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Avoiding health insurance crowd-out: evidence from the medicare as secondary payer legislation

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Abstract

The cost of expanding health insurance coverage increases when people who would otherwise purchase insurance obtain public coverage. This paper investigates the effects of one of the first efforts to target insurance benefits to the most needy, the 1982 medicare as secondary payer (MSP) provisions.

We find strong evidence of low compliance with the MSP both in terms of medical bill payments (payment compliance) and employer-sponsored insurance coverage (coverage compliance). We estimate payer compliance at approximately 33%. Coverage compliance is lower, at under 25%. We find weak evidence that the MSP caused older workers to shift toward MSP-exempt jobs.
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1. Introduction

Many people who are eligible for public insurance coverage would have obtained private insurance coverage if these public programs had not been adopted (Cutler and Gruber, 1995). The governmental cost of expanding insurance coverage is increased when those who would have otherwise purchased private coverage participate in a public program. Such subsidized purchases of insurance substitute for — or "crowd-out" — previously unsubsidized purchases.

Universal insurance programs necessarily generate 100% crowd-out of previously existing private coverage. As the costs of universal programs have risen, however, legislators

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have become increasingly interested in targeting public benefits only to those who need them. Before the current crowd-out debate began, Congress made changes in medicare to try to reverse some of the insurance substitution due to the program's universal coverage of the elderly. The 1982 medicare as secondary payer (MSP) legislation requires employers who offer health insurance to any of their workers to provide it, on similar terms, to their workers age 65 and over, and requires that any such insurance be "primary" to medicare. This paper examines the effects of that law.

Anti-crowd-out provisions raise two concerns. First, given the fragmented nature of the US health insurance market, the provisions may be very difficult to enforce. Second, the provisions may alter labor market behavior. Using data from the National Medical Care Expenditure Survey (NMCES) (1977), the National Medical Expenditure Survey (NMES) (1987), and the Current Population Survey for 1980–1988, a period surrounding passage and implementation of the MSP, we estimate the extent and nature of compliance with the legislation. We then estimate the extent of labor market responses to the tax by examining the hours worked by and types of firms where these workers were employed and the extent to which the legislation affected wages and employment. [1]

Our findings suggest that the MSP legislation was largely unsuccessful in forcing employers to provide primary insurance coverage for their elderly workers. Our estimates suggest that the MSP achieved only between 25 and 33% of its intended savings, mostly because of non-compliance with the legislation. We find some evidence that employers and employees changed their behavior to avoid complying with the mandate, and that these effects were concentrated in the largest firms.

2. The medicare as secondary payer legislation

Under MSP, beginning on 1 January 1983, medicare became the secondary payer if a person age 65 or over held employer-sponsored insurance and was employed by a firm of >20 employees. Employer-sponsored insurance paid first and medicare paid only those medicare-covered expenses that were not covered by the employer plan. If an employer chose to provide health insurance to employees under age 65, he/she had to offer coverage to those age 65 and over on identical terms and this coverage substituted for medicare. If a medicare-eligible senior chose to decline employer-sponsored coverage, he could not select employer-sponsored Medigap. Rather, such an employee would lose the coverage of medicare deductibles and co-payments as well as pharmaceutical coverage or other benefits

[1] Over this time period there were also changes in social security benefits, tax laws, mandatory retirement laws, and medicare laws. Most of the changes made in OASDI in this period were long term changes. Beginning in 1984, beneficiaries with incomes above certain thresholds were required to include a portion of their social security benefits in their taxable income. There were no major changes in mandatory retirement laws over this period. Overall, the financial status of retired households ages 65–69 and 55–64 changed little over the period following the legislation (1984–1991) according to analysis of the SIPP (Poterba et al., 1994). Over this period, medicare also implemented its DRG payment system for hospitals. This system reduced the length-of-stay of patients at hospitals and stabilized medicare hospital expenditures. This would also have implied a stabilization in the expected patient copay for hospital stays, possibly reducing the demand for supplemental coverage relative to what it would otherwise have been.

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