



Free Trade in Health Care

The Gains from Globalized Medicare and Medicaid

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Executive Summary

There are large differences between the per-person cost of providing health care in the United States and the per-person cost in other countries with comparable health care outcomes. In 2006, the per-person cost of health care in the United States was \$6,714, while the average cost in the 26 countries with longer life expectancies was \$2,964. This gap suggests the potential for substantial gains from trade.

This paper outlines a mechanism for taking advantage of these potential gains from trade: a globalization of the Medicare and Medicaid programs. Since most of the beneficiaries of Medicare are retirees, as are a substantial portion of the beneficiaries of Medicaid, they need not live near a workplace. Many beneficiaries have family or other ties to other countries. The globalization mechanism proposed in this paper would allow beneficiaries of these programs to have a voucher that would allow them to move to other countries and buy into their health care systems, with the government and the beneficiaries splitting the gains. To provide an inducement for other countries to participate, they would receive a premium (e.g. 10 percent) above their costs to ensure that they benefit from this process as well.

The projections in the paper show that:

- If 10 percent of Medicare beneficiaries opted to take advantage of this program, then by 2020, the government would be saving more than \$9 billion a year (in 2008 dollars). (This paper uses 2008 dollars throughout, unless otherwise specified.) If 50 percent of beneficiaries took advantage of the program, then the savings in 2020 would be more than \$40 billion a year. By 2030, the projected annual budget savings would have increased to \$20 billion if 10 percent of beneficiaries took part and to \$98 billion if 50 percent took advantage of this option. By 2085 the projected annual budget savings would have risen to almost \$290 billion with a 10 percent take-up rate and more than 1.4 trillion with a 50 percent take-up rate.
- The gains to beneficiaries would be quite substantial, with larger gains accruing to those who opt to move to countries with lower health care costs. Beneficiaries moving to Spain would be able to pocket \$10,900 in 2020, equal to 61 percent of the Social Security benefit for a medium earner retiring at age 65 in 2020. Those who moved to Canada would get an additional \$5,600 a year to supplement their retirement income, equal to 31.3 percent of a medium earner's benefit. By 2045, these sums are projected to increase to \$26,700 and \$22,600 a year, respectively. These gains are 22.6 percent and 3.8 percent above projected Social Security benefits for a medium earner retiring in 2045. In 2085 the gains from moving to these two countries would be \$74,700 and \$77,500, respectively, both more than double the projected Social Security benefits for medium earners retiring in 2085.
- There would be even larger gains if retirees who are eligible for both Medicare and Medicaid opted to take part in this program. The total annual savings for both federal and state governments from having a "dual eligible" move to another country in 2020 would be \$12,100 per beneficiary. In 2045 the savings would be \$29,400, and the annual savings in

2085 would be \$77,800. Approximately 57 percent of the government's savings on Medicaid would accrue to the federal government, with the remainder going to the states.

- If 10 percent of both the Medicare and senior Medicaid population opted to take part in this program in 2020, it would save the federal and state governments \$18 billion in 2008 dollars. If 50 percent of these populations took part in the program, the savings would be \$91 billion in 2020. By 2045, the savings would be \$99 billion and \$495 billion, respectively. And in 2085, the annual savings in these two scenarios would be \$505 billion and \$2.5 trillion, respectively.
- The savings to state governments alone would be \$2.9 billion by 2020 if 10 percent of these dual eligibles participated in the program and \$15.1 billion if 30 percent took part. This would rise to \$8.8 billion and \$26.3 billion in 2045, if 10 percent and 30 percent of eligible seniors took part, respectively. By 2085, the savings to state governments would be \$27.0 billion if 10 percent of eligible seniors took part in the program and \$80.9 billion if 30 percent took part.
- There would be substantial savings to dual eligibles who took advantage of this program. A dual eligible who moved to Spain would be able to pocket \$18,700 a year by 2020, \$42,000 by 2045, and \$103,000 a year by 2085. For Canada, the numbers would be \$13,500 in 2020, \$38,000 in 2045, and \$105,800 a year by 2085. The gains that dual eligibles are projected to receive in 2045 are nearly twice the projected Social Security benefit for a medium earner retiring at age 65 that year. The gains projected for 2085 are more than three times the projected Social Security benefits for a medium earner retiring in that year. This would qualitatively improve the standard of living that these dual eligibles could enjoy in retirement.

In principle it should be possible for the United States to negotiate arrangements with most other countries to allow Medicare and Medicaid beneficiaries to buy into their health care systems. This should allow for gains from trade that are several orders of magnitude larger than from other trade agreements. It should also put in place a mechanism that will lead to enormous budget savings and shift the health care cost curve down to a much slower growth path.

Introduction

There is an enormous gap between the price that people in the United States pay for health care and the price people pay in other countries with comparable health outcomes. The average annual per-person cost of health care in the United States in 2006 was \$6,714. By comparison, the average per-person cost in the 26 countries with longer life expectancies was \$2,964.¹ For a family of four this difference would be \$15,000, an amount that is comparable to the typical family's tax burden.

This sort of large gap in costs is exactly the situation in which trade provides the opportunity for the greatest gains. While health care is often place-specific in ways that manufactured goods and other traded items are not, there are still ways in which people in the United States can benefit from the lower-cost health care available elsewhere. In particular, an internationalization of the Medicare and Medicaid programs can offer enormous opportunities for gain both to beneficiaries and the country as a whole.

The basic point is straightforward: the vast majority of older Medicare and Medicaid beneficiaries are retired, so they have the freedom to travel that the working age population typically lacks. In addition, millions of beneficiaries have family, business, or emotional ties to other countries. These people could benefit enormously if these programs were restructured to allow them to buy into the health care systems of other countries and split the savings with the government. This could allow beneficiaries to enjoy a higher standard of living in their retirement years than would otherwise be possible, while also allowing taxpayers to save tens of trillions of dollars in the years ahead.

The Mechanics of Globalized Medicare

The gains from allowing beneficiaries the option of buying into lower-cost health care systems are so enormous that a program can easily be structured that will benefit everyone: the beneficiary, the taxpayers, and the countries that opt to accept beneficiaries from the United States. The basic mechanism would be to offer every Medicare beneficiary a voucher that they can use to buy into the health care system of any country with a longer life expectancy than the United States. This voucher would allow the beneficiary to move to the country and be fully covered by its health care system, just as any national of that country would be.

For example, under this system a person with ties to Germany would have the option of using their voucher to move to Germany and to buy into Germany's health care system. From the point of their buy-in, they would be covered by Germany's health care system, not Medicare. Medicare beneficiaries would have a similar choice of buying into the health care systems of the nearly three dozen countries with longer life expectancies than the United States.² In each case, they would be able to share the savings with the Medicare program, allowing them a substantial boost to their retirement income.

¹ A full list of these countries appears in Table 2.

² For a reasonable estimate of potential savings for both the U.S. and foreign governments, this analysis uses 26 out of 33 countries with longer life expectancies than the U.S. that have a population estimate of a million or more, based on 2009 United Nations Department of Economic and Social Affairs estimate.

