

Medicaid and Child Health Crowding Out: Synopsis of Resources

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The following document provides brief summaries of the current literature on crowd-out with respect to health insurance programs, primarily Medicaid and the State Child Health Insurance Program (CHIP). This document is not meant to be an exhaustive source as new research and articles are published on an ongoing basis. As is practical, we will periodically update it to include new articles that may be helpful to states establishing child health initiatives and other public health insurance programs.

Research

Medicaid Expansions and the Crowding Out of Private Health Insurance

Yazici EY, Kaestner R. Medicaid Expansions and the Crowding Out of Private Health Insurance. The National Bureau of Economic Research, Working Paper No. 6527. April 1998.

This study analyzed the effect of Medicaid eligibility expansions on health insurance coverage for indigent children using the data from the 1988 and 1992 National Longitudinal Survey of Youth (NLSY). It found an average crowd out of 14.5%, which coincides with the results of Sheppard-Shore (1997) and of Dubay and Kenney (1996). (14.5% of the increase in Medicaid enrollment came from private insurance.) The authors used the longitudinal data and difference-in-difference (DD) analysis to investigate whether changes in insurance coverage of children affected by the Medicaid expansions differed from changes in insurance status of children unaffected by the expansions. The “difference-in-difference approach compares the percentage of children moving from private coverage for an experimental group – children eligible for Medicaid, and a control group, children with similar characteristics who are not Medicaid eligible. The authors point out possible sources of error in their analysis. One potential source of bias is based on the authors’ assumption that time trends in insurance coverage are similar for the control group and the experimental group. As it is difficult to precisely determine Medicaid eligibility, measurement error could arise from mistakes in classifying children into the experimental or control groups.

The authors identify possible sources of bias or measurement error that may have affected the results of three other crowd-out researchers. The authors point out that the regression analysis conducted by Cutler and Gruber is subject to the same bias identified above – an assumption that time trends in insurance coverage are similar for both the experimental and control group. Measurement errors could have arisen in assigning individuals to the experimental and control groups by using reported past-year income instead of current-year income and their process of “simulating” eligibility. The 1997 Shore-Sheppard

analysis is similar to that of Cutler and Gruber but the analysis aggregates data to the state level, possibly omitting control variables that are correlated with insurance status and Medicaid eligibility. Finally, Dubay and Kenney, also using a “difference-in-difference” calculation but with cross-sectional data, used a control group that may be subject to different time variation in insurance coverage than the experimental group. The study may be subject to a similar measurement error related to misclassification of controls or experimental to poor and near poor groups.

The Potential for Crowd Out Due to CHIP: Results from a Survey of 450 Employers

Fox HB, McManus MA. The Potential for Crowd Out Due to CHIP: Results from a Survey of 450 Employers. Maternal and Child Health Policy Research Center. March 1998.

Fox and McManus conducted a telephone survey of 450 businesses nationwide to examine potential employer responses to the State Children’s Health Insurance Program (CHIP). The sample was equally distributed between small, medium, and large businesses and was regionally stratified. Not all employers surveyed offered coverage although a very high percentage, about 95% of survey respondents, did.¹ The vast majority of survey respondents indicated that they would continue to provide coverage for an employee's dependent children if public coverage became available to them. However, some employers would consider decreasing health benefits or increasing employee's contribution towards the premium. Twelve percent of employers queried stated that they would either discontinue or consider dropping coverage for dependent children if they were eligible for a public insurance benefit. Almost none, however, responded that they would drop dependent coverage for children who would be subject to a 12-month minimum uninsured period before becoming eligible for the public program. Fox and McManus suggest that firms most likely to discontinue coverage would be those that currently provide fewer benefits and impose greater cost-sharing requirements. Fox and McManus also discuss three strategies to reduce crowd-out. First, states could require that children be uninsured for a specified period before receiving coverage. Exemptions can be made in the case of families who lose coverage involuntarily. Second, the state could institute laws that would prohibit businesses from discontinuing or reducing coverage for child dependents. Third, the state could purchase or assist families in purchasing dependent coverage when it is available but not affordable.

This study has a number of potential weaknesses. The sample was not randomly selected and may suffer from respondent bias. Responses were based on a hypothetical question; in real life, on the other hand, economic incentives could drive very different behavior.

