FIGURE 16-1 How Does Medicaid Affect Health? • This diagram shows the channels through which expanding eligibility for Medicaid can affect health. Expansions increase eligibility and lead to greater take-up by the uninsured and some crowd-out of private insurance (Step 1). This increase in insurance coverage leads to increased medical utilization (Step 2), depending on access restrictions for Medicaid enrollees. Higher medical utilization then potentially leads to better health (Step 3). This better health is associated with increased program costs, leading to the ultimate question of the cost-effectiveness of this route to improving health (Step 4).

TABLE 16-1 Medicaid Eligibility Changes Across and within States

Eligibility for all children, by state		
Year	Missouri eligibility	Michigan eligibility
1982	12%	20%
2000	76%	34%
Eligibility for children by age, in Washington, D.C.		
Year	Age 13 eligibility	Age 0 eligibility
1982	18%	48%
2000	59%	56%

Data from: Calculations from the authors research with Kosali Simon at Cornell University.

Over the 1982–2000 period, Medicaid eligibility rose much more in Missouri than in Michigan (top panel). There were also dramatic differences in eligibility growth within states: eligibility rose much more for 13-year-olds in Washington, D.C., than for 0-year-olds (bottom panel).

TABLE 16-2 Medicaid and Medicare as of 2021

	Medicaid	Medicare
Eligibles	Families on welfare Low-income children, pregnant people Low-income older adults, people with disabilities	Retirees and spouses 65 and older Certain people with disabilities under 65 People with kidney failure (requiring dialysis or transplant)
Premiums	None	Hospital coverage: none Physician coverage: $148.5 per month Prescription drug coverage: Variable
Deductibles/copayments	None (or very small)	Hospital coverage: $1,484 deductible for benefit period Physician coverage: $203 deductible, 20% coinsurance Prescription drug coverage: Variable
Services excluded	None (or very minor)	Prescription drugs (until 2006), routine checkups (until 2010), dental care, nursing home care, eyeglasses, hearing aids
Provider reimbursement	Very low	Moderate (but falling)

Medicaid provides health insurance for low-income individuals, covering a wide range of health services at little cost to those individuals. Medicare provides health insurance for those age 65 and over, covering many, though not all, health services at some cost to those individuals.
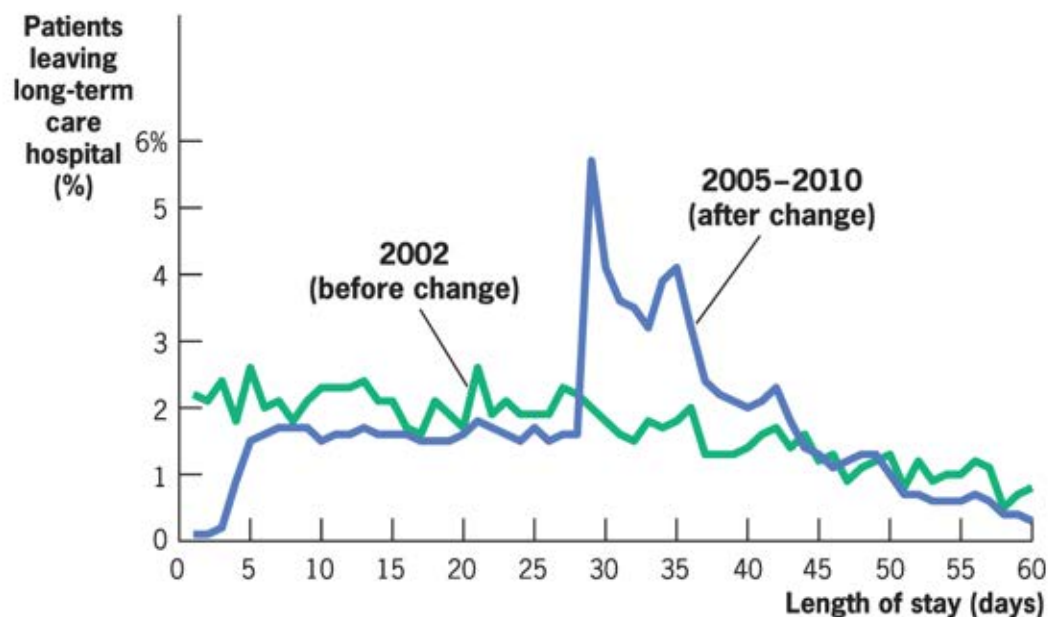