The voucher will be set at a level that is equal to the average cost of providing care in the countries with longer life expectancies than the United States, plus half the difference between per-person Medicare expenditures and this cost. This means that if the average cost to Medicare of providing care is \$10,000 per year and the average cost of treating someone over the age of 65 in countries with longer life expectancies is \$5,000, then the voucher would be set at \$7,500 a year. This would allow a beneficiary moving to one of these countries to pocket an additional \$2,500 a year on average. Of course, they could get an even larger amount if they moved to a country with costs that were lower than the average from this group.

The government would also save \$2,500 for each Medicare beneficiary who moved to another country and used their voucher to buy into their health care system. If millions of beneficiaries opted to take advantage of this option, the savings could easily reach into the tens of billions of dollars a year. The projected savings will expand rapidly through time since the Congressional Budget Office projects that health care costs in the United States will grow far more rapidly than in other wealthy countries.³

To make this voucher system work, the U.S. government would have to negotiate arrangements with each of the countries to ensure they could accommodate an inflow of older people from the United States who would be dependent on their health care system. Such negotiations would presumably take some time to work through, but would certainly be simpler than far-reaching trade agreements like NAFTA. The potential economic gains would also be much larger. It would be reasonable to allow for some premium on top of normal expenses to ensure that the receiving country benefits from the arrangement as well. For purposes of this analysis, it is assumed that the U.S. government will pay each country an amount that exceeds its cost by 10 percent.

These negotiations would presumably also structure the program in ways that limited problems like adverse selection. It would probably be necessary to impose rules that might require a beneficiary to opt into another country's program at their first point of eligibility, in order to avoid a risk that the population choosing to take advantage of this option are disproportionately more or less healthy than the Medicare population as a whole. Of course, it would also be possible to adjust for the size of the voucher through time, if it turned out that the expenses of those taking advantage of the option differed substantially from the Medicare population as a whole.

It is likely that institutions in host countries would evolve over time to accommodate an inflow of beneficiaries from the United States. If a country wanted to make itself more attractive to beneficiaries, then it might establish retirement communities with high quality medical facilities nearby. It may also ensure that it had large numbers of English-speaking medical personnel to ensure that they could accommodate beneficiaries who did not speak the native language. In principle, this could be an important source of growth for the host country.

³ The Congressional Budget Office calculates historical and projected rates of "excess cost growth" in Medicare, Medicaid, and other health care spending. Excess cost growth refers to the growth in health care costs per person in excess of growth in nominal GDP per capita. White (2007, see footnote 9 below) compares historical rates (1970-2002) of excess cost growth in the U.S. to other OECD countries and shows that health care costs in the U.S. grew faster than other OECD countries on average, except Portugal. Also refer to the appendix, and <http://www.cbo.gov/ftpdocs/102xx/doc10297/06-25-LTBO.pdf>.

The requirement that a country have a longer life expectancy than the United States is effectively a form of quality control. It would be important that Medicare beneficiaries not give up their Medicare for a grossly inferior system. This simple comparison of a key medical outcome should limit this risk. In addition, this criterion should also provide an incentive for less-developed countries to improve their health care system for their own population, since this would make them eligible to receive Medicare beneficiaries. For example, Mexico – which currently has a somewhat lower life expectancy than the United States – could be in a position to receive a large number of beneficiaries if it took steps that raised its life expectancy to the U.S. level.

Potential Savings From Globalized Medicare

Table 1A shows the potential savings to the government over the next 75 years for each beneficiary who opts to use a Medicare voucher to buy into the health care system of another country. The first column shows the projected Medicare cost per beneficiary over the age of 65 in the United States over the next 75 years. (See the appendix for the derivation of these numbers.) Per-person spending was more than \$8,600 in 2008. It is projected to increase to \$18,573 by 2030 and to exceed \$100,000 by 2085 (all numbers are in constant 2008 dollars).

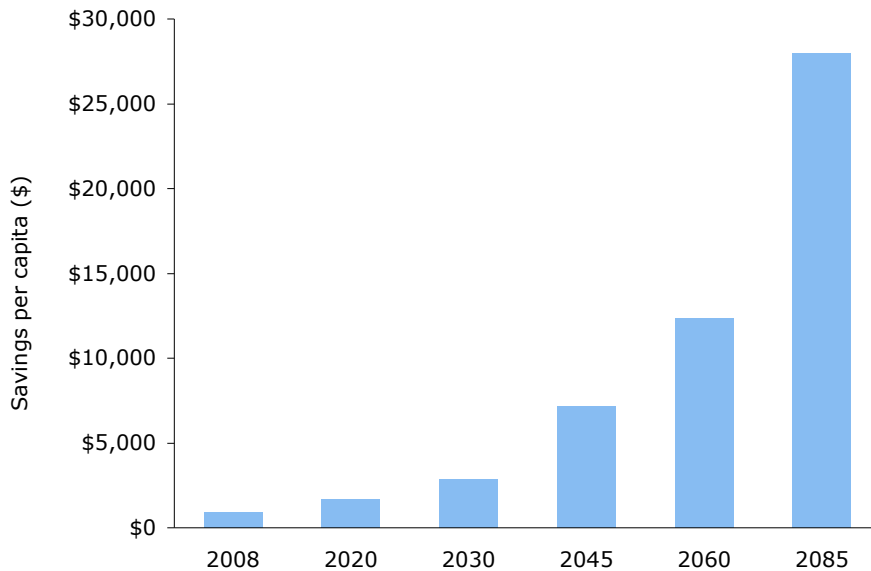
TABLE 1A: Annual U.S. Government Savings on Medicare Spending per Beneficiary, Age 65+

Year	Cost in US	Cost Elsewhere (26-country avg.)	Voucher	Savings
2008	\$8,642	\$6,769	\$7,705	\$937
2020	\$12,931	\$9,631	\$11,281	\$1,650
2030	\$18,573	\$12,869	\$15,721	\$2,852
2045	\$33,789	\$19,461	\$26,625	\$7,164
2060	\$53,304	\$28,615	\$40,959	\$12,344
2085	\$108,251	\$52,340	\$80,296	\$27,956

Notes: Authors' calculations; see appendix for sources and methodology.

Column 2 shows the average per-person government spending for providing care in the 26 countries that currently enjoy longer life expectancies than the United States. The average cost in these countries was \$6,769 in 2008. This is projected to increase to \$12,869 by 2030 and to reach \$52,340 in 2085. Column 3 shows the size of the voucher in each year, which will be halfway between the average cost in other countries and the cost in the United States. The voucher in 2008 would have been \$7,705. In 2030 it would be \$15,721. In 2085 it would be \$80,296.

Column 4 and **Figure 1A** show the projected savings to Medicare for each person who takes advantage of the voucher. In 2008, the savings would have been \$937 per person. In 2030 the savings would have risen to \$2,852 per person. In 2085 the savings would be \$27,956 per person.

FIGURE 1A: Annual U.S. Government Savings in Medicare Spending Per Beneficiary

Notes: Authors' calculations; see appendix for sources and methodology.