Avoiding Health Insurance Crowd-out: Evidence from the Medicare as Second Payer Legislation

Glied S, Stabile M. Avoiding Health Insurance Crowd-Out: Evidence from the Medicare as Second Payer Legislation. National Bureau of Economic Research No. 6277. November 1997.

This NBER paper examines whether the 1982 Medicare as Second Payer (MSP) provisions resulted in crowd-out of private employer-sponsored insurance among retirees. The MSP rules require that employers who offer coverage to their non-elderly employees also provide coverage for Medicare-eligible employees. Glied and Stabile examine compliance with the law and investigate changes in the labor force before and after enactment to determine if the provision caused crowding out. The authors used Current Population Survey data for 1981 through 1987 and Bureau of Labor Statistics data to determine the labor force participation of various age groups before and after MSP legislation. They hypothesize that the MSP mandate discouraged employers who offer coverage from hiring older workers and anticipated declines in employment and wages of the Medicare-eligible population. Results, however, suggest that the MSP mandate did not reduce the wages of workers over 64 but may have contributed to a small reduction in full-time employment among older workers. Ultimately, these reductions in hours made

¹ Personal communication with Harriette Fox.

fewer older workers eligible for employer-sponsored coverage. The authors found strong evidence, however, of low compliance with the MSP rules and question the efficacy of provisions designed to reduce crowd-out in future programs.

Stemming the Tide? The Effect of Expanding Medicaid Eligibility on Health Insurance Coverage

Shore-Sheppard L. *Stemming the Tide? The Effect of Expanding Medicaid Eligibility on Health Insurance Coverage*. University of Pittsburgh. November 1997.

Shore-Sheppard evaluates the effects of Medicaid legislation of the 1980s on Medicaid eligibility and health insurance coverage of newly eligible children. The first portion of the paper addresses the intended effects of the Medicaid expansions for children on enrolling eligible children. The second portion of the paper measures the unintended impact - the “crowding out” of private health insurance for the newly eligible. To measure crowding out, she uses data from the 1988 through 1996 Current Population Survey March Supplements. She imputed eligibility first based on the existing eligibility rules for that year and then for the eligibility rules that existed before the expansions for kids began. She compares the two calculations to decompose enrollments between children eligible because of legislative expansions or due to other reasons. To estimate crowding-out she compares the percentage of children moving from private coverage to no coverage and to Medicaid coverage between among three groups of children, those never Medicaid eligible, those always Medicaid eligible, and those newly Medicaid eligible. She finds that crowding out occurred, but was not constant over time or across states and ranged from 15 to 41 percent (the percentage of newly enrolled children coming from private coverage), depending on the time period examined. On the other hand, she finds that the decline in private coverage rates due to crowd-out among this group accounts for only a small fraction of the total loss of private coverage over the same period. She concludes that the rise in Medicaid coverage rates may have contributed to fairly steady rates of health insurance coverage for the whole population during a period of declining private insurance.

The Shore-Sheppard analysis may be subject to several sources of measurement error. Because Medicaid eligibility is difficult to precisely impute, the groups of never/always/or newly eligible children may include misclassifications.

Did Medicaid Expansions for Pregnant Women Crowd out Private Coverage?

Dubay L, Kenney G. *Did Medicaid Expansions for Pregnant Women Crowd Out Private Coverage?* *Health Affairs* 16:1:185-193. January/February 1997.

In this article, Dubay and Kenney build on their previous work on crowding out by analyzing coverage of pregnant women (their earlier work focused on all women). The authors explicitly account for secular changes in employer-sponsored coverage and examine the potential for crowding out at different eligibility levels. Using 1989 and 1993 CPS-based TRIM2², the authors estimate the coverage status for pregnant women in two income groups. To account for secular changes in employer based coverage, they net out the decline in private coverage that occurred during the same period among a group not likely to be affected by the Medicaid expansions – adult men. They find virtually no crowding out among pregnant women with income below poverty – perhaps attributable to the low level of employer coverage among this group. For pregnant women with income between 100% and 185% of poverty, crowding out appears to have occurred. It is calculated to have been 27% of the increase in Medicaid coverage for women with income between 100% and 133% of poverty and possibly higher for those with income between 133% and 185%. Due to small sample sizes, these estimates include large standard errors. Overall, Dubay and Kenney estimate that 14% of the increase in coverage for pregnant women between

² The Urban Institute’s Transfer Income Model, Version 2 is a microsimulation model of tax and transfer programs that is based on the March Current Population Survey.

