value. Washington, having tied the leash around its own waist, is dragged along for the ride. The national political obsession with health care compounds the effect and resists any attempt at reform. The emotional salience of a medical treatment denied has proved uniquely powerful, and politicians have shown no interest in challenging it or offering alternative and, potentially, more effective uses of taxpayer dollars.

Yet the evidence available from low-income households offers little support for health care's preeminence. Those who are ineligible for Medicaid, or who choose not to enroll, allocate less than 10 percent of their consumption to health care and use relatively few additional health care services for which they are subsequently unable to pay. This pattern holds at higher-income levels, too: most middle-class households eligible for Affordable Care Act (ACA) subsidies to purchase their own insurance decline to do so.

Extensive empirical evidence suggests that these spending preferences are not irrational. As explained below, the best randomized controlled study of Medicaid's impact could not find that Medicaid recipients were any healthier than eligible poor people who did not enroll. Many other studies have shown worse outcomes. Further, these analyses compare Medicaid with the absence of Medicaid. Medicaid's poor performance would look far worse if compared with other uses of those same funds—higher-quality housing, access to transportation, better job training—that might better influence physical well-being and upward mobility.

The glaring lack of justification for Medicaid's disproportionate role in the safety net, coupled with an obvious structural reason for its rise, suggests that enormous sums are being misspent. Still, the response need not be federal overreaction in the other direction. States that genuinely believe health care to be the best use of their funds should not be penalized for continuing current policy. But the federal government should remove the magnetic attraction of matching federal funds, which skew state incentives in the current direction. Ideally, Congress should give state and local governments the flexibility to allocate funds as they see fit—and even to craft programs that would customize benefits to the needs of groups or individuals. Various reforms to enable such flexibility are outlined later in this paper.

How large is the opportunity for reallocating U.S. safety-net spending? Simply bringing states with above-average enrollment levels or per-enrollee spending back to the national median could release more than $100 billion—and Medicaid coverage in those states would still be at least as generous as what most states now offer. Allowing funds on this scale to flow back toward better uses would dramatically improve the quality of America's safety net at no fiscal cost, which might meet the needs of not only low-income households but also warring factions in Washington.

II. How Medicaid Swallowed America's Safety Net

The U.S. has dramatically expanded social spending that targets lower-income households, from less than $100 billion per year in 1965 to more than $1 trillion in 2015. (This paper uses 2015 dollars adjusted with the Office of Management and Budget's composite deflator, unless otherwise noted. See Appendix for a description of the spending database described in Section II, as well as for a compilation of figures. The spending database excludes Medicare and Social Security, whose benefits are paid regardless of income.)

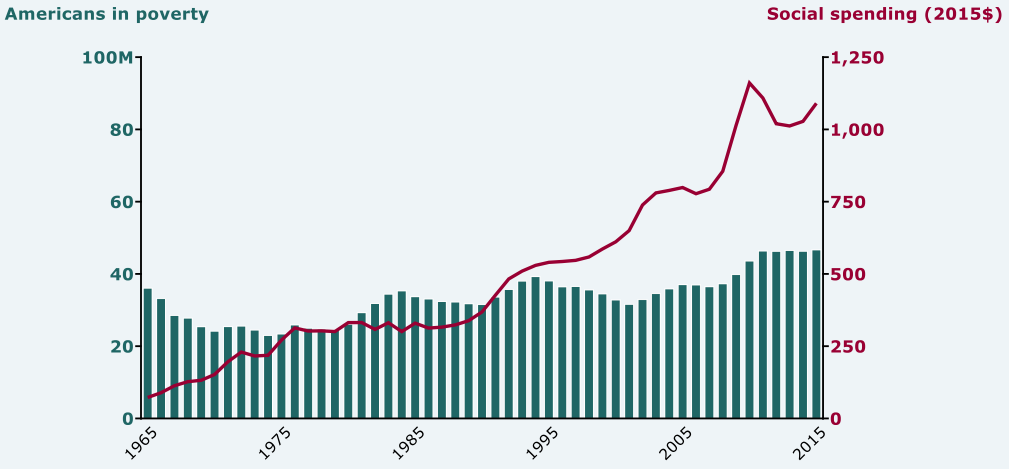
Yet the number of Americans living below the federally defined poverty line has grown only from 36 million in 1965 to 47 million in 2015[1]—roughly in line with population growth—while the absolute material conditions of those in poverty has improved dramatically (**Figure 1**).[2] Rather, the amount and types of government support have expanded, in two distinct phases.

In the first phase, the first decade of the War on Poverty, social programs grew across the board. Spending increased, from $73 billion per year to $271 billion per year, while the population below the poverty line fell, from 36 million to 23 million. Spending per person in poverty[3] rose from $2,000 in 1965 to $11,600 in 1975, with Medicaid accounting for 24 percent of that increase. Training and employment expenditures increased fourfold, housing expenditures fivefold, and other social services nearly sixfold. The Supplemental Nutrition Assistance Program (SNAP, or food stamps) grew from zero to nearly $20 billion, while other nutrition programs quadrupled in size. Supplemental Security Income (SSI), which did not exist in 1965, paid out $18 billion in benefits ten years later.

In the second phase, during 1975–2015, social spending increased another fourfold, to $1,090 billion, while the total number of Americans in poverty more than doubled, from 23 million to 47 million. Per-person spending rose, from

FIGURE 1.

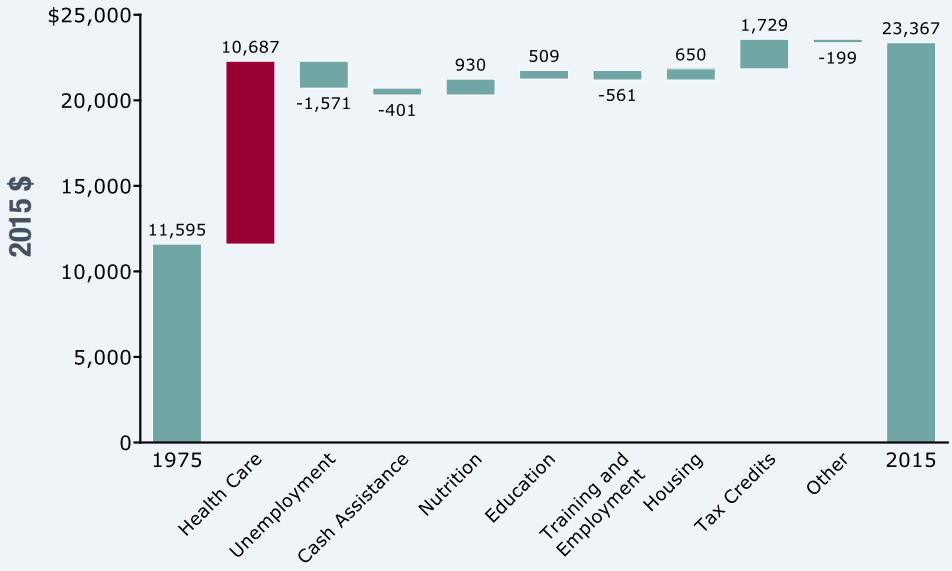
U.S. Social Spending and Americans in Poverty, 1965–2015



Source: Appendix

FIGURE 2.

Growth in Social Spending per Person in Poverty, 1975–2015



Source: Appendix

$11,600 to $23,400. Unlike in the earlier period, the composition of that spending increase skewed overwhelmingly toward health care. More than two-thirds of the total spending increase over these 40 years went to Medicaid (from $55 billion to $568 billion), to the Children's Health Insurance Program (CHIP) (from $0 to $13 billion), and, in the most recent years, to premium subsidies under the ACA.

On a per-person basis, spending on health care rose by more than $10,000 (a 453 percent increase) while the increase in spending on all other programs was barely $1,000 (a 12 percent increase). Spending on training and employment fell by more than half overall and from $700 to $150 per person in poverty (**Figure 2**). The White House Office of Management and Budget (OMB) forecasts that, from 2015 to 2020, social spending will increase by another $171 billion: 89

percent of the increase would come from further health care spending increases.

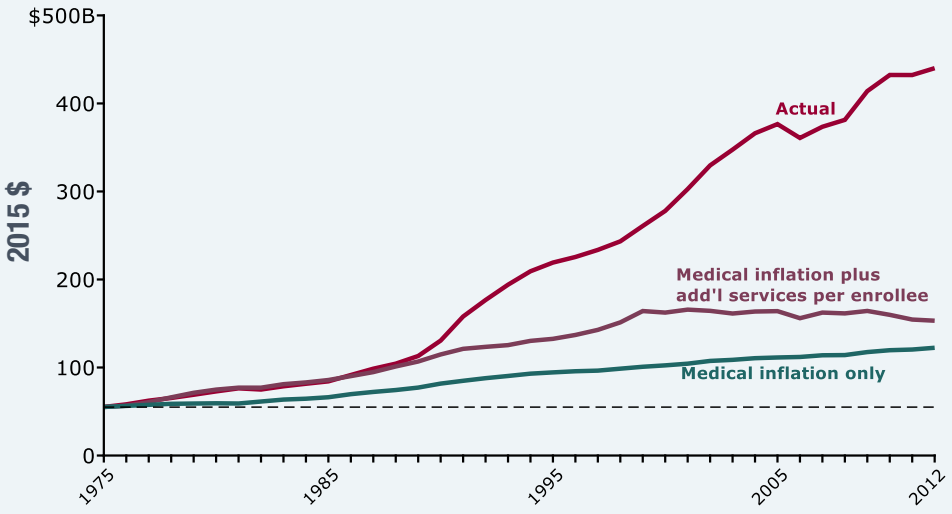
Drivers of Medicaid's Growth

There is a widespread belief that the rising cost of medical services is responsible for Medicaid's astronomical growth. This is not true. To be sure, medical inflation has exceeded general inflation in recent decades, producing annualized constant-dollar spending growth of 2.2 percent during 1975–2012.[4] (This analysis stops in 2012 to exclude spending arising from the ACA.) But Medicaid spending over this period grew at an annualized rate of 5.8 percent. The largest source of growth was increasing enrollment, which grew at an annualized rate of 2.9 percent.[5] Growth in spending per enrollee, even after accounting for medical inflation, contributed additional annualized growth of 0.6 percent (**Figure 3**).[6]

Data published by Medicaid's actuary for 2000–12 provide a detailed view into recent trends.[7] During that period, Medicaid spending attributable to per-person benefits increased, from $249 billion to $400 billion (**Figure 4**). (In some instances, Medicaid spending represents direct payment from states to service providers; in others, the state contracts with a private insurer at a fixed rate per enrollee and the insurer pays for the services ultimately consumed. Medicaid's Disproportionate Share Hospital Payments [DSH] and other program and administrative costs, which, in 2012, totaled nearly $50 billion in additional spending, are excluded).[8]

FIGURE 3.