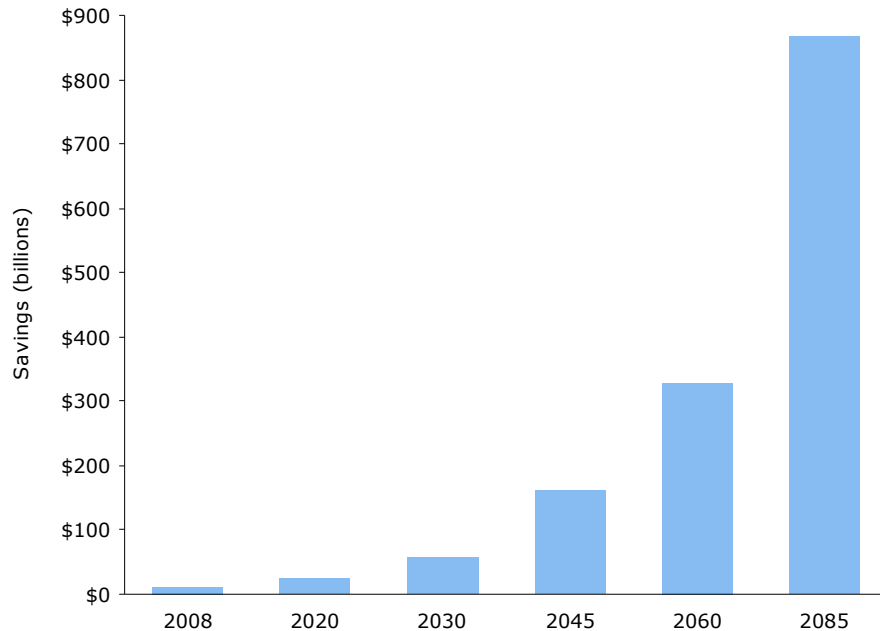
Table 1B shows the implied savings to the Medicare system under the assumptions that alternatively 10 percent, 30 percent, and 50 percent of the eligible population opt to take advantage of this system. In 2008, if 10 percent of beneficiaries had taken advantage of this system, Medicare would have saved \$3.5 billion. If 50 percent of beneficiaries had taken advantage of the program, the savings would have been \$17.7 billion.

TABLE 1B: Annual U.S. Government Savings on Medicare Spending by Participation Rate (billions)

Year	Participation Rate		
	10 percent	30 percent	50 percent
2008	\$3.5	\$10.6	\$17.7
2020	\$8.6	\$25.9	\$43.2
2030	\$19.5	\$58.5	\$97.5
2045	\$53.9	\$161.8	\$269.7
2060	\$109.2	\$327.5	\$545.9
2085	\$288.9	\$866.8	\$1,444.6

Notes: Authors' calculations; see appendix for sources and methodology.

The projected savings rise substantially through time. In 2030, if 10 percent of beneficiaries opt to take advantage of a voucher, the savings to Medicare would be \$20 billion. If 50 percent of beneficiaries took advantage of the program, the savings would be \$98 billion. In 2085, if 10 percent of beneficiaries take part in this program, then the savings would be \$289 billion. If 50 percent of beneficiaries opted to take advantage of the program, then the savings in that year would be almost \$1.5 trillion. **Figure 1B** shows the annual savings under the assumption that 30 percent of beneficiaries opt to buy into the program.

FIGURE 1B: Annual U.S. Government Savings on Medicare Spending, 30 Percent Participation Rate

Notes: Authors' calculations; see appendix for sources and methodology.

Table 2 shows the savings to beneficiaries who opt to take part in the program. The savings will vary depending on which country's health care system the beneficiary opts to buy into since the value of the voucher is fixed, while the cost of health care differs by country. The savings to beneficiaries are calculated by first adding together the value of the voucher and other health care expenses borne by Medicare beneficiaries in the United States, including premiums paid for Medicare coverage, premiums for supplemental insurance, and out of pocket payments. To get a projection of savings, the cost of the public health care program in each country (multiplied by 1.1) was subtracted from this amount, as was the average cost for private insurance premiums and out of pocket expenditures in those countries. (See the appendix for a full explanation of this calculation.)

TABLE 2: Annual Savings to Medicare Beneficiaries with Medicare Choice Plus

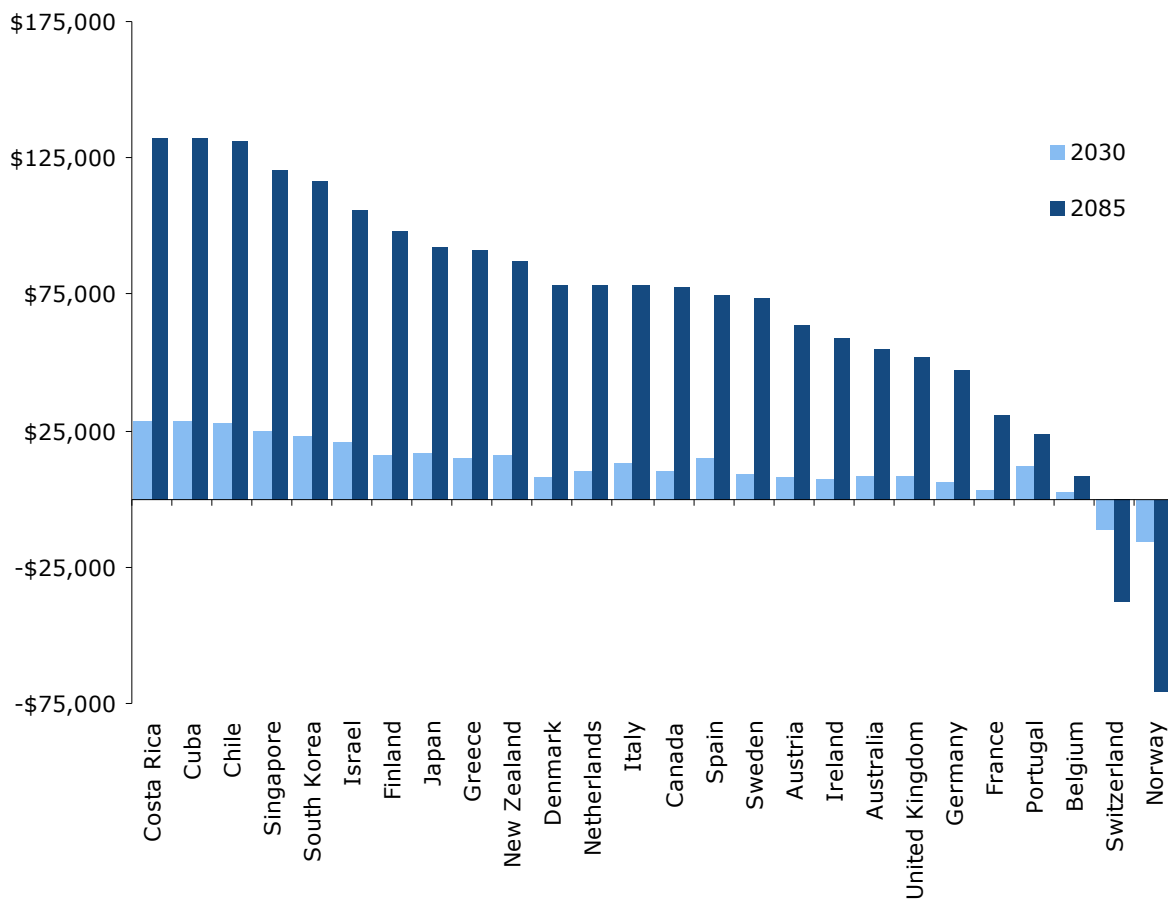
Country	2008	2020	2030	2045	2060	2085
Australia	\$4,475	\$6,129	\$8,749	\$17,939	\$27,351	\$54,859
Austria	\$2,699	\$4,795	\$8,091	\$18,757	\$30,375	\$63,642
Belgium	\$3,445	\$3,091	\$3,006	\$6,137	\$6,350	\$8,816
Canada	\$2,722	\$5,638	\$9,921	\$22,603	\$37,044	\$77,543
Chile	\$13,895	\$20,146	\$27,855	\$46,954	\$69,776	\$130,902
Costa Rica	\$14,257	\$20,656	\$28,513	\$47,864	\$70,987	\$132,783
Cuba	\$14,235	\$20,624	\$28,466	\$47,773	\$70,822	\$132,393
Denmark	-\$294	\$2,878	\$7,504	\$20,830	\$36,135	\$78,538
Finland	\$5,687	\$9,977	\$15,712	\$31,116	\$49,126	\$98,318
France	\$1,874	\$2,287	\$3,465	\$9,617	\$14,667	\$30,683
Germany	\$3,226	\$4,497	\$6,693	\$14,974	\$23,074	\$47,072
Greece	\$6,712	\$10,317	\$15,287	\$29,357	\$45,706	\$91,263
Ireland	\$2,580	\$4,420	\$7,401	\$17,411	\$28,091	\$58,927
Israel	\$10,133	\$14,846	\$20,906	\$36,858	\$55,494	\$106,243
Italy	\$6,017	\$9,048	\$13,277	\$25,650	\$39,443	\$77,981
Japan	\$6,540	\$11,139	\$16,412	\$29,475	\$46,424	\$92,016
Netherlands	\$3,006	\$6,010	\$10,368	\$23,141	\$37,656	\$78,174
New Zealand	\$7,416	\$11,020	\$15,863	\$29,413	\$44,773	\$87,204
Norway	-\$5,754	-\$10,488	-\$15,522	-\$22,471	-\$36,398	-\$70,419
Portugal	\$9,137	\$10,839	\$12,551	\$18,180	\$20,286	\$23,883
Singapore	\$12,140	\$17,673	\$24,643	\$42,420	\$63,577	\$120,797
South Korea	\$11,579	\$16,884	\$23,588	\$40,799	\$61,141	\$116,193
Spain	\$7,884	\$10,899	\$14,929	\$26,692	\$39,381	\$74,702
Sweden	\$2,706	\$5,417	\$9,444	\$21,572	\$35,213	\$73,552
Switzerland	-\$4,011	-\$7,785	-\$11,434	-\$14,651	-\$22,284	-\$37,905
United Kingdom	\$4,137	\$5,826	\$8,433	\$17,364	\$26,178	\$51,605