1988 and 1991 can be attributed to crowding out of employer coverage. The authors speculate that further expansions of Medicaid are likely to be subject to increased crowd-out.

The authors summarize seven “caveats” or possible sources of bias or measurement error including 1) The CPS does not directly measure the number of people without insurance. As a result investigators are required to use a default category of respondents who indicate that they do not have other sources of coverage. 2) It has never been certain that respondents to CPS health insurance status questions are reporting coverage at the time of questioning or for the prior year. 3) Medicaid enrollment is thought to be underreported on the CPS – the authors attempt to resolve this problem by using TRIM2 which imputes enrollment for certain eligible populations. 4) It is not clear how to handle changes in insurance status for those respondents reporting both Medicaid and employer coverage. 5) Since pregnant women are not identified on the CPS, their number must be imputed. 6) Longitudinal data would be preferable for measuring changes in insurance status over time. 7) The analysis assumes the secular and other time variation changes in insurance status are similar for the control group and the experimental group. Since this control group is demographically very different from the experimental group, this source of bias could be significant.

Medicaid and Private Insurance: Evidence and Implications

Cutler DM, Gruber, J. Medicaid and Private Insurance: Evidence and Implications. Health Affairs 16:1:194-200. January/February 1997.

Cutler and Gruber review the results of their earlier work linking an increase in Medicaid enrollment with a decline in employer-sponsored coverage during 1987 to 1992. In that analysis, Cutler and Gruber hypothesized that if there is a correlation between these two factors, states with a greater expansion in Medicaid eligibility would have a greater reduction in private insurance coverage than states with relatively smaller expansions. This analysis found a strong correlation between Medicaid expansions and declining private coverage. The authors estimated that 1.5 million more uninsured children received Medicaid coverage during the expansion periods while private coverage declined by 0.6 million children. They estimated the decline in private insurance to account for 50% of the increase in Medicaid coverage induced by expansions. This difference accounts for much of the disparity between their estimates of crowd-out and those of Dubay and Kenney. Cutler and Gruber discuss possible policy implications of their findings. They discourage restricting Medicaid eligibility based on the results but suggest that better targeting Medicaid to previously uninsured persons may be possible. A possible approach for better targeting of Medicaid may be to require a Medicaid “buy-in” for eligibles at higher income levels or establish a sliding scale of cost-sharing. The authors also question whether Medicaid should be a focus of new initiatives for expanding health insurance coverage to modest income uninsured.

The authors point out that estimates of crowd-out depend upon how the question is framed. Some of the research attempts to answer different versions of the question “How large is the substitution of Medicaid for private insurance”. Cutler and Gruber propose that the answer to the question “What is the reduction in private insurance coverage as a share of the persons *enrolled* in Medicaid *as a result of the expansions*” is about 50%. A second version of the question is “what is the reduction in private insurance coverage as a share of the *total increase in Medicaid enrollment* over the period”. That question, posed by Dubay and Kenney, would logically result in a lower number.

The Effects of Expanding Medicaid Eligibility on the Distribution of Children's Health Insurance Coverage

Shore-Sheppard L. The Effects of Expanding Medicaid Eligibility on the Distribution of Children's Health Insurance Coverage (*thesis*). University of Pittsburgh. September 1996.

Shore-Sheppard investigates the extent of crowd out before and after legislation broadened Medicaid eligibility by expanding coverage to children in families with incomes above poverty. To determine the extent of crowd out, Shore-Sheppard compared Current Population Survey (CPS) data from the March 1988 and 1989 surveys with the surveys from 1994 and 1995 to examine the distribution of health insurance, income, and residence of children before and after expansions. She found that after the Medicaid expansions, regional differences in coverage rates of children of working poor had declined. Simply viewing the coverage changes between 1988 and 1994 would lead one to conclude that crowd out may have resulted in a decline in private coverage. However, when comparing changes in private coverage during the period among near poor children and single men age 15 to 45, the author found that coverage among the control group declined in nearly the same magnitude as the decline among Medicaid eligible children. She concludes that the decline in private coverage may be attributed to underlying macroeconomic trends rather than Medicaid expansions. She further examined crowd-out by testing the hypothesis that regions where larger portions of the population became eligible for Medicaid would have undergone larger declines in private coverage. She finds, however, no correlation between larger portions of the population eligible in a region and larger declines in private coverage. As a result, she concludes that the decline in private coverage between 1988 and 1994 was not likely to have been caused by the Medicaid expansions.