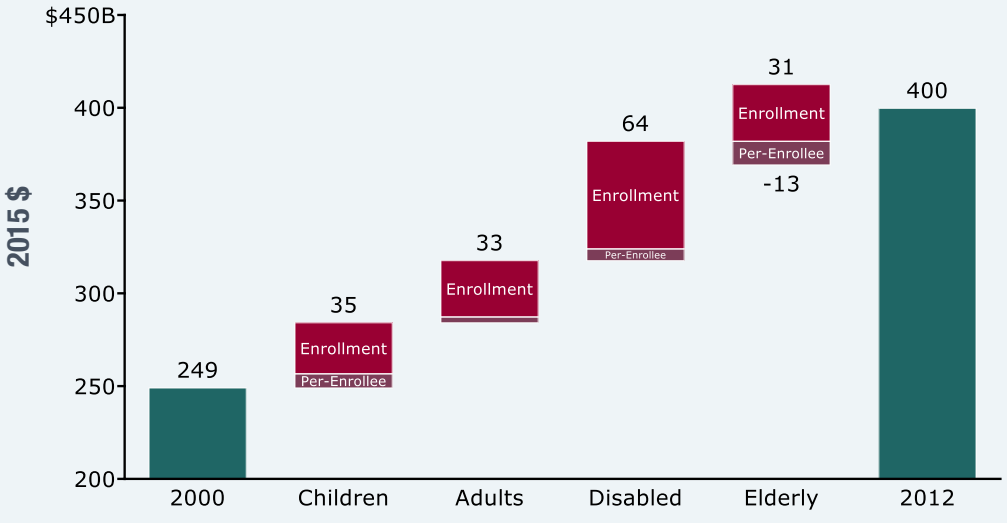
Drivers of Medicaid Spending Growth, 1975–2012



Source: National Health Expenditure Accounts, Bureau of Labor Statistics, MACStats

FIGURE 4.

Drivers of Medicaid Spending Growth, 2000 v. 2012*



*Excludes DSH and other program and administrative costs; see endnote 8.
Source: Medicaid Actuary

Of the $151 billion increase in benefit payments, 97 percent was the result of higher enrollment and only 3 percent was the result of higher spending per enrollee. Similarly, while long-term care for elderly recipients is often cited as a primary driver of Medicaid's growth, those recipients accounted for only 12 percent of the higher spending.[9]

Disability

Medicaid benefits for disabled recipients account for 43 percent of the 2000–2012 growth in the program's spending—due largely to an increase in enrollees, from 6.7 to 10.0 million.[10] In 2012, benefits for the average disabled recipient were $17,800 per year, compared with $4,300 for other adults. Most of Medicaid's disabled recipients are also recipients of SSI, the program that pays cash benefits to low-income individuals who are elderly, blind, or disabled as well as qualifies them for Medicaid. (SSI is distinct from Social Security Disability Insurance, which pays cash benefits to workers who become disabled after having "paid into" the system. SSDI recipients receive Medicare.)[11]

SSI was initially intended as a program for the low-income elderly;[12] but it has since been transformed into a benefit primarily for working-age adults. During 1975–2012, the number of elderly recipients declined by half (from 2.3 million to 1.2 million), while the number of disabled recipients more than tripled (from 1.9 million to 7.0 million).[13] Studies suggest that enrollments in SSI have been driven by looser screening standards and that benefits have become relatively more attractive to prospective recipients than opportunities in the labor market.[14] The prospect of Medicaid access increases the incentive to exit the labor force and enroll in SSI. Higher enrollments then drive up Medicaid spending, which, in turn, constrains other antipoverty approaches that might have better assisted those SSI applicants in the first place.

The Affordable Care Act

Medicaid's actuary expects that the expansion of Medicaid under the ACA will increase Medicaid's spending by $47 billion per year from 2015 to 2020.[15] The OMB has forecast that premium subsidies for insurance bought on the ACA health exchanges will increase government spending on health care by $68 billion annually over the same period. Together, those ACA-driven increases of $115 billion in annual spending will be responsible for 75 percent of the growth in the safety net's health care spending from 2015 to 2020, which, in turn, will represent nearly 90 percent of all growth in U.S. social spending. The OMB forecasts training and employment programs, by contrast, to grow by $2 billion; and housing assistance, by $5 billion.

III. Can Medicaid's Dominant Position Be Justified?

The government's single-minded emphasis on health care is not inherently good or bad; but it should be subject to close scrutiny. Does this emphasis reflect a coherent strategy for lifting people out of poverty, based on their highest-priority needs? Is it working? The evidence suggests that the answer to both questions is no.

State Incentives

Medicaid operates on a matching-funds system, in which state-operated programs receive federal dollars in proportion to the state dollars spent. The Federal Medical Assistance Percentage (FMAP) establishes each state's share of responsibility for its Medicaid program, based on the state's per-capita income.[16] For higher-income states, the FMAP is 50 percent, which means that the state receives one federal dollar for each state dollar spent. By law, the FMAP can reach 83 percent (five federal dollars per state dollar),[17] though, for fiscal year 2017, the highest FMAP is 74.6 percent (Mississippi).[18]

One consequence of the matching structure is that states face relatively little incentive to operate their programs efficiently—to the contrary, even an entirely wasted dollar brings in at least as much additional federal money.[19] In some instances, states have intentionally increased their own spending to earn federal dollars, while simultaneously increasing state taxes on the providers that receive those dollars so that the funds ultimately flow right back into the state treasury.[20]

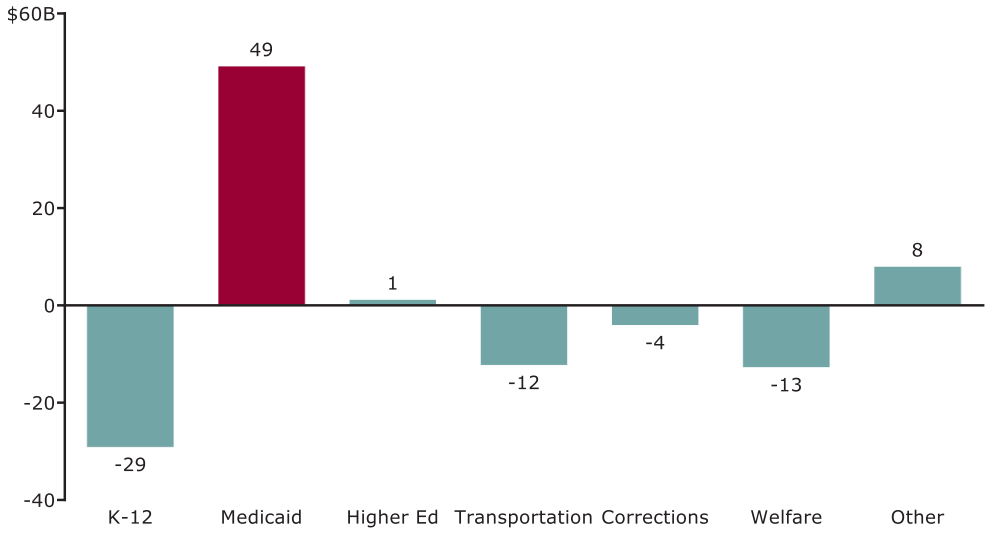
The larger problem arises when states establish the parameters of their programs. Enormous controversy has swirled around states choosing whether to expand their Medicaid programs, under the ACA, to include all households with income below 138 percent of the poverty line.[21] In reality, every state has already chosen to expand its Medicaid program beyond the federal requirements.

The federal Medicaid law establishes "mandatory" recipient groups (e.g., children under age six below 133 percent of the poverty line) and benefits that all states must cover (e.g., inpatient hospital services). It also establishes a broad range of "optional" recipients (e.g., low-income children at higher-income levels) and benefits (e.g., prosthetic devices).[22] Every state goes far beyond the mandatory level. An in-depth analysis by the Kaiser Family Foundation and the Urban Institute found that, as of 2007, 44 states were spending the *majority* of their Medicaid funds on optional beneficiaries and/or benefits.[23]

FIGURE 5.