Notes: Authors' calculations; see appendix for sources and methodology.

In some of the higher-cost countries the voucher will not be large enough to fully cover the cost of health care so beneficiaries would still be required to make some additional health care payments. For example, it would have cost a beneficiary \$4,011 annually to buy into Switzerland's health care system and \$294 to buy into Denmark's system in 2008. On the other hand, a beneficiary would have been able to pocket \$7,416 by moving to New Zealand and buying into its health care system. They would have been able to pocket \$2,722 by buying into Canada's system.

The gains to beneficiaries are projected to rise rapidly through time. A beneficiary moving to Canada is projected to be able to pocket \$9,921 annually in 2030. A beneficiary moving to Spain would gain \$14,929 in 2030. By 2085 the projected gains to beneficiaries would be quite large. The gains for a beneficiary living in Canada in that year would be \$77,543. A beneficiary living in Spain would be able to pocket \$74,702. The gains to beneficiaries from moving to another country for 2030 and 2085 are shown in **Figure 2**.

FIGURE 2: Annual Gains to Medicare Beneficiaries Aged 65+, 2030 and 2085



Notes: Authors' calculations; see appendix for sources and methodology.

Potential Savings From Globalized Medicaid

If the principle of sharing the gains from lower-cost health care was applied to those Medicare beneficiaries who are also eligible for Medicaid, then the potential benefits would be even larger. Medicaid for people over age 65 is means-tested. It effectively covers most of the cost of health care that is not paid by Medicare. Since the cost of providing medical care to beneficiaries who move to other countries will already be covered by the Medicare voucher, there is no reason why the U.S. government would make any additional payments for beneficiaries who are also eligible for Medicaid. This means that the savings from having those eligible for Medicaid become covered under another country's health care system can be split entirely between the government and the beneficiary.

Table 3A shows the savings for dual eligibles (people who qualify for both Medicare and Medicaid) who chose to take advantage of the voucher and move to a country with a longer life expectancy than the United States. The first column shows the projected per-beneficiary cost of Medicaid for dual eligibles through 2085. This cost is projected to rise from \$14,607 in 2008 to \$99,650 in 2085. Column 2 shows the size of the voucher in each year. Note that this voucher would be paid directly

to the beneficiary, not to the country in which they chose to receive health care. The voucher is equal to half of the projected per-person cost for Medicaid. It rises from \$7,303 to \$49,825 in 2085. Column 3 shows the savings to the government for each Medicaid beneficiary who opts to take advantage of this program. Note that this is equal to the size of the voucher, since the gain from not having to pay for Medicaid is split evenly between the beneficiary and the government.

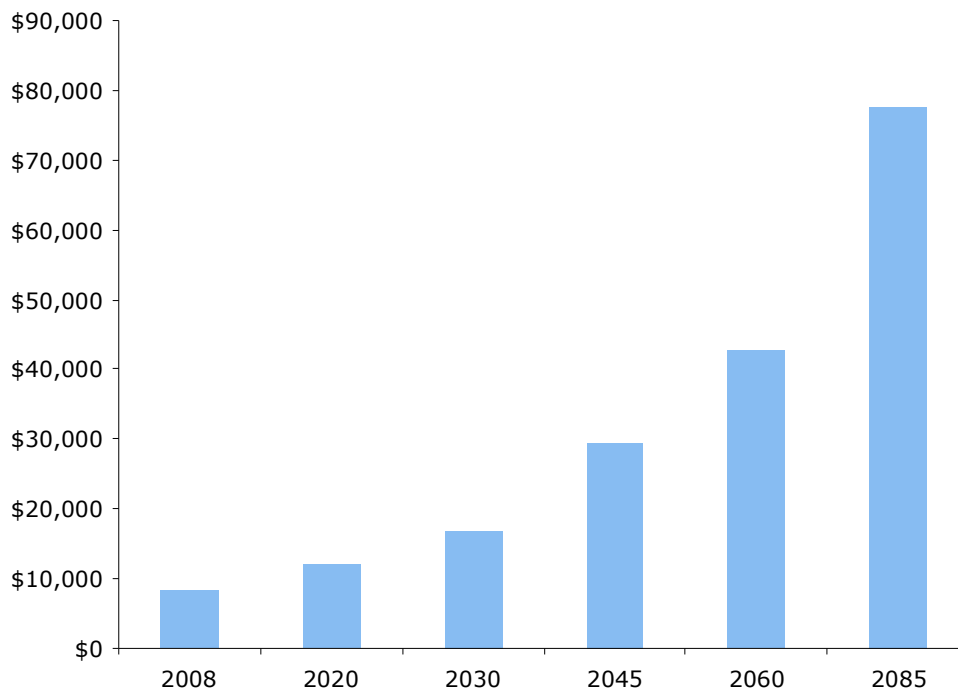
Column 4 shows the total saving to the government for each dual eligible who opts to move to another country as part of this program. This combines the savings shown in column 3 with the savings from Medicare shown in column 4 of Table 1A. In 2008, the savings would have been \$8,240 per beneficiary. The savings are projected to rise to \$16,871 by 2030 and to \$77,781 by 2085. These per-person savings are also shown in **Figure 3A**.