This research was later refined by the author. The crowd-out estimates that result from that analysis are near those of Dubay and Kenny. See above.

Does Public Insurance Crowd Out Private Insurance?

Cutler DM, Gruber J. Does Public insurance crowd out Private Insurance? Quarterly Journal of Economics. 111:391-429. May 1996.

The cost of expanding public sector health programs depends critically on the extent to which public eligibility will cover just the uninsured or will crowd out existing private insurance coverage. Cutler and Gruber estimated the extent of crowd-out arising from the expansions of Medicaid to pregnant women and children over the 1987-1992 period. The results suggest that approximately 50% of the increase in Medicaid coverage was associated with a reduction in private insurance coverage. This occurred largely because employees increasingly refused employer-sponsored insurance. There is also evidence, according to Cutler and Gruber, that over the same period employers contributed less for insurance, making the employee responsible for a greater portion of the contribution, possibly prompting employees to withdraw coverage for their dependent children.

Revisiting the Issues: The Effects of Medicaid Expansions on Insurance Coverage of Children

Dubay L, Kenney G. Revisiting the Issues: The Effects of Medicaid Expansions on Insurance Coverage of Children. The Urban Institute. October 1995.

Dubay and Kenney examine the Current Population Survey (CPS) using TRIM2 to determine whether Medicaid expansions crowded-out private insurance during the 1990s. In this analysis, Dubay and Kenney attempt to control for secular declines in the offering, financing, and take-up of employer-sponsored insurance between 1989 and 1994 by comparing changes in private insurance coverage of Medicaid eligible children with changes in private insurance coverage of a population that is not likely to be Medicaid eligible- men ages 18 to 44. Overall, the authors conclude that about 12% of the *increase* in Medicaid coverage of children between 1989 and 1993 was attributable to crowd-out and that it was greater for near-poor children than for poor children. Further, the authors suggest that raising Medicaid eligibility thresholds beyond the poverty could have the additional effect of reducing the number of children with employer-sponsored coverage.

(**Note:** This article can also be found in the Spring 1996 edition of The Future of Children. The citation is as follows: Dubay LC, Kenney GM. The Effects of Medicaid Expansions on Insurance Coverage. The Future of Children 6:1:152-160. Spring 1996.)

Does Public Insurance Crowd Out Private Insurance?

Cutler D, and Gruber J, “Does Public Insurance Crowd Out Private Insurance?”, Washington, DC: National Bureau of Economic Research, Working Paper No. 5082, 1995 – Quarterly Journal of Economics

Children and Health Insurance: An Overview of Recent Trends

Newacheck PW, Hughes DC, Cisternas M. Children and Health Insurance: An Overview of Recent Trends. *Health Affairs*. 14:1. Spring 1995.

Newacheck, Hughes, and Cisternas offer a detailed description of recent trends in employer-sponsored coverage and an increase in Medicaid enrollment. Using the Current Population Survey (CPS), the authors examine differences in health insurance coverage patterns in 1992 according to family characteristics and parents' attachment to the work force. Analysis of the data suggests that patterns of insurance coverage varied considerably for children of different family characteristics. Children who were most likely to have employer-based coverage were non-Hispanic white adolescents who came from two-parent households, had parents who were employed full-time, and who had relatively comfortable incomes. As might be expected, minority children from single-parent, low-income households were less likely to have employer-based coverage. Consequently, this particular population was likely to have medical coverage through Medicaid. Despite public- and private-sector efforts to broaden private health insurance coverage and congressionally mandated Medicaid expansions, a significant minority of children remain uninsured. These children are predominately Caucasian, members of a two-parent household, and belong to families with incomes above the poverty level. Newacheck, Hughes, and Cisternas argue that while the percentage of children who were uninsured declined from 1988 to 1992, the number remained virtually unchanged over the period. Secular factors such as economic recessions, medical care inflation, and an increase in manufacturing and service sector employment opportunities may have attributed to a decline in employer-sponsored insurance. Had employer coverage rates remained the same in 1992 as they had in 1988, an estimated three million children who are currently uninsured would have received coverage. Legislative changes enacted by Congress during the latter portion of the 1980s broadened eligibility standards among Medicaid enrollees but ultimately benefited children who had previously been excluded from Medicaid coverage.