Medicaid Crowd-Out in State Budgets, 2000 v. 2012*

2012 state budget shifts from 2000 allocations (2015$)

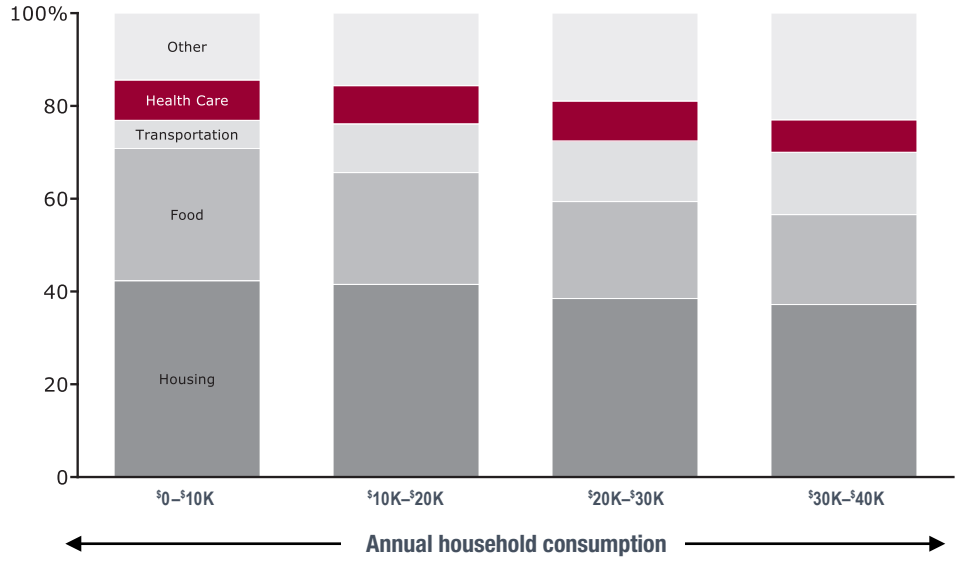


*Excludes federal spending
Source: National Association of State Budget Officers

FIGURE 6.

How Low-Income Households Spend, 2012*

2012 average household consumption



*For households under 65 years of age and not enrolled in Medicaid
Source: Bureau of Labor Statistics

States with Democrat-controlled legislatures had expanded their programs by 177 percent, on average, beyond the mandated level; in Republican-controlled states, the average optional expansion was 129 percent.[24] Even states that (later) rejected the ACA Medicaid expansion chose other, optional expansions that increased spending 133 percent above the mandated level.[25] In total, $215 billion of the $356 billion that states spent on Medicaid services in 2007 was optional; to consume that $215 billion in optional spending, the states committed only $95 billion of their own funds.[26]

At the margin, a state acting rationally should choose to expand its Medicaid program far beyond its optimal level because each additional dollar needs to produce only a fractional return to be worthwhile. If a given expansion will produce only 70 cents of value for each dollar spent, the state will pursue it: the state dollar is matched by at least one federal dollar, yielding two dollars of spending and, thus, $1.40 of return for the one dollar of state funds. In fact, states should stop expansions to their programs only when the return becomes so poor that the combined state and federal spending produces less value than the state spending costs—depending on the state's FMAP, 25 cents–50 cents of value per dollar spent.

Given the finite budget of each state, state dollars spent to get the federal match not only pull federal spending away from potentially better uses; they distort the state's budget. During 2000–2012, state Medicaid spending increased as a share of state budgets (from 10.7 percent to 14.9 percent), while K–12 education spending fell (26.5 percent to 24.0 percent) and welfare spending fell (2.0 percent to 0.9 percent). Such shifts appear small in percentage-point terms; but they represent an absolute increase of 39 percent in Medicaid spending and decreases of 9 percent and 54 percent in education and welfare spending, respectively, as compared with a scenario where programs expanded in proportion to the overall size of government (**Figure 5**).[27]

If states were not uniquely rewarded for Medicaid spending with increased federal funds—i.e., if a set level of federal funding were guaranteed independent of the state's Medicaid rules, or if comparable matching were available for all forms of social spending—states would not rationally place the emphasis on Medicaid that they do today.

Expressed Preferences

Still, it could be argued that Congress designed the Medicaid match not by accident but because only such an approach could shift state priorities as far toward health care as low-income households wanted and needed. Or, perhaps, Congress and the states together inadvertently stumbled on the right spending priorities. This notion is intriguing but not persuasive.

The contours of the safety net should follow roughly the consumption preferences of low-income households—not in every instance, but broadly in keeping with the priorities that similarly situated households express, absent government support. Departures should come where persuasive evidence suggests that market obstacles stand between households and their preferred allocation of resources, or where an allocation different from those households' priorities is best suited to improve their quality of life and raise them out of poverty. Yet the consumption patterns of low-income households not enrolled in Medicaid indicate that health care spending is a far lower priority for poor and nearly poor Americans than it is for politicians seeking to demonstrate compassion.

Consider the set of households (a) with annual spending of $10,000–$20,000, (b) that do not receive Medicaid benefits, and (c) whose head of household is younger than 65. Consumption choices within this group should be broadly representative of those made by households below the federal poverty line and reflect the relative emphasis that such households place on health care in the absence of government support. In 2012, before implementation of the ACA, these households allocated only 8 percent of their spending to health care. By comparison, they allocated 42 percent to housing, 24 percent to food, and 10 percent to transportation (**Figure 6**).[28]

Some of these households are eligible for Medicaid but have chosen not to enroll, suggesting that they are in better health and have lower demand for health care services than the typical Medicaid enrollee. Yet, as with any large insurance pool, a relatively low share of children and adults who do enroll in Medicaid will face major health challenges in any given year. Conversely, a significant share of those unenrolled are ineligible, regardless of their medical needs, whether because of their demographic characteristics relative to their income characteristics or because of their immigration status. Indeed, out-of-pocket health care spending for the unenrolled is more than three times higher than for the enrolled, which makes unlikely the hypothesis that many in the group choose to forgo coverage. In aggregate, the underlying demand for health services among the unenrolled and enrolled should at least be similar.

Unenrolled households are not hiding their health care spending by "going to the emergency room" and leaving hospitals with unpaid bills. In 2012, total uncompensated care reported by hospitals totaled $49 billion,[29] or just under

$1,000 for each of the 48 million uninsured Americans (at all income levels and regardless of Medicaid eligibility).[30] This pales in comparison with the $7,000 spent by the government per Medicaid enrollee in 2012, or even the $4,300 spent per adult after excluding the elderly and disabled.[31] While hospitals record uncompensated care based on their average costs, hospitals accepting Medicaid patients must tolerate far lower reimbursement rates for their services. Thus, $1,000 in services at Medicaid rates likely would far exceed the services represented by $1,000 of uncompensated care.

To some extent, the low level of health care spending could reflect the unaffordability of purchasing health insurance. If even the cheapest plan were beyond its budget, a household ineligible for Medicaid might forgo the coverage that it desperately wished to purchase, and a unique opportunity for aggressive government intervention might present itself. Yet before the ACA proscribed lower-cost insurance options, a market for low-cost plans could have served such demand—and certainly provided coverage of a caliber comparable with what Medicaid, in practice, offers. In 2012, the average annual premium in the individual market was $2,834 per person,[32] meaning that many plans were available for substantially less. While such cost would still have been prohibitive for a household with consumption of less than $10,000 per year, it should not have been for one spending $25,000—if health care were the indisputable top priority that the safety net accords it.

In any event, if low-income households needed greater resources simply to pay for health care, their spending on it should increase disproportionately as resources at their disposal rise. It does not. Comparing households with annual consumption below $10,000 with those in the $10,000–$20,000 bracket, only 8 percent of the additional spending goes to health care. From that bracket to the $20,000–$30,000 bracket, only 9 percent of the additional spending goes to health care. From there to the $30,000–$40,000 bracket, only 3 percent of the additional spending goes to health care. Meanwhile, as consumption increases, households consistently allocate more than one-third of their marginal resources to housing and 15 percent–20 percent to transportation (Figure 6).

The ACA has provided further evidence about the expressed preferences for health spending, slightly higher up the income ladder: the significant under-enrollment in individual insurance plans through the exchanges. As the Manhattan Institute's Yevgeniy Feyman has observed, new enrollments in 2016 were only 10 percent of what the Congressional Budget Office projected one year earlier, leaving total enrollment at only 60 percent of the expected level. Less than half of eligible individuals at 100 percent–250 percent of the federal poverty line have enrolled, even with the offer of subsidies designed to ensure affordability. For eligible young adults (aged 18–34) of all income levels, only 26 percent have acquired insurance.[33]

To be sure, the case remains circumstantial that low-income households do not put a high priority on health care spending—as it must, absent a policy experiment offering households the choice between Medicaid-style health coverage and alternative uses of equivalent resources on their behalf. Yet the evidence seems to point in that direction. Certainly, the case appears stronger than the contrary one: that government has accidentally, but correctly, discerned an unexpressed preference for the majority of all social spending to go there. The argument here is not that Medicaid is useless and every dollar wasted but only that policymakers lack evidence to justify spending nine of every ten new antipoverty dollars on it for decades on end.

Meanwhile, spending on other social programs is much lower in areas that appear to be greater priorities for low-income households. Housing consumes by far the largest share of every marginal dollar that a lower-income household can afford to spend; demand for public housing assistance is so large that only one in four eligible households is able to receive the benefit.[34] Yet federal funding for housing assistance has increased by only 13 percent in the past 20 years, while health care assistance has increased by 178 percent. Had growth in the latter merely been held to 160 percent, spending on housing could have more than doubled.