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FIGURE 16-2 Timing of Hospital Discharges Before and After the Policy Change • The figure shows the percentage of patients discharged from long-term care hospitals at different lengths of stay. Before the policy change, 2% of patients were discharged at 29 days. After the change, the discharge rate almost tripled, hitting 5.7%.
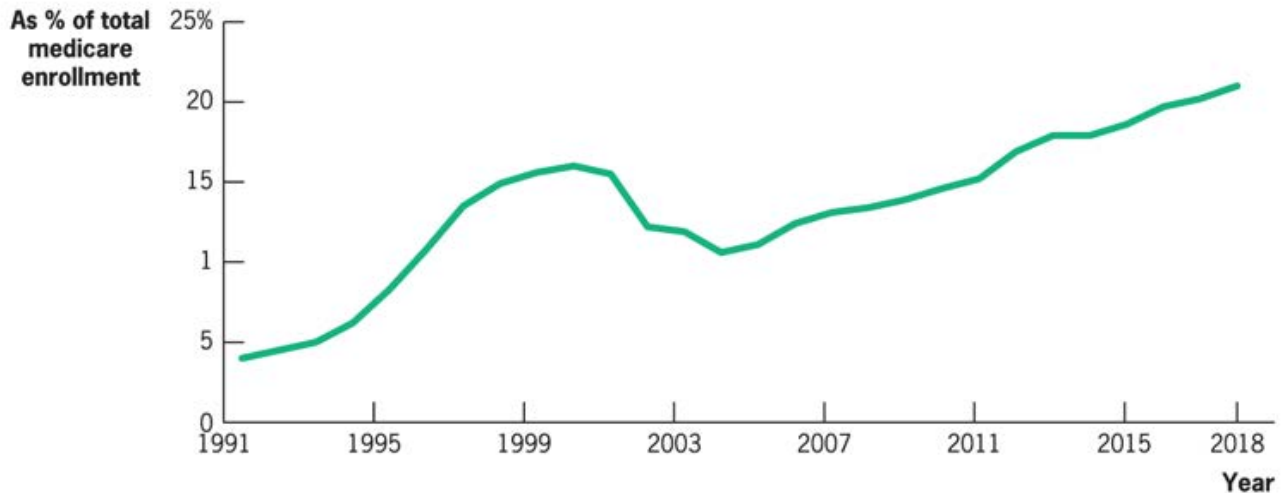
Data from: Kim et al. (2015).

As % of total medicare enrollment

| 25% |
| 20 |
| 15 |
| 1 |
| 5 |
| 0 |

1991 1995 1999 2003 2007 2011 2015 2018

Year

FIGURE 16-3 Managed Care Enrollment of Medicare Beneficiaries • When the managed care option was first introduced to Medicare, enrollment rose steadily, to a peak of 16% of Medicare beneficiaries by 1999. Enrollment then declined in the early 2000s because of the government's decision to lower reimbursement rates to managed care providers. An increase in these reimbursement rates in 2003 led to a subsequent further rise in managed care enrollment, which has continued since to surpass the 1999 peak.

Per person average cost	Traditional Medicare (number of people)	Medicare plus HMOs (number of people)	
$1,000:	100	70 → to HMO	30
$2,000:	100	85 → to HMO	15
$3,000:	100	100	

Average cost per Medicare recipient =
(100 × $1,000 + 100 × $2,000 + 100 × $3,000)/300 =
$2,000

Total cost to government =
(100 × $1,000 + 100 × $2,000 + 100 × $3,000) =
$600,000

Average cost per Medicare recipient =
(70 × $1,000 + 85 × $2,000 + 100 × $3,000)/255 =
$2,118

Average cost per HMO enrollee =
(30 × $1,000 + 15 × $2,000)/45 =
$1,333

Total cost to government =
(70 × $1,000 + 85 × $2,000 + 100 × $3,000) + 45 × (0.95 × $2,118) =
$630,530

FIGURE 16-4 Incorporating HMOs into Medicare • Before HMOs are introduced (first column), there are 100 persons at each of three cost levels, with average Medicare costs of $2,000 per recipient. When HMOs are introduced (second column), they are chosen primarily by the lowest-cost individuals, resulting in a higher average Medicare cost ($2,118) and a low average HMO cost ($1,333). Yet the government reimburses HMOs at 95% of the average Medicare cost ($2,012), so the government spends $30,530 more when the HMO option is allowed.

TABLE 16-3 Premium Support Systems with and without Adverse Selection

Full-choice Medicare (before adverse selection)			
Plan	Plan cost (per person)	Voucher (median plan cost)	Individual payment
A	$1,800	$2,000	−$200
B	$2,000	$2,000	0
C	$2,500	$2,000	$500

Full-choice Medicare (after adverse selection)			
Plan	Plan cost (per person)	Voucher (median plan cost)	Individual payment
A	$1,600	$2,100	−$500
B	$2,100	$2,100	0
C	$3,000	$2,100	$900