Program Evaluations

Who is still uninsured in Minnesota?

Call KT, Lurie N, Jonk Y, Feldman R, Finch MD. Who is still uninsured in Minnesota? Journal of the American Medical Association 278:1191-1195. October 9, 1997.

Call et al. conducted a study to measure the effectiveness of MinnesotaCare in serving its target population. MinnesotaCare, a state subsidized health plan, was established in 1992 to provide affordable health insurance to low-income uninsured residents who do not qualify for Medicaid. Families and individuals with income below 275% of the federal poverty level are eligible for a subsidized premium calculated on a sliding scale. The authors used three surveys to measure the effectiveness of MinnesotaCare. Two statewide telephone surveys, conducted in 1990 and 1995 randomly sampled state residents. The third survey, also via telephone, examined 800 MinnesotaCare enrollees. In 1990 and 1995 surveys, respondents were asked about health status, eligibility for public programs, and access to private insurance. Analysis of the surveys indicated that the percentage of Minnesotans without insurance remained the same while those lacking insurance for part of the year increased over the period. Of the

continuously uninsured, the proportion of children declined and the proportion of adults increased. Between 1990 and 1995 the percentage of uninsured with access to other sources of coverage through employers or family members declined. Of those with access to employer-sponsored insurance, most were ineligible because they do not work enough hours to qualify or must wait until their traditional waiting period expires to enroll. Twenty percent of the uninsured with access to an employer or family member's plan cited cost as the reason for declining coverage. In the third telephone survey of MinnesotaCare enrollees, seven percent of respondents said that they gave up private insurance to enroll in MinnesotaCare. (More than half of those gave up individual policies.)

The Florida Healthy Kids Program: Are there indications of crowd out?

Shenkman E, Naff R, Wegener DH, Freedman S. The Florida Healthy Kids Program: Are there Indications of Crowd Out? Institute for Child Health Policy. September 1997.

This paper investigates whether the Florida Healthy Kids Program encouraged the erosion of employer-based coverage. The authors examine children's health insurance status before entry and upon leaving the program. Created in 1990, Florida Healthy Kids was established to provide school based coverage to uninsured children. School districts serve as a group for which the Healthy Kids Corporation negotiates group insurance health policies and contracts with HMOs to provide healthcare. A telephone survey was conducted by randomly sampling approximately 1,405 parents of children who had been enrolled in the program for at least three months. When asked about the children's coverage status during the 12 months preceding enrollment in Healthy Kids Program, only 2% of respondents report having had private, employer based coverage at any time during the year. In addition, families whose children had disenrolled from the Healthy Kids Program were surveyed. The survey found that 45% of those surveyed disenrolled because they obtained employer-based insurance. The majority of parents were employed full-time, had few health benefits, and had a relatively low income. The authors conclude that Healthy Kids Program is responsible for very little crowding-out since few children had access to employer-sponsored coverage in the year prior to enrollment and many parents choose employer-sponsored coverage over the public program upon disenrollment.

The article provides some insight that the findings are not likely to be replicated under CHIP programs. First, the enrollment in the Healthy Kids Program is primarily among children in families with income below 130% of poverty. CHIP programs will be focused on children with family income as high as 200% of poverty. At that income there are almost seven children insured with employer sponsored plans for every one uninsured child. Further, family premium contributions in the Healthy Kids program are not insignificant. Families with income below 130% pay \$5 to \$10 per child per month, families with income between 131% to 185% of FPL are pay between \$15 and \$25 per child per month. Those in families with income above 186% of FPL could be required to pay between \$50 and \$60 per child per month.

Other

What is Crowd Out and Why should Children's Health Advocates Care?

Families USA. What is crowd out and why should children's health advocates care? *Draft*. December 1997.