Likewise, no program exists to help low-income families with the cars that they might need to reach their jobs, even though the share of households that own a car increases three times faster than the share with health insurance between the less than $10,000 bracket and $10,000–$20,000 brackets, and four times faster between the $10,000–$20,000 and the $20,000–$30,000 brackets. Total 2015 spending on employment and training represents less than one-tenth of the increase in health care spending during 2014–15 alone.

There is also strong bipartisan recognition that the Earned Income Tax Credit, considered by many to be the most effective federal antipoverty measure, should be substantially expanded for low-income households without children. House Speaker Paul Ryan and President Barack Obama have both put forward proposals along these lines. But progress has stalled on the question of how to cover the annual cost of $6 billion[35]—as if social spending would not be more effective with that expansion in place and Medicaid spending only 1 percent lower.

Most important, perhaps: housing, education, transportation, training, and earned-income subsidies can all facilitate opportunity and help low-income households gain an economic foothold more effectively than can Medicaid. Yet Medicaid's unquestioned first claim on every government dollar continues to crowd out the spending that its recipients might prefer, from which they would most greatly benefit, and through which the future need for government-provided health care might decline.

Health Benefits

The government might still have a paternalistic interest in concentrating resources on health care—perhaps the poor are simply unaware that they are best served by resources directed overwhelmingly in that direction. Certainly, a strong civic commitment across party lines stands behind the proposition that America should not let people "die in the streets." But evidence from a variety of sources suggests that the health benefits of Medicaid coverage are often low, at best.

In "How Medicaid Fails the Poor," Manhattan Institute senior fellow Avik Roy summarizes studies finding that Medicaid recipients in a variety of contexts experience worse health outcomes than not only the privately insured but the uninsured, too. For instance, a University of Virginia study[36] reviewed nearly 900,000 major surgeries performed during 2003–07, and, as Roy explains: "The results were jarring. Patients on Medicare who were undergoing surgery were 45 percent more likely to die before leaving the hospital than those with private insurance; the uninsured were 74 percent more likely; and Medicaid patients were 93 percent more likely. That is to say, despite the fact that we will soon spend more than $500 billion a year on Medicaid, Medicaid beneficiaries, on average, fared slightly worse than those with *no insurance at all*."[37]

These were the results after controlling for demographic characteristics, location, income, and health status. Roy highlights narrower studies finding similarly poor outcomes for Medicaid recipients—compared with those for both the privately insured and the uninsured—undergoing surgery for colon cancer (University of Pennsylvania researchers, publishing in *Cancer*),[38] suffering from vascular disease (Columbia and Cornell University researchers, publishing in the *Journal of Vascular Surgery*),[39] and receiving lung transplants (Johns Hopkins researchers, publishing in the *Journal of Heart and Lung Transplantation*),[40] among other conditions.

Even more robust results come from the Oregon Health Insurance Experiment, where a state initiative to expand Medicaid in 2008 offered the opportunity for a randomized controlled study in which low-income, uninsured adults were selected by lottery to receive coverage.[41] Over the next two years, researchers studied the outcomes of the lottery's "winners" and "losers" to determine the marginal value that Medicaid coverage offered.

Some benefits emerged immediately. Specifically, the new Medicaid recipients self-reported better mental and physical health than their counterparts in the control group. They used health care services at a significantly higher rate. And they also had lower out-of-pocket medical costs and less medical debt.[42] Yet researchers ultimate concluded: "This randomized, controlled study showed that Medicaid coverage generated no significant improvements in measured physical health outcomes in the first 2 years."[43] Recipients felt good about having the coverage, it eased financial burdens, and it increased the consumption of health care services. But it produced no statistically significant improvement in physical health. Nor did it show any significant effect on employment or earnings,[44] undermining the notion that the provision of health insurance might remove obstacles to participation in the workforce.

A subsequent analysis concluded that each incremental dollar of Medicaid spending provided 20 cents–40 cents of value to the recipient, based on factors including how much households were willing to pay for medical care in the absence of Medicaid coverage and how much coverage affected life expectancy.[45] This result is consistent with the level to which Oregon should have rationally expanded its Medicaid program, given its FY2009 FMAP of 73 percent.[46] In other words, Oregon chose to spend an additional 27 cents to attract 73 cents of federal spending and generate value on the order of 30 cents for a state resident.

One important limitation of the Oregon study was its short time frame: How much effect on physical health can emerge from only a year or two of improved insurance coverage? Yet wider-lens assessments of insurance coverage, health care access, and mortality point in the same direction. A study conducted by researchers at Harvard University and published in the *New England Journal of Medicine* asked: Does an expansion of Medicaid keep more people alive? Comparing mortality rates for the five years before and after some states expanded their Medicaid coverage in the early 2000s, the study found no consistent result. Overall, states expanding Medicaid appeared to have reduced annual deaths by 20 per 100,000 people. However, of the three states studied, only one (New York) showed a statistically significant reduction.

One (Arizona) showed a statistically insignificant reduction. One (Maine) showed a statistically insignificant increase in deaths.[47]

Comparison of mortality rates across states with varying levels of optional Medicaid spending produces a similar conclusion. If more aggressive expansion of Medicaid improves health, states with higher levels of optional spending should see smaller age-adjusted mortality gaps between higher- and lower-income groups. But when using rates for non-Hispanic whites and African-Americans as proxies for those groups, no such relationship exists.[48]

During 2008–10, in states whose optional Medicaid expansion, as of 2007, exceeded the nationwide median, the mortality rate for African-Americans was, on average, 17 percent higher than for non-Hispanic whites. In states with below-median expansions, African-American mortality was only 10 percent higher. Across all 46 states (and the District of Columbia) with available data, no correlation existed between the extent of optional Medicaid expansion and relative levels of mortality.[49] The story repeats itself for infant mortality: during 2006–08, in states with larger Medicaid expansions, infant mortality for African-Americans was, on average, 160 percent higher than for non-Hispanic whites; for states with smaller expansions, the gap was only 133 percent. Again, no correlation existed across states.[50]

How could it be that Medicaid coverage often fails to produce substantial health benefits? Medicaid coverage does not guarantee access to care: a doctor must still agree to see the patient at the dramatically reduced rate that Medicaid will offer to pay. Nevertheless, all those Medicaid dollars spent represent services ultimately rendered. Yet even access to care may prove less beneficial than intuition would suggest. An April 2016 study in the *Journal of the American Medical Association*, by Raj Chetty of Stanford University and coauthors at MIT, Harvard, McKinsey & Company, and the U.S. Treasury, found "geographic differences in life expectancy for individuals in the lowest income quartile were significantly correlated with health behaviors such as smoking, but were not significantly correlated with access to medical care, physical environmental factors, income inequality, or labor market conditions."[51]

None of these studies shows that no one benefits from Medicaid or that the entire program budget is wasted. Undoubtedly, recipients value the opportunity to obtain health care services paid for by someone else, and some achieve better health outcomes as a result. Some studies identify significant effects for larger classes: for instance, providing pregnant women with Medicaid coverage appears to reduce infant mortality[52] and leads to better long-term outcomes for their children.[53] This observation argues for the existence of *some* program and, likely, a carefully targeted one. It provides no basis for prioritizing health care spending over other forms of assistance, or for fearing that the redirection of resources to other forms of support would be calamitous—or, on balance, harmful to recipients.

One Program Among Many

Too often, debates over Medicaid's efficacy are framed over the choice between maintaining it or cutting it. Fashioning effective antipoverty policy requires a different question: Would some chunk of Medicaid spending be better spent on something else? The unique status awarded Medicaid, under which it grows without limit at the expense of all other programs, presumes a special interest in providing health care above all else—presumably as a means of protecting life. Yet the program fares poorly at even that narrowly defined mission.

The main benefits of Medicaid identified in the Oregon study are improvements in self-reported well-being and reductions in financial stress and depression. But health insurance has no unique claim to such results. A government offer to cover the recipient's rent or car payment might offer similar effects. Indeed, given that the value that low-income households receive from Medicaid represents only a fraction of each dollar spent there, and that those households prefer to direct their own resources elsewhere, the results from other spending should be far greater.

Even if the specific goal is better health outcomes, Medicaid is not clearly the appropriate investment. For example, compared with the barely measurable gains offered by Medicaid expansions, what would happen to diabetes, hypertension, and mortality if the recipients were instead offered vouchers to move to high-quality affordable housing in better neighborhoods? Or were offered a paid six-month apprenticeship? A May 2016 study published in *Health Affairs* reports that "states with a higher ratio of social to health spending (calculated as the sum of social service spending and public health spending divided by the sum of Medicare spending and Medicaid spending) had significantly better subsequent health outcomes for the following seven measures: adult obesity; asthma; mentally unhealthy days; days with activity limitations; and mortality rates for lung cancer, acute myocardial infarction, and type 2 diabetes."[54]

Imagine returning to 1975 and facing the question: We are going to double social spending per person over the next 40 years, so where should we direct it? Knowing what we know now, could "all on Medicaid!" possibly have been the right answer?

IV. Paths to Reform

Every marginal dollar shifted from a lower-value use in Medicaid to a higher-value use in a different antipoverty program should improve the well-being of low-income households at no cost to taxpayers. The optimal shift is impossible to predict *ex ante*; but it should represent a significant share of the optional Medicaid funding that states are encouraged by the federal match to spend. In 2011, before the ACA-driven expansion, optional spending across the state and federal levels totaled approximately $255 billion,[55] helping to produce enormous variations in coverage and cost by state. To estimate the scale of misallocation, one useful approach is to identify potentially excess spending created where a state's enrollment rate or per-person spending in a group exceeds the national average.

