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Medicaid vs Medicare: Evidence from Medicaid to Medicare Transitions at 65

TIMOTHY LAYTON, HARVARD UNIVERSITY AND NBER
NICOLE MAESTAS, HARVARD UNIVERSITY AND NBER
DANIEL PRINZ, WORLD BANK
MARK SHEPARD, HARVARD UNIVERSITY AND NBER
BORIS VABSON, HARVARD UNIVERSITY

Key Findings and Policy Implications

This paper examines the changes in healthcare and healthcare costs that occur when individuals are involuntary moved from Medicaid-only to dual Medicare-Medicaid coverage when they turn age 65. The analysis uses measures of healthcare costs, quality, access, and outcomes from CMS administrative records for both the Medicare and Medicaid programs from 2008 to 2015. The study finds that:

- The transition from Medicaid-only to dual coverage leads to a 13% increase in the government's fiscal cost of providing coverage. The cost increase is 12% for those shifting from Medicaid Fee-for-Service coverage and 27% for those shifting from Medicaid Managed Care plans.

- The bump in fiscal spending is primarily attributable to higher reimbursement rates under Medicare, as there is a much less pronounced increase in price-normalized spending, for which rates are kept constant across Medicaid and Medicare.

- There are also healthcare utilization changes. For example, we find higher usage of primary and professional care under Medicare, specifically in the form of physician office visits. We also find lower levels of acute care usage such as ED visits, which could be indicative of improved quality and health outcomes.

A key takeaway from the study is that higher spending on coverage (at least in the particular case of Medicare compared to Medicaid) does appear to translate into improved access to care and potentially also quality. Moreover, the mechanism driving these improvements is not greater intensity of utilization overall, but rather a shift away from acute care to primary care. This shift of utilization towards primary care may result at least in part from higher physician payment rates under Medicare.

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