This position paper defines crowding out as "the substitution of public programs for private ones" and discusses methods states can use to minimize such substitution without denying access to the most needy. Families USA asserts that crowd out research conducted to date has not provided conclusive evidence that Medicaid expansions resulted in a decline in employer-sponsored insurance. The organization notes that among states with health insurance initiatives for modest income populations, such as Florida and Minnesota, none have complained of serious problems with crowd out. It is reasoned that while strict eligibility requirements may lessen the potential for crowd out, it may also prevent uninsured children

from receiving coverage. For instance, requiring uninsured children to wait for a lengthy period before receiving coverage or denying eligibility to uninsured children who had access to employer-sponsored plans without considering the cost of those plans may unfairly reduce access to coverage. Several options, however, are presented that may discourage higher-income families from voluntarily discontinuing private coverage. Among those presented are 1) states should ask about the prior insurance status of applicants and be prepared to take corrective action if there are indications of large-scale crowd-out, 2) narrowly targeted eligibility restrictions and premium contribution requirements could reduce incentives for dropping private coverage for public coverage. (If waiting periods are instituted, states can include exemptions for uninsured children whose families lost insurance involuntarily.); 3) states may offer financial incentives for employers to retain or expand coverage to their employees; 4) states can provide financial assistance to businesses that offer coverage to all of their employees.

Examining Substitution: State Strategies to Limit "Crowd Out" in the Era of Children's Health Insurance Expansions

Fallieras A, O'Brien MJ, Ginsburg S, Westprahl A. Examining Substitution: State Strategies to Limit Crowd Out in the Era of Children's Health Insurance Expansions. The Lewin Group. December 1997.

Fallieras, et al. review the research on crowd-out, examine the experience of states with children's health insurance programs created prior to Title XXI, and explore the effectiveness of strategies used to deter individuals from shifting coverage from employer-sponsored insurance to public programs. The authors point out that limited data and the complexity of the crowd-out issue make it difficult to precisely determine the catalysts for declining employer-sponsored coverage, to measure the degree of substitution, or develop a profile of "substitutors." Substitution is complicated by secular trends, including the decline in employer-sponsored insurance, increasing levels of employee premium contributions, the decrease of unionization, and shifts from manufacturing to lower wage service industries. The authors distinguish between the substitution that occurs when individuals forgo private coverage to enroll in public coverage and when employers reduce or eliminate premium contributions because families are able to obtain subsidies. States have used the following mechanisms to address either individual-based or employer-based substitution. 1. Setting premiums and copayments that are low enough to encourage participation, yet high enough to limit substitution. 2. Setting eligibility rules based on access to employer coverage, periods of uninsurance and employer contributions. 3. Using subsidies to help pay for employer sponsored coverage. 4. Limiting the scope of benefits. 5. Using health insurance purchasing cooperatives to make the provision of insurance more affordable for small businesses. 6. Allowing employers to buy directly into state programs at a reasonable cost. 7. Assisting certain *employers* with the cost of health insurance.

The authors state that most state officials indicate they have seen little evidence of crowd-out and believe that few enrollees have had access to affordable private group coverage. Few have collected data to accurately estimate the extent of crowd-out and those that have conducted analyses of participants' access to private coverage suggest lower estimates of crowd-out than nationally-based research reveals. The authors do not attempt to compare the methods or measures of the states' analyses with the national analyses.

Deterring Crowd-out in Public Insurance Programs: State Policies and Experience

Chollet D, Birnbaum M, Sherman M. Deterring Crowd-Out in Public Insurance Programs: State Policies and Experience. Alpha Center. October 1997

This monograph investigates, through telephone interviews with state officials, approaches and experiences, with respect to crowd-out, of sixteen state insurance programs. The authors found widely differing views among the officials about the magnitude and importance of crowd-out for their programs. Those states that have only extended eligibility to the near-poor population have devoted little attention to

the issue of crowd-out whereas states that have extended eligibility to the middle-income population consider crowd-out a significant issue. Provisions established under the various state programs to restrain crowd-out are described and categorized as either indirect or direct measures. Indirect measures to target benefits to uninsured populations include eligibility restrictions (for example, on income, assets and age), premium contribution requirements and benefits plan configurations. Direct measures that may deter crowding out include restrictions that applicants are uninsured, uninsured for some minimum period prior to enrollment, underinsured, or do not have access to employer-sponsored insurance. The authors found that states have experienced difficulty in enforcing provisions to deter crowd-out and have little evidence about the effectiveness of such provisions. Further, the limits of the 1996 Health Insurance Portability and Accountability Act (HIPAA) and the 1974 Employee Retirement Income Security Act (ERISA) may make efforts to deter crowd-out more difficult. HIPAA's portability provisions do not protect enrollees leaving public insurance programs, thereby hindering their ability to obtain private insurance. ERISA governs most practices of employee benefit plans, however, it allows employers substantial latitude to exclude various classes of workers or to offer such low contributions toward premiums that coverage is unaffordable for low-income workers.