TABLE 3A: Annual U.S. Government Savings (Federal and State) on Medicaid, per Beneficiary Aged 65+

Year	Medicaid cost in US	Voucher	Savings on Medicaid	Savings on Dual Eligibles
2008	\$14,607	\$7,303	\$7,303	\$8,240
2020	\$20,842	\$10,421	\$10,421	\$12,071
2030	\$28,039	\$14,019	\$14,019	\$16,871
2045	\$44,501	\$22,250	\$22,250	\$29,415
2060	\$60,740	\$30,370	\$30,370	\$42,714
2085	\$99,650	\$49,825	\$49,825	\$77,781

Notes: Authors' calculations; see appendix for sources and methodology.

FIGURE 3A: U.S. Government Savings (Federal and State) per Dual Eligible Beneficiary Aged 65+



Notes: Authors' calculations; see appendix for sources and methodology.

Table 3B shows the savings to the Medicaid program under scenarios in which alternatively 10 percent, 30 percent, and 50 percent of dual eligibles opt to take part in this program. In 2008, if 10 percent of dual eligibles had taken part the savings would have been \$3.8 billion. If 50 percent had taken part in the program, the savings would have been \$19 billion. If 10 percent of dual eligibles opt to move to another country in 2085, the savings to Medicaid would be \$97.9 billion. If half of dual eligibles move to another country, the savings would be \$489.4 billion in 2085.

TABLE 3B: Annual U.S. Government Savings (Federal and State) on Medicaid Spending by Participation Rates of Dual Eligibles (billions)

Year	Participation Rate		
	10 percent	30 percent	50 percent
2008	\$3.8	\$11.4	\$19.0
2020	\$7.7	\$23.1	\$38.5
2030	\$14.0	\$42.1	\$70.2
2045	\$27.0	\$80.9	\$134.8
2060	\$46.0	\$138.0	\$230.0
2085	\$97.9	\$293.7	\$489.4

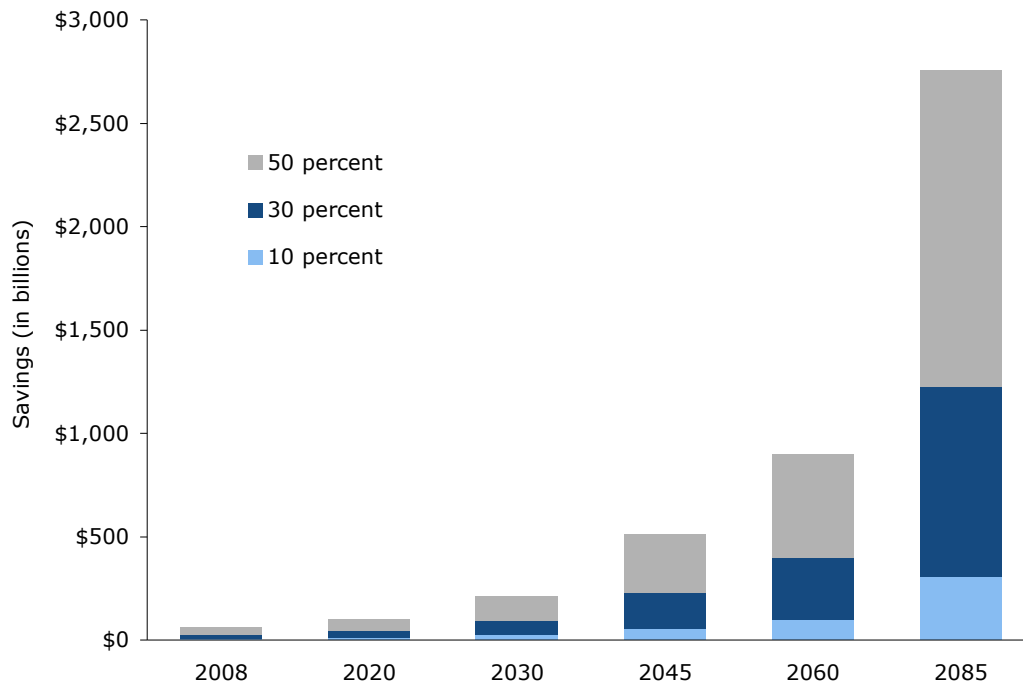
Notes: Authors' calculations; see appendix for sources and methodology.

Table 3C combines the savings in the Medicaid and Medicare program, in effect adding the projections from Table 1b to the projections from Table 3b. It shows that the government would have saved \$6.8 billion under this program in 2008 if 10 percent of both Medicare and Medicaid beneficiaries opted to take advantage of the health care system in another country. If 50 percent took advantage of this program, the savings would be \$34.1 billion. By 2085, the annual savings are projected to increase to \$505.3 billion, if 10 percent of those eligible take advantage of this program, while they would be over \$2.5 trillion if half of those eligible for both programs opted to buy into the health care system of another country. This information is also graphed in **Figure 3B**.

TABLE 3C: Annual U.S. Government Savings (Federal and State) on Medicare and Medicaid Spending, by Participation Rates (billions)

Year	Participation Rate		
	10 percent	30 percent	50 percent
2008	\$6.8	\$20.4	\$34.1
2020	\$18.1	\$54.3	\$90.5
2030	\$41.9	\$125.8	\$209.7
2045	\$99.0	\$297.0	\$495.0
2060	\$198.8	\$596.4	\$993.9
2085	\$505.3	\$1,516.0	\$2,526.6

Notes: Authors' calculations; see appendix for sources and methodology.

FIGURE 3B: Annual U.S. Government Savings (Federal and State) in Medicare and Medicaid Spending, by Participation Rates of Dual Eligibles

Notes: Authors' calculations; see appendix for sources and methodology.

Table 3D shows the gains that state governments would receive as a result of the program. The table uses the assumption that 43 percent of the savings – the states' current share of the program's cost – accrues to state governments. The savings to state governments alone would be \$2.9 billion by 2020 if 10 percent of these dual eligibles participated in the program and \$8.6 billion if 30 percent took part. This would rise to \$8.8 billion and \$26.3 billion in 2045, if 10 percent and 30 percent of eligible seniors took part, respectively. By 2085, the savings to state governments would be \$27.0 billion if 10 percent of eligible seniors took part in the program and \$80.9 billion if 30 percent took part. If 50 percent of eligible seniors took part in the program, then the savings to state governments in 2085 would be \$134.8 billion.