Under a typical premium support system, individuals pay the difference between the cost of their plan and the median-cost plan, as shown in the top panel. Adverse selection, however, will cause sicker patients to choose the most expensive plans, making these plans even more expensive, while the least costly plans fall in price as they are chosen by healthier individuals. In the long term, a voucher system thus ends up rewarding the healthy and costing the sick more (bottom panel).
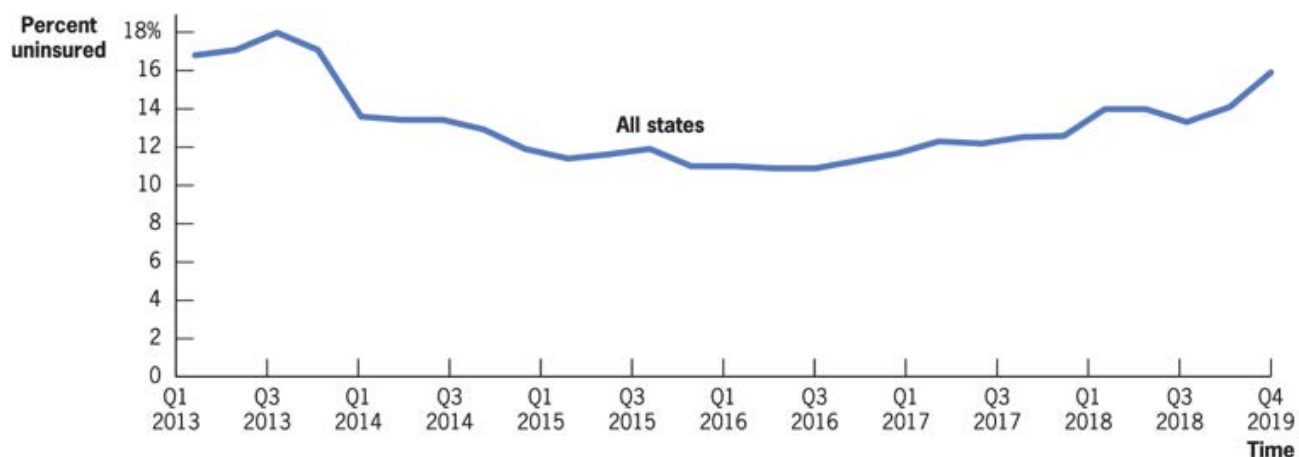

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FIGURE 16-5 Trends in Uninsurance for Adults Ages 18–64 • Uninsured rates among the states declined precipitously from 2014 through 2016, before rising again in 2017.

Data from: Gallup (2018) and Centers for Disease Control and Prevention (2020), Supplemental Quarterly Tables on Health Insurance Coverage.
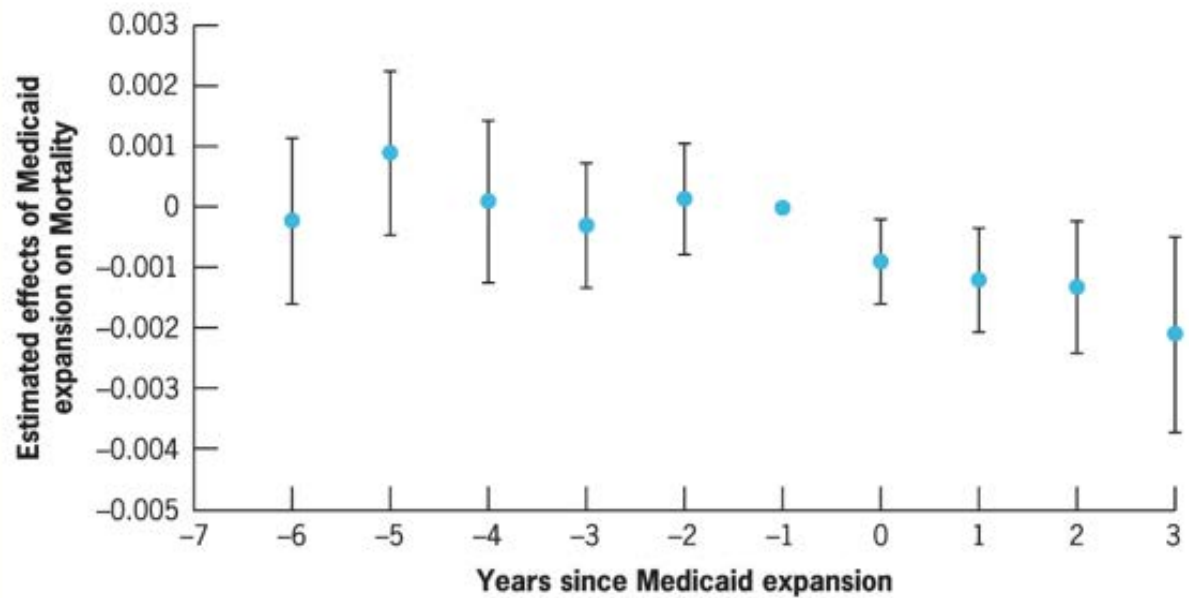
FIGURE 16-6 Decrease in Mortality Following Medicaid Expansion • The blue dots show the coefficient estimate for the effects of Medicaid expansion on mortality, and the black bars show confidence intervals. The negative numbers on the Y axis represent the years before Medicaid is expanded. These data show a downward trend in mortality following the expansion of Medicaid.

Data from: Miller, Johnson, ans Wherry (2020).

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