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Public policy and health insurance choices of the elderly: evidence from the medicare buy-in program

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Abstract

This study provides evidence on health insurance decisions of senior citizens. Nearly all senior citizens have health insurance coverage through Medicare, but poor seniors may also qualify for Medicaid that fills many gaps in Medicare coverage. Since 1987, the Medicaid program has expanded eligibility. Using the SIPP, I find that Medicaid eligibility increased from 8.7% in 1987 to 12.4% in 1995. For every 100 elderly who became eligible, approximately 50 took up Medicaid, but more than 30 dropped private coverage, resulting in crowd-out of 60%. Crowd-out came from individuals dropping privately purchased health insurance rather than dropping employer-provided retiree health insurance. The roles of asset tests, health status, and the panel structure of the SIPP are also explored. I find that a major strength of the SIPP is in its point-in-time asset information for determining Medicaid eligibility, while the changing income and demographic information over the course of the 2-year panel adds little insight beyond cross-sectional data.

Keywords: Medicaid; Medicare; Health insurance; Crowd-out; Aging

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1. Introduction

The US federal government spent more than $352 billion on entitlements for the elderly in 1990.[1] Although 80% of the money went to two programs — Social Security and Medicare — a significant amount was also spent on means-tested welfare programs, such as health insurance through Medicaid, cash assistance through Supplemental Security Income (SSI), food stamps, public housing, and energy assistance. Welfare programs for the elderly do not receive as much attention as those for the young, but combined federal spending on elderly SSI and Medicaid recipients amounted to $11.7 billion in 1990, approximately 54% of the amount spent on cash assistance and health insurance for younger households on AFDC.[2]

An aim of this study is to provide evidence on the economic behavior of senior citizens with respect to the largest of these means-tested programs, Medicaid. Nearly all senior citizens have health insurance coverage through Medicare, but poor seniors may also be eligible for Medicaid, which fills many gaps in Medicare coverage and offers first-dollar coverage. During the past decade, the Medicaid program has undergone a series of changes relating to eligibility. In particular, two new categories of elderly Medicaid recipients, known as Qualified Medicare Beneficiaries (QMBs) and Specified Low-Income Medicare Beneficiaries (SLMBs), were created. The income and asset limits to qualify under these programs were less strict than the limits under existing Medicaid categories, and 1.9 million senior citizens were enrolled in the QMB program in 1993.[3] My particular focus will be on two issues relating to the QMB (and SLMB) expansions. First, how much did the QMB expansions increase Medicaid eligibility? The QMB expansions added to an existing and confusing patchwork of Medicaid rules that varied across states — in states where Medicaid was already generous the QMB expansions may not have made many individuals newly eligible. Second, how did increases in Medicaid eligibility affect supplemental insurance coverage? To address this, I estimate the effects of Medicaid eligibility on Medicaid coverage, private insurance coverage, and total supplemental insurance coverage.

In addressing these questions, this study makes two primary contributions. The first contribution is adding evidence to the growing literature on government provision of health insurance and crowd-out of private insurance through a conceptually clean example. Although a recent and controversial literature has addressed the magnitude of the effect of Medicaid expansions for pregnant women and children on private insurance coverage, there are two real-world problems associated with the structure of employer-provided health insurance and the timing

[1] US House of Representatives, *Overview of Entitlement Programs* (1993) p. 1564.
[2] This amount excludes the cost of nursing homes, which disproportionately benefit the elderly.
[3] Neumann et al. (1995).