TABLE 3D: Annual U.S. State Government Savings on Medicare and Medicaid Spending, by Participation Rates of Dual Eligibles (billions)

Year	Participation Rate		
	10 percent	30 percent	50 percent
2008	\$1.4	\$4.3	\$7.2
2020	\$2.9	\$8.6	\$14.3
2030	\$5.0	\$15.1	\$25.1
2045	\$8.8	\$26.3	\$43.9
2060	\$14.1	\$42.2	\$70.3
2085	\$27.0	\$80.9	\$134.8

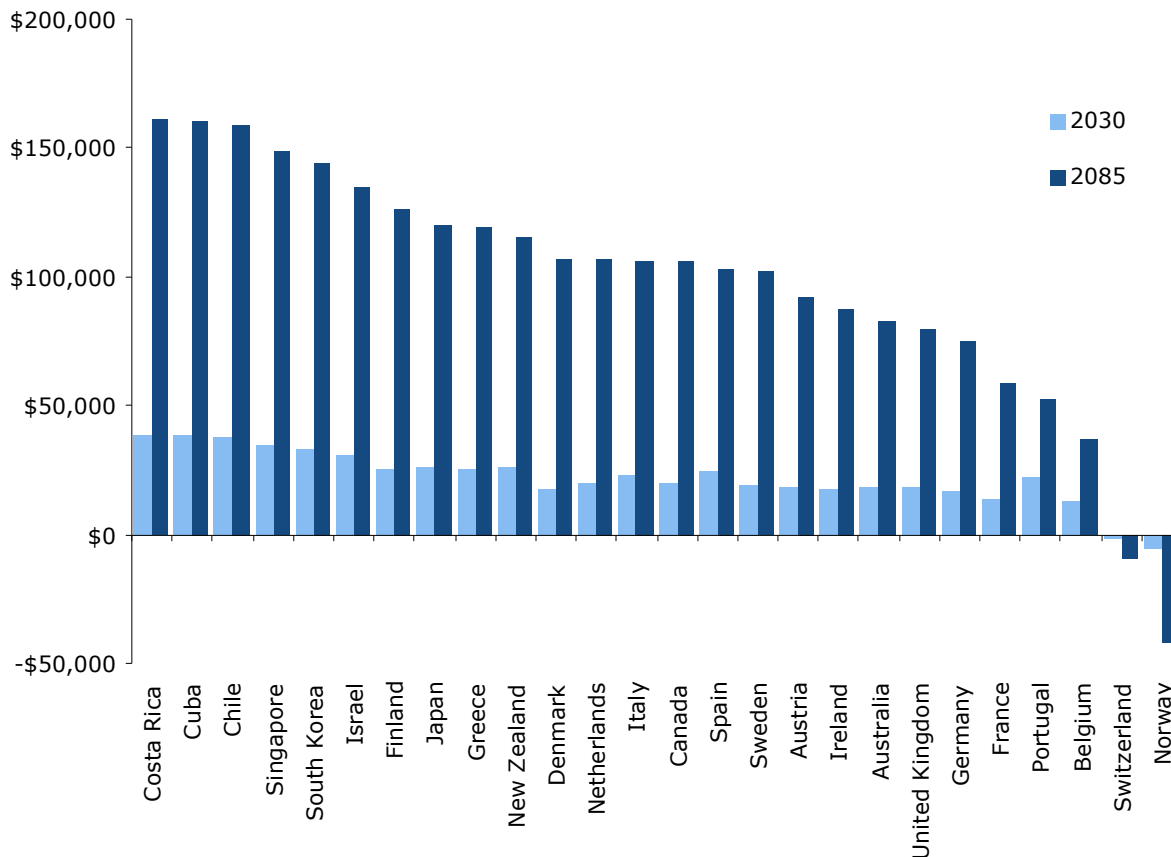
Notes: Authors' calculations; see appendix for sources and methodology.

Table 4 shows the combined payments to dual eligibles who opt to take buy into the health care systems of one of the countries with a longer life expectancy than the United States. It shows that in 2008, a dual eligible who had opted to buy into Canada's system could have pocketed more than \$8,500 under this program. A dual eligible who had opted to buy into Spain's system would have saved more than \$13,500 in 2008. By 2030, the savings would be projected to rise to almost \$20,000 in the case of Canada and almost \$25,000 in the case of Spain. The savings rise to more than \$105,000 in 2085 for people moving to Canada and more than \$102,000 for people moving to Spain. The per-person gains for dual eligibles living in each country are shown for 2030 and 2085 in **Figure 4**.

TABLE 4: Annual Savings to Dual Eligibles with Medicare/Medicaid Choice Plus (in US\$)

Country	2008	2020	2030	2045	2060	2085
Australia	\$10,278	\$13,973	\$18,606	\$33,185	\$46,587	\$83,130
Austria	\$8,503	\$12,639	\$17,947	\$34,003	\$49,610	\$91,913
Belgium	\$9,248	\$10,935	\$12,863	\$21,383	\$25,585	\$37,087
Canada	\$8,525	\$13,482	\$19,778	\$37,849	\$56,280	\$105,814
Chile	\$19,698	\$27,990	\$37,711	\$62,201	\$89,012	\$159,174
Costa Rica	\$20,060	\$28,500	\$38,369	\$63,111	\$90,223	\$161,054
Cuba	\$20,038	\$28,468	\$38,322	\$63,020	\$90,057	\$160,664
Denmark	\$5,509	\$10,722	\$17,360	\$36,076	\$55,371	\$106,809
Finland	\$11,490	\$17,821	\$25,568	\$46,363	\$68,361	\$126,589
France	\$7,677	\$10,131	\$13,321	\$24,864	\$33,902	\$58,954
Germany	\$9,030	\$12,341	\$16,549	\$30,221	\$42,310	\$75,344
Greece	\$12,516	\$18,161	\$25,143	\$44,603	\$64,942	\$119,534
Ireland	\$8,383	\$12,264	\$17,257	\$32,658	\$47,327	\$87,198
Israel	\$15,936	\$22,690	\$30,762	\$52,104	\$74,729	\$134,515
Italy	\$11,820	\$16,892	\$23,133	\$40,897	\$58,679	\$106,252
Japan	\$12,343	\$18,983	\$26,269	\$44,721	\$65,659	\$120,287
Netherlands	\$8,809	\$13,854	\$20,224	\$38,387	\$56,892	\$106,446
New Zealand	\$13,220	\$18,864	\$25,720	\$44,659	\$64,009	\$115,475
Norway	\$49	-\$2,644	-\$5,665	-\$7,224	-\$17,162	-\$42,147
Portugal	\$14,941	\$18,683	\$22,407	\$33,426	\$39,521	\$52,155
Republic of Korea	\$17,382	\$24,728	\$33,444	\$56,045	\$80,376	\$144,464
Singapore	\$17,943	\$25,517	\$34,499	\$57,666	\$82,812	\$149,069
Spain	\$13,687	\$18,743	\$24,786	\$41,938	\$58,616	\$102,973
Sweden	\$8,509	\$13,261	\$19,300	\$36,818	\$54,449	\$101,824
Switzerland	\$1,792	\$59	-\$1,578	\$595	-\$3,048	-\$9,634
United Kingdom	\$9,941	\$13,669	\$18,289	\$32,611	\$45,414	\$79,876

Notes: Authors' calculations; see appendix for sources and methodology.