For instance, spending per disabled recipient ranged from a low of $8,500 in Alabama to $17,900 in Massachusetts to a high of $32,100 in New York. The share of the state's population qualifying as disabled recipients ranged from a low of 1.4 percent in Utah to 3.0 percent in Washington to a high of 6.8 percent in West Virginia.[56] If the 25 states with spending per disabled recipient above the national median of $17,100 reduced their spending to that level, and the 25 states with an enrollment share above the national median of 2.9 percent reduced enrollment to that level, Medicaid spending would decline by $47 billion. Applying the same methodology across children, adults, and elderly recipients would free up a total of $115 billion annually for other poverty-fighting strategies.

This estimate is intended to show the magnitude of potential savings, not to imply that the median spending and enrollment level is an automatically appropriate maximum for every participant category in every state. Some states with particular demographic, economic, or public health challenges might find sensible reasons to remain high-spending outliers. And there is no question that resource reallocation on this scale would force states to make difficult choices about their programs. The point is that, even after shifting $100 billion, no state would be reducing access below what half of states make do with already. No public health crisis or politically unsustainable deprivation would ensue.

Still, in charting a course for reform, an important principle should be that no state is forced to make such reallocation; if a state believes that Medicaid is the highest and best use of every dollar that it and the federal government currently put toward its program, so be it. The question is how best to remove the incentives for irrational expansion and offer flexibility to states that would make different choices for their populations.

The Block-Grant Mistake

In response to concerns over Medicaid's exploding costs, policymakers on the right have typically proposed block-granting the program. The rationale: if each state received a fixed quantity of Medicaid dollars, growing annually at a fixed rate, the incentive to spend more and thus attract more federal funding would disappear and efforts to control cost would take precedence. The problem with this approach is its exclusive emphasis on budgetary concerns at the expense of improving support for low-income households. Medicaid spending growth might decline, but the resources already committed through past overexpansion would remain trapped there.

More recent proposals to reform the broader safety net have emphasized the need to combine funding streams across programs. Yet such proposals often exclude Medicaid from their scope. Speaker of the House Paul Ryan, for instance, has proposed "Opportunity Grants" that would allow a state to combine the federal dollars that it currently receives from 11 federal programs (primarily SNAP, TANF, and Section 8 housing) into a single funding stream to spend on antipoverty efforts as it sees fit.[57] Former Florida governor Jeb Bush, in his presidential campaign, proposed similar "Right to Rise Grants" emphasizing SNAP, TANF, and housing assistance as well.[58] Neither proposal includes Medicaid.

Those proposals are flawed. A crucial premise of combining disparate programs rests on the need to redistribute funding that has been inefficiently allocated by the tangle of federal bureaucracies. But nearly all that misallocation has flowed in one direction: to Medicaid. If Medicaid funds are excluded from consolidated funding efforts, the majority of all funds—and the vast majority of the funds in need of reallocation—will remain inaccessible to state-led reform.

One justification for leaving Medicaid dollars aside holds that they are needed for the funding of health care reforms that might replace the ACA. Unfortunately, that strategy will only worsen the safety net's distortion by moving the funding away from "antipoverty" efforts entirely and dedicating them to "universal health coverage." Funds once intended to combat poverty will increasingly be allocated through the lens of what middle- and upper-middle-class households demand (i.e., generous health insurance coverage). Directing the spending in ways best suited to the particular needs of low-income households will only become harder.

The Flex Fund

The most attractive solution for the safety net would be a "Flex Fund" for each state that encompasses all federal social spending within the state, including Medicaid.[59] Florida

senator Marco Rubio has endorsed this approach.[60] Unlike a block grant, a Flex Fund is aimed not at constraining spending but rather at allowing any given level of spending to flow toward its most effective uses without the distortions of existing bureaucratic silos and fund-matching incentives.

Under a Flex Fund, each state would, by default, be free to continue operating its current, federally defined programs. But absent the matching incentive to overinvest in health care relative to other services, a state might choose to shift significant resources out of Medicaid and toward, say, its own, redesigned housing-voucher program—or double or triple the Earned Income Tax Credit. Under a Flex Fund, the state might also give low-income households their own say in the matter, offering various programs to choose among. The state might launch entirely new programs to support early-childhood interventions, access to transportation, or residential relocation.

For example, Topher Spiro and Lanhee Chen of the Hoover Institution have highlighted the broad, bipartisan support for "nurse coaches" for first-time, low-income mothers, which they call "among the most effective interventions ever studied." They write:

> Researchers have accumulated decades of evidence from randomized controlled trials—the gold standard in social science research—following participants for up to 15 years. They have consistently found that nurse coaches reduce pregnancy complications, pre-term births, infant deaths, child abuse and injury, violent crimes and substance abuse. What's more, nurse coaches improve language development, and over the long term, cognitive and educational outcomes. Nurse coaching is a vital tool that addresses both the liberal concern about income inequality and the conservative concern about inequality of opportunity. For fiscal conservatives in particular, nurse coaching sharply reduces long-term government spending on Medicaid, welfare and food stamps. And for advocates of good government, the independent Coalition for Evidence-Based Policy rates nurse coaching as "top tier"—meaning that it yields sizable, sustained effects.[61]

Yet, they note, support of this kind reaches only 2 percent–3 percent of eligible families, primarily because state governments are given neither the flexibility nor incentives to direct resources toward it.

Universal Match

Short of releasing control entirely, the federal government could achieve substantial reform by replacing the Medicaid-only match with a "universal" match that provides matching federal funds under the same FMAP formula to state spending on any antipoverty program. A universal match would not allow states the flexibility of a Flex Fund; but, at least among federal programs, a universal match would allow funds to flow toward what each state believes to be the best use. When setting relative funding levels for housing assistance and health insurance, state governments would no longer face a unique offer of federal reward when—and only when—they choose the latter.

To avoid net spending increases, each state's FMAP would be proportionally reduced to ensure that projected total federal funding in the year after reform was unchanged from the previous year. A state that wished to target all its matching funds back into Medicaid could do so; but it could also engineer a transition toward higher spending in other areas.

Waivers

As a preliminary step to pilot and validate the approach, the federal government could expand the use of Medicaid waivers for redirecting Medicaid funding toward other uses. Currently, two such waiver programs exist:

- Section 1115 waivers, under the Social Security Act, allow states latitude to experiment with applying Medicaid funding toward groups or services not usually eligible, or toward innovative systems for delivering care.[62] For example, the 2007 Massachusetts health care reform used a Section 1115 waiver to divert Medicaid funds toward subsidies for private insurance premiums.[63]

- Section 1332 waivers, under the ACA, allow states similar latitude to deviate from the ACA's core requirements and repurpose funds that would otherwise have subsidized health care premiums for the state's residents.[64] These waivers do not begin until 2017, and their potential scope remains a subject of debate.[65]

Both waivers require that spending remain dedicated to health care: as written, they could not allow sufficient flexibility to reallocate spending to other programs entirely. But similarly structured waivers, if created by Congress, could begin the process of experimenting with greater state latitude. Such waivers could allow an open-ended shifting of funds or, in an especially constrained model, provide a specific set of options. For instance, a state could apply to shift a fixed percentage of its Medicaid funding toward either an expansion of its Earned Income Tax Credit or toward clearing its Section 8 housing waiting list.

Waivers are far from ideal. They vest authority in an executive agency that can wield its discretion as a weapon against state-level policymakers. Waivers can insert an entire new level of bureaucratic complexity. For example, when California attempted to implement a three-year program, via a Section 1115 waiver, in 2008, it took 14–30 months for counties to begin receiving federal reimbursement.[66] And waivers will accomplish only so much if the result is to let states choose between spending too much on Medicaid or increasing investment in a fundamentally broken program, such as Section 8. Still, waivers could offer a starting point to validate the thesis that states and low-income households would prefer to see more Medicaid money spent elsewhere.

V. Conclusion

Medicaid's dominant role in the social safety net lacks a firm justification. To the extent that it is intentional, this role stems from a political obsession with prioritizing health care funding even when that choice does not align with the preferences of low-income households and does not produce the expected results. But to a large extent, it is not intentional and stems, instead, from poorly designed incentive structures and funding streams.

Americans may insist on continuing the current Medicaid-dominated approach to safety-net spending. Yet the choice should be explicit, rather than an emergent property of a system that no one understands. The further that choice can be devolved, to allow states—or even individual households—to go their separate ways, the better the chance that low-income households will receive the help that they need most.