FIGURE 4: Annual Gains Per Dual Eligible Beneficiary, 2030 and 2085

Notes: Authors' calculations; see appendix for sources and methodology.

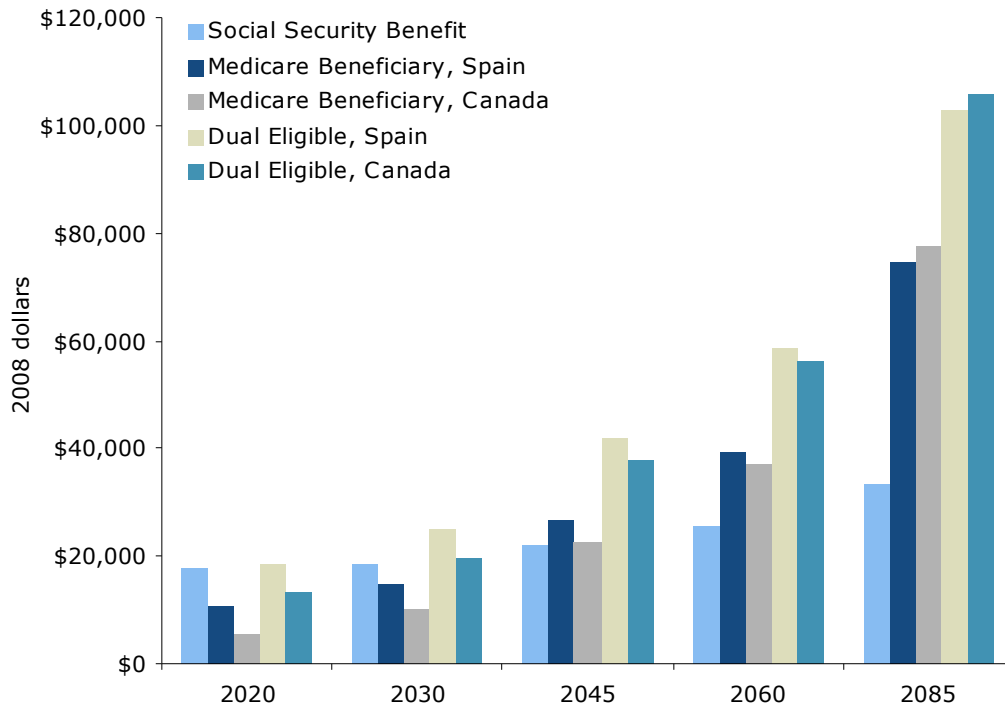
Implications of Globalized Medicare and Medicaid for the Budget and Retirement Income

The projections in the prior sections indicated the enormous potential gains from allowing senior Medicare and Medicaid beneficiaries the option of buying into other countries' health care systems. The savings to the U.S. government are potentially enormous. If just 10 percent of beneficiaries in Medicare and Medicaid in 2020 opted to take part in this program, the savings in that year would be \$18 billion. If 50 percent opted to take part, the savings would be about \$91 billion. And, as noted in the prior section, these savings are projected to grow rapidly through time. In short, the saving from this program would substantially alter the long-term budget picture and make other programs, like universal health care, readily affordable.

The potential gains to beneficiaries would also be substantial. Social Security currently accounts for more than half of the retirement income for two-thirds of retirees. The benefits to beneficiaries opting to buy into the health care systems of other countries would be very large relative to

projected Social Security benefits, and therefore relative to their retirement income. **Figure 5** compares the projected Social Security benefit for a medium wage earner retiring at age 65 in 2020, 2030, 2045, 2060, and 2085 with the gains from moving to Spain or Canada under this program.

FIGURE 5: Annual Social Security Benefits and Savings for Medicare Beneficiaries and Dual Eligibles Moving to Spain and Canada



Notes: Authors' calculations; see appendix for sources and methodology.

The gains are shown for both dual beneficiaries and for those who are only eligible for Medicare. As can be seen, the savings for a Medicare beneficiary moving to Spain would be more than 60 percent of a medium earner's Social Security benefit in 2020. A medium earner moving to Canada would get a supplement to their income that is more than 30 percent of their benefit. A person who was eligible for both Medicare and Medicaid in 2020 would get a supplement that is larger than their Social Security benefit if they moved to Spain and 75 percent of their benefit if they moved to Canada.

By 2045, a Medicare beneficiary moving to either country would receive a benefit that is larger than the Social Security benefit for a medium earner. A dual eligible would get a benefit that is nearly twice as large as the medium earner's Social Security benefit. By 2085, the gains to a Medicare beneficiary moving to either country would be more than twice as large as the medium earner's Social Security benefit, while a dual eligible would pocket an amount that is more than three times as large as the medium earner's Social Security benefit.

As a practical matter, with the gap between health care costs in the United States and costs in most other countries projected to grow rapidly through time, the potential benefits to beneficiaries of

moving to other countries will increase correspondingly. It is therefore reasonable to expect that the percentage of Medicare beneficiaries who opt to move to other countries will grow through time. This is also likely to be the case due to the fact that other countries will likely develop infrastructures that better support large number of beneficiaries from the United States. This could mean, for example, that in addition to English-speaking providers, that they will also develop retirement communities with ready access to transportation facilities so that family members from the United States can easily visit. In principle, the host countries could enjoy substantial economic benefits from an influx of U.S. beneficiaries. Therefore, it is likely that even if the initial take-up on a program of globalized Medicare and Medicaid is limited, the eventual impact will almost certainly be considerably larger.

It is also worth noting the important feedback effect that a globalized Medicare and Medicaid program could have on the cost of health care in the United States. By substantially reducing the demand for health care services in the U.S., these programs would likely result in substantial reductions in the cost of health care for Medicare beneficiaries who remain, as well as the rest of the population. Because health costs are so large, even modest reductions in price would lead to substantial savings. For example, if the program led to a 10 percent reduction in demand by 2020 and this led to a 3 percent fall in the price of medical care services (implying a supply elasticity of approximately 0.3) this would imply a savings to the country from lower prices in that year of more than \$150 billion (in 2020 dollars).

Conclusion

The huge gap between the cost of health care in the United States and the cost in other countries with comparable health care outcomes suggests the potential for substantial gains from trade. This paper has described one mechanism for taking advantage of these gains – through a globalization of the country’s Medicare and Medicaid programs. The projections in this paper suggest that the country’s long-term budget situation would be substantially improved if beneficiaries of these two programs were allowed to take advantage of the lower-cost health care available in other countries. This could also allow them to enjoy much higher retirement incomes than they would otherwise receive.