Appendix

This paper presents data on total social spending for 1965–2015 and forecasts for 2015–20 based on the historical tables published by the Office of Management and Budget and relies on the classifications provided in those tables. Most spending comes from the "human resource programs" section of the Office of Management and Budget Table 8.5 (Outlays for Mandatory and Related Programs)[67] and is treated as follows:

Category	Treatment
Education, training, employment, and social services	Included but adjusted
Health: Medicaid	Included but adjusted
Health: Refundable premium tax credit and cost-sharing reductions	Included as Affordable Care Act
Health: Children's health insurance	Included but adjusted
Health: Other	Excluded
Medicare	Excluded
Income security: General retirement and disability	Excluded
Income security: Federal employee retirement and disability	Excluded
Income security: Unemployment compensation	Included as Unemployment
Income security: Food and nutrition assistance	Included but adjusted
Income security: Supplemental Security Income	Included as Supplemental Security Income
Income security: Family and other support assistance	Included but adjusted
Income security: Earned Income Tax Credit	Included as Earned Income Tax Credit
Income security: Child Tax Credit	Included as Child Tax Credit
Income security: Making Work Pay Tax Credit	Included as Making Work Pay Tax Credit
Income security: Payments to states for foster care / adoption assistance	Included but adjusted
Income security: Housing assistance and other (including offsetting receipts)	Included but adjusted
Social Security	Excluded
Veterans benefits and services: Income security for veterans	Excluded
Veterans benefits and services: Other	Excluded

Additional spending comes from select programs in the Office of Management and Budget Table 8.7 (Outlays for Discretionary Programs)[68] but is, in all cases, adjusted:

- **Community and regional development**
- **Education**
- **Training, employment, and social services**
- **Housing assistance**
- **Income security: Other**

The data are adjusted and supplemented as follows:

- For 1965–2014, Medicaid and CHIP spending from OMB program outlays is replaced with data from the National Health Expenditure Accounts,[69] which provide detailed spending for Medicaid federal, Medicaid state, CHIP federal, and CHIP state. For 2015–20, state Medicaid and CHIP spending are imputed by multiplying OMB-reported federal spending in each category by the 2014 ratio of NHE-reported state to federal spending in the category.

- For 1969–2015, SNAP-specific data from the U.S. Department of Agriculture[70] are used for SNAP. OMB-reported "food and nutrition assistance" spending less USDA-reported SNAP spending is used for "other nutrition."

- For 1965–2020, program-specific OMB data[71] for "payments to states for child support enforcement and family support programs," "payments to states for the child care and development block grant," and Temporary Assistance to Needy Families are used for "AFDC/TANF federal." For 1994–2013, CBO data[72] are used for "AFDC/TANF state." For each year before 1994, state spending is imputed by multiplying AFDC/TANF federal spending by the 1994 ratio of state to federal spending. For each year after 2013, state spending is imputed using the 2013 ratio. OMB-reported "family and other support assistance," "payments to states for foster care /adoption assistance" and "income security: other" spending less AFDC/TANF spending is used for "other social services, family support, and income security."

- For 1965–2020, education, training, employment, and social-services spending from OMB program outlays is replaced by function- and program-specific data.[73] Function-specific OMB data for "elementary, secondary, and vocational education" are used for "K–12 education." Program-specific OMB data for "student financial assistance" are used for "higher education." Function-specific OMB data for "training and employment" are used for "training and employment." Function-specific OMB data for "social services" are added to the aforementioned category "other social services, family support, and income security."

- For 1965–2020, "community and regional development" spending from OMB program outlays is replaced by function-specific OMB data for "community development" and is used for "community development."

- For 1965–2020, mandatory "housing assistance and other (including offsetting receipts)" and discretionary "housing assistance" spending from OMB program outlays are combined as "housing."

The resulting database is not entirely comprehensive (not all sources of state and local spending are included), and classification is not always precise (e.g., the "training and employment" line item includes $7.7 billion reported by OMB in 2009, a total less than the $13 billion of employment and training funding and $5 billion in additional American Recovery and Reinvestment Act funding identified by GAO across 47 programs that year).[74] However, the database provides a useful, directionally correct picture of how U.S. federal and state social spending has evolved in recent decades.

All figures are adjusted to 2015 dollars, using the composite deflator provided by OMB for use in its historical tables.[75] Data on the number of Americans in poverty—used to compute spending per person in poverty—come from the U.S. Census Bureau.[76]

U.S. Federal and State Social Spending, 1965–2020

2015$ (B)	1965	1970	1975	1980	1985	1990	1995	2000	2005	2010	2015	2020	SHARE OF INCREASE 1965-1975	SHARE OF INCREASE 1975-2015	SHARE OF INCREASE 2015-2020
Medicaid Federal	1.9	16.5	30.4	40.6	46.5	75.5	130.1	162.1	216.1	289.9	349.8	405.0	14%	39%	32%
Medicaid State	-	14.2	24.8	32.2	37.8	55.0	89.2	115.8	160.4	142.4	218.5	253.0	12%	24%	20%
CHIP Federal	-	-	-	-	-	-	-	2.9	6.4	8.8	9.2	5.4	0%	1%	-2%
CHIP State	-	-	-	-	-	-	-	1.3	2.8	3.8	4.0	2.4	0%	0%	-1%
Affordable Care Act	-	-	-	-	-	-	-	-	-	-	27.2	95.2	0%	3%	40%
Health Care Subtotal	1.9	30.8	55.2	72.8	84.3	130.6	219.2	282.1	385.7	444.9	608.7	761.0	27%	68%	89%
Unemployment	16.7	17.9	52.5	47.3	32.6	30.4	32.2	28.8	39.3	170.9	31.6	37.7	18%	-3%	4%
SNAP	-	3.4	18.9	25.8	24.1	27.4	37.3	23.7	37.8	74.3	74.0	N/A	10%	7%	N/A
Other Nutrition	2.1	2.2	8.3	10.9	10.2	10.4	13.5	15.2	17.4	21.3	23.8	91.7	3%	2%	-4%
Supplemental Security Income	-	-	17.7	16.0	17.8	20.4	35.7	40.9	43.0	47.8	52.2	52.2	9%	4%	0%
Housing	1.7	2.9	8.4	15.8	52.0	28.2	41.8	38.9	44.7	64.2	47.2	52.2	3%	5%	3%
AFDC/TANF Federal	19.8	24.1	21.0	20.5	19.0	21.7	27.3	27.0	28.6	27.3	22.3	24.2	1%	0%	1%
AFDC/TANF State	14.3	17.4	15.1	14.7	13.7	15.6	19.8	15.0	13.4	16.5	14.3	15.6	0%	0%	1%
Other Soc Serv, Fam Support, Income Security	4.3	15.8	23.6	32.0	29.9	31.8	38.9	44.1	48.6	56.2	49.0	55.7	10%	3%	4%
Earned Income Tax Credit	-	-	-	3.6	2.3	7.7	23.1	36.2	42.1	59.6	60.1	62.2	0%	7%	1%
Child Tax Credit	-	-	-	-	-	-	-	1.1	17.8	24.7	20.6	20.2	0%	3%	0%
Making Work Pay Tax Credit	-	-	-	-	-	-	-	-	-	14.9	-	-	0%	0%	0%
K-12 Education	5.1	16.8	17.8	19.3	15.6	17.6	22.2	28.5	46.6	79.7	40.0	43.7	6%	3%	2%
Higher Education	-	2.9	6.1	10.3	8.6	10.5	10.7	12.6	18.4	37.0	31.6	31.2	3%	3%	0%
Training and Employment	3.8	9.3	16.7	28.9	10.2	10.0	11.2	9.4	8.3	10.7	7.1	9.0	7%	-1%	1%
Community Development	2.9	8.4	9.5	13.7	9.5	6.3	7.2	7.6	7.1	10.8	7.8	4.9	3%	0%	-2%
Total	$72.6	$152.0	$271.0	$331.6	$329.7	$368.4	$540.1	$611.1	$798.9	$1,160.6	$1,090.2	$1,261.5	100%	100%	100%
Americans in poverty (millions)	36.1	24.1	23.4	26.1	33.7	31.5	38.1	32.8	37.0	43.6	46.7	N/A			
Health care spending per person in poverty	$54	$1,275	$2,360	$2,794	$2,500	$4,142	$5,760	$8,602	$10,414	$10,211	$13,047		24%	91%	
Other spending per person in poverty	$1,959	$5,020	$9,234	$9,924	$7,283	$7,545	$8,431	$10,034	$11,156	$16,429	$10,320		76%	9%	
Total	$2,013	$6,295	$11,595	$12,718	$9,783	$11,686	$14,190	$18,636	$21,569	$26,639	$23,367		100%	100%	

Endnotes

[1] U.S. Census Bureau, "Historical Poverty Tables—People," last revised September 16, 2015, https://www.census.gov/hhes/www/poverty/data/historical/people.html (table 2).

[2] See, e.g., Robert Rector and Rachel Sheffield, "Air Conditioning, Cable TV, and an Xbox: What Is Poverty in the United States Today?," Heritage Foundation, July 19, 2011, http://www.heritage.org/research/reports/2011/07/what-is-poverty.

[3] Not all social spending is targeted toward those below the poverty line, so dividing total spending by the population below the poverty line does not reflect actual government benefits received specifically by those in poverty. However, the population in poverty provides a proxy for the scale of need and, therefore, the extent to which spending grows in response to an increasing number of individuals in need or to increasing resources per individual. Further, the calculation identifies the resources targeted generally at low-income populations that, therefore, *could* be focused on those in poverty—but for a policy decision to reallocate them to individuals higher up the income ladder.

[4] "Consumer Price Index—All Urban Consumers: Medical Care," Bureau of Labor Statistics, accessed April 29, 2016, http://data.bls.gov/timeseries/CUUR0000SAM?output_view=pct_12mths (increase is relative to Office of Management and Budget's composite deflator, used throughout this paper for conversion to 2015 dollars).

[5] "MACStats: Medicaid and CHIP Data Book," MACPAC, December 2015, https://www.macpac.gov/publication/macstats-medicaid-and-chip-data-book-2 (exhibit 10).

[6] Spending per enrollee is equal to total state and federal Medicaid spending, adjusted for medical inflation (see n. 4 above), divided by full-year-equivalent Medicaid enrollees (see n. 5). Note that, due to covariance between spending per enrollee and total enrollees, the component growth rates sum to 5.7 percent, less than the overall growth rate of 5.8 percent.

[7] "2014 Actuarial Report on the Financial Outlook for Medicaid," Center for Medicare & Medicaid Services, 2014, https://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/downloads/medicaid-actuarial-report-2014.pdf (tables 15 and 16).

[8] Costs attributable to per-person benefits are calculated by multiplying enrollee totals by cost per enrollee. To include DSH and other Medicaid spending, see "2014 Actuarial Report on the Financial Outlook for Medicaid," Center for Medicare & Medicaid Services, 2014, https://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/downloads/medicaid-actuarial-report-2014.pdf (tables 14 and 17).

[9] Growth by enrollment category and driver calculated by holding constant one while increasing the other, and then vice versa. Note that, due to covariance between spending per enrollee and total enrollees, the component growth amounts sum to $145 billion, less than the total growth of $151 billion. Percentages are therefore reported as each component's share of the sum of components.

[10] See n.7 above. For pre-2000 Medicaid enrollment data, see "Data Compendium, 2011 Edition," Center for Medicare & Medicaid Services, December 2011, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/DataCompendium/2011_Data_Compendium.html (table IV.8).

[11] "Annual Statistical Supplement, 2015," Social Security Administration, April 2016, https://www.ssa.gov/policy/docs/statcomps/supplement (table 7.A9).

[12] Mary Daly and Richard V. Burkhauser, "The Supplemental Security Income Program," in "Means-Tested Transfer Programs in the United States," Robert A. Moffit, ed., January 2003, http://www.nber.org/chapters/c10255.pdf.

[13] "Annual Statistical Supplement, 2015," Social Security Administration, April 2016, https://www.ssa.gov/policy/docs/statcomps/supplement (table 7.A9).

[14] See n. 12 above. For an in-depth examination of the similar trends driving rapid enrollment increases in Social Security Disability Insurance, see Scott Winship, "How to Fix Disability Insurance," *National Affairs*, Spring 2015, http://www.nationalaffairs.com/publications/detail/how-to-fix-disability-insurance.

[15] "2014 Actuarial Report on the Financial Outlook for Medicaid," Center for Medicare & Medicaid Services, 2014, https://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/downloads/medicaid-actuarial-report-2014.pdf (tables 15 and 16).

[16] "Medicaid Financing: An Overview of the Federal Medicaid Matching Rate," Kaiser Family Foundation, September 2012, https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8352.pdf.

[17] Social Security Act § 1905(b), https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

[18] "FY2017 Federal Medicaid Assistance Percentages," U.S. Department of Health and Human Services, December 29, 2015, https://aspe.hhs.gov/basic-report/fy2017-federal-medical-assistance-percentages.

[19] See, e.g., Michael F. Cannon, "Governors' Letter Shows Why Medicaid Block Grants Are Necessary," Kaiser Health News, April 18, 2011, http://www.cato.org/publications/commentary/governors-letter-shows-why-medicaid-block-grants-are-necessary.

[20] John Holahan and David Liska, "Where Is Medicaid Spending Headed?," Kaiser Family Foundation, December 1996, http://kff.org/medicaid/report/where-is-medicaid-spending-headed-report.

[21] Robert Pear, "State-Level Brawls over Medicaid Reflect Divide in G.O.P.," *New York Times*, December 27, 2015, http://www.nytimes.com/2015/12/28/us/politics/state-level-brawls-over-medicaid-reflect-wider-war-in-gop.html.

[22] "Medicaid: An Overview of Spending on 'Mandatory' vs. 'Optional' Populations and Services," Kaiser Family Foundation, June 2005, http://www.kaiserfamilyfoundation.files.wordpress.com/2013/01/medicaid-an-overview-of-spending-on.pdf. For detailed benefit lists, see "Benefits," Center for Medicare & Medicaid Services, https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/medicaid-benefits.html.

[23] Brigette Courtot et al., "Medicaid Enrollment and Expenditures by Federal Core Requirements and State Options," Kaiser Family Foundation, January 2012, https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8239.pdf (appendix B, table 1).

[24] Legislative control based on 2006 session; states with split legislatures excluded. See "Partisan Composition of State Legislatures 2002–2014," National Conference of State Legislatures, accessed April 30, 2016, http://www.ncsl.org/documents/statevote/legiscontrol_2002_2014.pdf.

[25] For list of states rejecting the ACA Medicaid expansion, see "Where the States Stand on Medicaid Expansion," Advisory Board Company, January 13, 2016, https://www.advisory.com/daily-briefing/resources/primers/medicaidmap.

[26] For mandatory and optional 2007 Medicaid spending by state, see n. 23. For 2007 FMAPs by state, see "Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier," Kaiser Family Foundation, accessed April 30, 2016, http://kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier (FY2007).

[27] "State Expenditure Report: Examining Fiscal 2011–2013 State Spending," National Association of State Budget Officers, 2013, http://www.nasbo.org/sites/default/files/State%20Expenditure%20Report%20%28Fiscal%202011-2013%20Data%29.pdf (table 3). The table reports spending in percentage terms only. See table 1 for 2012 spending in absolute dollars and table 1 in the equivalent fiscal 1999–2001 report for 2000 spending in absolute dollars.

[28] Consumption data in this paper are based on analysis of Consumer Expenditure Public-Use Interview Survey Microdata published by the Bureau of Labor Statistics for 2012. See http://www.bls.gov/cex/pumd_2012.htm. The analysis uses all responses from the five quarters of the 2012 survey for which detailed health insurance expenditure data are available, the head of household was under 65, and no household member was enrolled in Medicaid (N=3,393). The three months of household consumption across the previous and current quarters were annualized, and households were then grouped into consumption brackets, at $10,000 increments. Consumption totals and subsequent income brackets are in 2012 dollars. Average spending within each bracket was calculated for the 14 main categories of expenditure reported by the BLS.

[29] "Uncompensated Hospital Care Cost Fact Sheet," American Hospital Association, January 2014, http://www.aha.org/content/14/14uncompensatedcare.pdf.

[30] "Income, Poverty, and Health Insurance Coverage in the United States: 2012," U.S. Census Bureau, September 2013, https://www.census.gov/prod/2013pubs/p60-245.pdf.

[31] See n.7 above.

[32] "Average Monthly Premiums per Person in the Individual Market," Kaiser Family Foundation, accessed April 30, 2016, http://kff.org/other/state-indicator/individual-premiums (2012).

[33] Yevgeniy Feyman, "Will Obamacare Lead to Universal Coverage?," Manhattan Institute for Policy Research, April 15, 2016, http://www.manhattan-institute.org/html/issues-2016-will-obamacare-lead-universal-coverage-8773.html.

[34] "Federal Housing Assistance for Low-Income Households," Congressional Budget Office, September 2015, https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/50782-LowIncomeHousing-OneColumn.pdf.

[35] "The President's Proposal to Expand the Earned Income Tax Credit," U.S. Treasury Department, March 3, 2014, https://www.whitehouse.gov/sites/default/files/docs/eitc_report.pdf; Richard V. Reeves and Joanna Venator, "Are Obama and Ryan Proposals for an EITC Expansion Pro- or Anti-Mobility?," Brookings Institution, August 1, 2014, http://www.brookings.edu/blogs/social-mobility-memos/posts/2014/08/01-ryan-poverty-plan-eitc-reeves; and Dylan Matthews, "Paul Ryan and Obama Support the Same Proposal—and It's Still Not Going to Pass," Vox, July 25, 2014, http://www.vox.com/2014/7/25/5934857/eitc-ryan-obama-expansion-poverty.

[36] Damien J. LaPar et al., "Primary Payer Status Affects Mortality for Major Surgical Operations," Annals of Surgery, 2010, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3071622.

[37] Avik Roy, "How Medicaid Fails the Poor," Encounter Broadside, No. 36, November 2013 (p. 19, emphasis in original).

[38] R. R. Kelz et al., "Morbidity and Mortality of Colorectal Carcinoma Surgery Differs by Insurance Status," *Cancer*, November 2004, http://www.ncbi.nlm.nih.gov/pubmed/15382089.

[39] J. K. Giacovelli et al., "Insurance Status Predicts Access to Care and Outcomes of Vascular Disease," *Journal of Vascular Surgery*, October 2008, http://www.ncbi.nlm.nih.gov/pubmed/18586449.

[40] J. G. Allen et al., "Insurance Status Is an Independent Predictor of Long-Term Survival After Lung Transplantation in the United States," *Journal of Heart and Lung Transplantation*, January 2011, http://www.ncbi.nlm.nih.gov/pubmed/20869264.

[41] See, e.g., "The Oregon Health Insurance Experiment," http://www.nber.org/oregon.

[42] Amy Finkelstein et al., "The Oregon Health Insurance Experiment: Evidence from the First Year," *Quarterly Journal of Economics*, 2012, http://qje.oxfordjournals.org/content/127/3/1057.

[43] Katherine Baicker et al., "The Oregon Experiment—Effects of Medicaid on Clinical Outcomes," *New England Journal of Medicine*, May 2, 2013, http://www.nejm.org/doi/full/10.1056/NEJMsa1212321.

[44] Katherine Baicker et al., "The Impact of Medicaid on Labor Market Activity and Program Participation: Evidence from the Oregon Health Insurance Experiment," *American Economic Review*, May 2014, https://www.aeaweb.org/articles.php?doi=10.1257/aer.104.5.322.