Appendix

This paper assumes that the ratio of the health care cost for seniors over the age of 65 to the overall population in the U.S. is the same for other countries examined. The Center for Medicare and Medicaid Services provides age-specific data on Personal Health Care Spending (PHC) for 2004,⁴ and the ratio of PHC for seniors to the overall average is approximately 2.8. Per capita total and government health care expenditures in 26 countries with longer life expectancies than the U.S. in 2006 were obtained from the World Health Organization database.⁵ U.S. ranks 34th in life expectancy rate at birth, also based on WHO data. For purposes of our analysis, out of the 33 countries with longer life expectancy rates, we only examine 26 countries that have populations of a million or more, based on the United Nations Department of Economic and Social Affairs estimate for 2009.

Medicare

Table 1A shows the U.S. government savings on Medicare spending for every senior who opted to take advantage of this voucher system in 2008 dollars. We assume that every Medicare beneficiary would be allowed to have a voucher that is equal to the average cost of providing Medicare-equivalent care to seniors in 26 countries with longer life expectancy than the U.S., plus 50 percent of the difference between per capita Medicare cost and the average cost elsewhere. The U.S. government would save the difference between the actual Medicare expenditures and the voucher.

Medicare spending per capita in the U.S. for beneficiaries over the age of 65 is calculated by taking net Medicare spending and dividing it by the number of beneficiaries, assuming that Medicare spending for aged and disabled beneficiaries is roughly comparable. The Congressional Budget Office has data on net Medicare outlays for 2008 and has short-term projections up to 2019.⁶ The number of Medicare beneficiaries is available in the Medicare Trustees Report.⁷

The Medicare cost projections beyond 2019 use CBO's Medicare excess cost growth projections over the long term. CBO projects Medicare excess cost growth (beyond per capita GDP) at the historical rate of 2.3 percentage points in 2020, declining 1.5 percent a year until 2083, when it reaches 0.9 percentage points.⁸ Using CBO's methodology, Medicare spending per beneficiary for each year is projected by taking the cost in the initial year and multiplying it by the change in real GDP per capita and by the change in AgeCompIndex (age-weighted cost index for Medicare spending that removes changes in cost due to changing age distribution of the 65 and over population). The excess cost growth is multiplied by this number to get the Medicare cost.⁹

The same methodology is used to project health care spending per capita in 26 countries in the analysis. The excess cost growth in health spending per capita in OECD countries is calculated by

⁴ <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/2004-age-tables.pdf>

⁵ <http://www.who.int/whosis/en>

⁶ <http://www.cbo.gov/budget/factsheets/2009b/medicare.pdf>

⁷ Medicare Trustees Report, 2009, Table 3A1, <http://www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2009.pdf>

⁸ <http://www.cbo.gov/ftpdocs/102xx/doc10297/06-25-LTBO.pdf>, Table 2-4

⁹ <http://www.cbo.gov/ftpdocs/87xx/doc8758/11-13-LT-Health.pdf>, Appendix B

White (2007)¹⁰ using OECD Health Data, for the period 1970 to 2002. It is assumed that the excess cost growth declines at the same rate as in U.S. for Medicare. We use the historical OECD average of 1.1 percent per capita GDP growth rate for countries where data is not available.

Table 1B calculates the overall savings to the U.S. government under the scenarios that 10 percent, 30 percent, and 50 percent of beneficiaries take advantage of the voucher. This number is adjusted for projected growth in the population over age 65 for coming decades,¹¹ under the assumption that the number of older Medicare beneficiaries grows at the same rate as the growth in the aged population.

Table 2 calculates the savings to individuals who choose to use the voucher in any of the 26 countries. The cost to an individual senior moving abroad is assumed to be 10 percent more than the public health care cost in these countries, plus private health care spending in U.S. and Medicare premiums minus private health care spending in each of the countries. This is under the assumption that seniors do not pay premiums for government care in other countries. If any of the countries require premium payments, per-person premium cost can be subtracted from the projected savings in this table for the relevant country. Medicare premiums are added to individual senior savings since seniors are no longer required to make the payment. Private health care spending is calculated by taking total spending minus public spending. It includes co-payments, other out-of-pocket spending, and private health insurance expenditures, but excludes premiums paid to the government. Both total health care spending and public spending data for U.S. and other countries is from the WHO database. Medicare premium numbers are calculated by subtracting Net Medicare from Gross Medicare (total outlays not including offsetting receipts), this data is available from CBO.¹²

Medicaid and Dual Eligibles

Table 3A shows U.S. federal and state government savings on both Medicaid spending and Medicare and Medicaid spending on dual eligibles. The data on the Medicaid cost per beneficiary over the age of 65 is available in the CMS 2008 Actuarial Report.¹³ Medicaid cost projections through 2085 are also made by using the excess cost growth projections explained above. CBO also projects excess cost growth for Medicaid. **Table 3B** is calculated using the same methodology used for Table 1b.

Table 3C is calculated by adding savings from Medicare spending on Table 1B and from Medicaid spending on Table 3B and subtracting per aged beneficiary cost-sharing liability for Medicare Part A and B. These projections are taken from CMS Medicare and Medicaid Statistical Supplement database for 2008.¹⁴ Cost-sharing for Medicare Part A and B is covered by Medicaid.

Table 3D shows state government savings on dual eligibles. Medicaid costs to state governments are calculated assuming that 57 percent (following CBO's estimate) of total Medicaid is funded

¹⁰ White, Chapin. "Health Care Spending Growth: How Different is the United States from the Rest of the OECD?," *Health Affairs*, January/February 2007, pp. 157, Exhibit 2.

¹¹ <http://www.ssa.gov/OACT/TR/2009/lr5a2.html>, Table V.A2

¹² <http://www.cbo.gov/budget/factsheets/2009b/medicare.pdf>

¹³ <http://www.cms.hhs.gov/ActuarialStudies/downloads/MedicaidReport2008.pdf>, Table 2

¹⁴ <http://www.cms.hhs.gov/MedicareMedicaidStatSupp/>, Medicaid, 2008, Table 4.2

federally, with 43 percent funded by the state.¹⁵ State governments save half of Medicaid spending per beneficiary, since the Medicaid voucher is equal to half of projected costs per person. The rest of the calculation follows methods used for Tables 1B and 3B.

Table 4 uses a slightly modified calculation from the methods used for Table 2. The voucher that each dual eligible gets is higher than the voucher of the Medicare beneficiary. Calculating the cost to an individual senior moving abroad is the same as those used for Table 2, except that cost-sharing expenditures for Medicare Part A and B is taken out. This is because this table calculates savings to seniors that are eligible for both Medicare and Medicaid, and cost-sharing expenditures are covered by Medicaid.

Figure 5 compares the projected benefit (in 2008 dollars) for a medium wage earner¹⁶ retiring in each of the listed years, at age 65, with the savings to individual Medicare beneficiaries and dual eligibles who move to Canada and Spain. The projections are taken from the 2009 Social Security Trustees Report, Table VI. F10.¹⁷ The projected savings are taken from Tables 2 and 4.

¹⁵ <http://www.cbo.gov/ftpdocs/102xx/doc10297/06-25-LTBO.pdf>, page 27.

¹⁶ The Social Security Administration describes medium wage earners as those whose career-average earnings are about 100 percent of the national average wage index.

¹⁷ http://www.ssa.gov/OACT/TR/2009/VI_OASDHI_dollars.html#119381