[45] Amy Finkelstein et al., "The Value of Medicaid: Interpreting Results from the Oregon Health Insurance Experiment," June 2015, http://economics.mit.edu/files/10580.

[46] "Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier," Kaiser Family Foundation, accessed April 30, 2016, http://kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier (FY2009).

[47] Benjamin D. Sommers et al., "Mortality and Access to Care Among Adults After State Medicaid Expansions," *New England Journal of Medicine*, September 13, 2012, http://www.nejm.org/doi/full/10.1056/NEJMsa1202099 (table 2).

[48] For an example of previous analysis comparing mortality rates by race across states, see T. J. Matthews et al., "Infant Mortality Statistics from the 2013 Period," National Vital Statistics Reports, August 6, 2015, http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_09.pdf (table 2).

[49] "Health, United States 2011: Age-Adjusted Death Rates, by Race, Hispanic Origin, and State: United States, Average Annual 1979–1981, 1989–1991, 2008–2010," National Center for Health Statistics, accessed April 29, 2016, http://www.cdc.gov/nchs/hus/contents2011.htm (updated table 23).

[50] "Health, United States 2011: Neonatal Mortality Rates, by Race and Hispanic Origin of Mother, and State: United States, Average Annual 1989–1991, 2003–2005, and 2006–2008," National Center for Health Statistics, accessed April 29, 2016, http://www.cdc.gov/nchs/hus/contents2011.htm (updated table 19).

[51] Raj Chetty et al., "The Association Between Income and Life Expectancy in the United States, 2001–2014," *Journal of the American Medical Association*, April 26, 2016, http://jama.jamanetwork.com/article.aspx?articleid=2513561.

[52] Janet Currie and Jonathan Gruber, "Saving Babies: The Efficacy and Cost of Recent Changes in the Medicaid Eligibility of Pregnant Women," *Journal of Political Economy*, December 1996, http://www.jstor.org/stable/2138939.

[53] Sarah Miller and Laura Wherry, "The Long-Term Health Effects of Early Life Medicaid Coverage," http://www-personal.umich.edu/~mille/MillerWherry_Prenatal2015.pdf.

[54] Elizabeth H. Bradley et al., "Variation In Health Outcomes: The Role of Spending on Social Services, Public Health, and Health Care, 2000–09," *Health Affairs*, May 2016, http://content.healthaffairs.org/content/35/5/760.abstract.

[55] "Medicaid Spending by Enrollment Group," Kaiser Family Foundation, accessed May 1, 2016, http://kff.org/medicaid/state-indicator/medicaid-spending-by-enrollment-group (data view: Currency). Assumes no change in optional share of total spending since 2007 analysis. See Courtot et al., "Medicaid Enrollment and Expenditures by Federal Core Requirements and State Options" (appendix B, table 1).

[56] "Distribution of Medicaid Enrollees by Enrollment Group," Kaiser Family Foundation, accessed May 1, 2016, http://kff.org/medicaid/state-indicator/distribution-of-medicaid-enrollees-by-enrollment-group (data view: Number); "Medicaid Spending by Enrollment Group," Kaiser Family Foundation, accessed May 1, 2016 (data view: Currency). Enrollment percentages are calculated by applying FY2011 enrollment totals to 2014 U.S. population totals. See "Population Distribution by Age," Kaiser Family Foundation, accessed May 1, 2016, http://kff.org/other/state-indicator/distribution-by-age (data view: Number).

[57] "Expanding Opportunity in America: A Discussion Draft from the House Budget Committee," House Budget Committee, July 24, 2014, http://budget.house.gov/uploadedfiles/expanding_opportunity_in_america.pdf (appendix I).

[58] Steve Holland, "Jeb Bush Offers Welfare Reform Plan," Reuters, January 8, 2016, http://www.reuters.com/article/us-usa-election-bush-idUSKBN0UM0HM20160108.

[59] Oren Cass, "Send Spending Power Back to the States," *City Journal*, Winter 2016, http://www.city-journal.org/html/send-spending-power-back-states-14273.html.

[60] Remarks by Senator Marco Rubio, "Reclaiming the Land of Opportunity: Conservative Reforms for Combatting Poverty," U.S. Capitol, January 8, 2014, http://www.rubio.senate.gov/public/index.cfm/press-releases?ID=958d06fe-16a3-4e8e-b178-664fc10745bf.

[61] Topher Spiro and Lanhee Chen, "Sending Nurses to Work with Poor Moms Helps Kids: So Why Don't We Do More of It?," *Washington Post*, April 5, 2016, https://www.washingtonpost.com/posteverything/wp/2016/04/05/sending-nurses-to-work-with-poor-moms-helps-kids-so-why-dont-we-do-more-of-it.

[62] "Section 1115 Demonstrations," Centers for Medicare & Medicaid Services, accessed May 1, 2016, https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/section-1115-demonstrations.html.

[63] Greg D'Angelo and Edmund F. Haislmaier, "Health Care Reform in Massachusetts: Medicaid Waiver Renewal Will Set Precedent," Heritage Foundation, July 2, 2008, http://www.heritage.org/research/reports/2008/07/health-care-reform-in-massachusetts-medicaid-waiver-renewal-will-set-a-precedent.

[64] Heather Howard and Galen Benshoof, "Section 1332 Waivers and the Future of State Health Reform," *Health Affairs* Blog, December 5, 2014, http://healthaffairs.org/blog/2014/12/05/section-1332-waivers-and-the-future-of-state-health-reform.

[65] Yevgeniy Feyman, "The Obamacare Bait-and-Switch No One Noticed," National Review Online, January 11, 2016, http://www.nationalreview.com/article/429530/obamacare-innovation-waiver-hhs.

[66] Gerald Kominski et al., "Interim Evaluation Report on California's Health Care Coverage Initiative," UCLA Center for Health Policy Research, June 1, 2010, http://healthpolicy.ucla.edu/programs/health-economics/projects/coverage-initiative/health-care-coverage-initiative/Documents/Interim%20Evaluation%20Report%20on%20the%20Health%20Care%20Coverage%20Initiative%20in%20California.pdf.

[67] "Historical Tables—Outlays for Mandatory and Related Programs: 1962–2021," White House Office of Management and Budget, accessed April 30, 2016, https://www.whitehouse.gov/omb/budget/Historicals (table 8.5).

[68] "Historical Tables—Outlays for Discretionary Programs: 1962–2021," White House Office of Management and Budget, accessed April 30, 2016, https://www.whitehouse.gov/omb/budget/Historicals (table 8.7).

[69] "National Health Expenditures by Type of Service and Source of Funds: Calendar Years 1960–2014," Centers for Medicaid & Medicaid Services, accessed April 30, 2016, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html.

[70] "National Level Annual Summary: Participation and Costs, 1969–2015," U.S. Department of Agriculture, accessed April 30, 2016, http://www.fns.usda.gov/pd/supplemental-nutrition-assistance-program-snap.

[71] "Supplemental Materials—Public Database: Outlays," White House Office of Management and Budget, accessed April 30, 2016, https://www.whitehouse.gov/omb/budget/Supplemental (program titles appear in the "Account Name" field).

[72] "Temporary Assistance for Needy Families: Spending and Policy Options," Congressional Budget Office, January 21, 2015, http://www.cbo.gov/publication/49887 (fig. 3).

[73] For function-specific data, see "Historical Tables—Outlays by Function and Subfunction: 1962–2021," White House Office of Management and Budget, accessed April 30, 2016, https://www.whitehouse.gov/omb/budget/Historicals (table 3.2); for program-specific data, see "Supplemental Materials—Public Database: Outlays," White House Office of Management and Budget, accessed April 30, 2016, https://www.whitehouse.gov/omb/budget/Supplemental (program titles appear in the "Account Name" field).

[74] "Multiple Employment and Training Programs: Providing Information on Colocating Services and Consolidating Administrative Structures Could Promote Efficiencies," Government Accountability Office, January 13, 2011, http://www.gao.gov/products/GAO-11-92.

[75] "Historical Tables—Summary of Receipts, Outlays, and Surpluses or Deficits (-) in Current Dollars, Constant (FY 2009) Dollars, and as Percentages of GDP: 1940–2021," White House Office of Management and Budget, accessed April 30, 2016, https://www.whitehouse.gov/omb/budget/Historicals (table 1.3).

[76] See n.1 above.

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REPORT 12

Abstract

The American social safety net's overwhelming emphasis on health care is the unintentional result of skewed incentives, leading to an ineffective antipoverty strategy poorly aligned with the needs and preferences of low-income Americans. Reforms that allow states to reroute substantial sums from Medicaid to other programs would better meet the needs of the poor at no additional cost to taxpayers, marking the first step toward a more flexible and effective safety net.

Key Findings

1. Health care dominates America's safety-net spending: during 1975–2015, government social spending per person in poverty more than doubled, from $11,600 to $23,400; rising health care expenditures accounted for more than 90 percent of that increase.
2. This allocation is an ineffective poverty-fighting strategy: while the majority of government social spending goes to health care, low-income households not enrolled in Medicaid allocate less than 10 percent of their spending to health care, compared with 40 percent for housing, 22 percent for food, and 12 percent for transportation.
3. Over-allocation to Medicaid may exceed $100 billion annually: if states with above-median Medicaid enrollment rates or spending per enrollee in each recipient category (adult, child, disabled, etc.) returned to median levels, more than $100 billion could become available for other antipoverty programs.

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