Fears that employer coverage will fall if uninsured children are helped are exaggerated

Children's Defense Fund. Fears that Employer Coverage will fall if Uninsured Children are Helped are Exaggerated. October 1997.

This position paper argues that there is little definitive evidence to suggest that crowd-out may become a serious consequence of CHIP. According to the agency, eligibility policies intended to reduce crowd-out are administratively burdensome and may discourage families from seeking the coverage they need. The issue brief suggests that states such as Minnesota and Washington, with state subsidized health insurance programs have not found crowd-out to be a serious problem during the administration of their program. Further, CDF argues that increased Medicaid coverage for eligible children does not necessarily cause reductions in employer-sponsored dependent coverage. CDF argues that employer-based coverage for children has been declining since the 1970s, regardless of shifts in Medicaid funding. In addition, the agency argues that states can discourage crowd-out without excluding children. First, federal and state anti-discrimination laws can prevent employers from reducing contributions or coverage of modest-income employees. Second, brief waiting periods can be established to ensure that uninsured children receive coverage before children who voluntarily dropped employer-sponsored insurance. Third, laws can be established to prevent employers from coercing employees and their families to substitute employer-sponsored insurance for publicly subsidized insurance.

Employer Coverage and the Children's Health Insurance Program under the Balanced Budget Act of 1997: Options for States

Merlis M. Employer Coverage and the Children's Health Insurance Program under the Balanced Budget Act of 1997: Options for States. Institute for Health Policy Solutions. August 1997.

This report reviews the recent findings on crowd-out, reviews the CHIP legislation with respect to crowd-out, and proposes program features that may minimize crowd-out. Programs to subsidize the employee share of the premiums for employer-sponsored coverage are presented as an option under CHIP. Merlis reviews efforts to deter crowd-out among six state programs that pre-dated the federal CHIP program. All six offer comprehensive benefits to children (and sometimes to other family members) who are in families with income above Medicaid levels. Of those programs, the Florida Healthy Kids program imposed a 6-month minimum uninsured period but subsequently dropped it because it was viewed as being too punitive. MinnesotaCare imposed a 4-month minimum uninsured period for any insurance and an 18 month minimum for employer subsidized insurance when the employer contributes at least 50% of the cost for the employee. The New Jersey program includes a 12-month minimum uninsured period. In Pennsylvania applicants for the program may not participate if they are eligible for other coverage. In

Tennessee, applicants for TennCare must not have access to an employer plan. The Basic Health Plan in Washington has no restrictions intended to minimize crowd-out. Merlis argues that there has been little systematic analysis of the extent to which participants substituted public for private coverage or whether employers have modified benefits in response to these public subsidies. The author proposes that states can discourage crowd-out in new or existing programs by establishing sliding-scale premiums so that higher-income families pay a larger portion of the premium than lower-income families. He notes that states such as Colorado and Oregon have enacted legislation (again, both pre-dated the federal CHIP legislation) authorizing programs that subsidize for employee contributions for employer-based health insurance. Finally, the paper defines two approaches for computing sliding-scale subsidies, and discusses the problems of rate tiers in employer benefit plans, targeting subsidies, and evaluating employer benefit packages.

Employment-Based Health Insurance: Costs Increase and Family Coverage Decreases

General Accounting Office. Employment-Based Health Insurance: Costs Increase and Family Coverage Decreases. GAO/HEHS 97-35. Washington, DC: United States Printing Office. February 1997.

The General Accounting Office (GAO) examined recent trends in employer-sponsored coverage and changes in the number of adults and children with private insurance coverage. The agency found evidence of eroding employer financial support for health insurance for employee's families, health insurance premiums rising at rates surpassing inflation, and many employers considering altering their contributions towards family coverage. In addition, GAO found that some families are facing increased difficulty in obtaining coverage and that employers may have become increasingly hesitant to contribute to expensive premiums. GAO cites a 1996 survey conducted by the Economic and Social Research Institute (ESRI) that found that of 601 employers, 40% would prefer to contribute less than half towards their employee's insurance premiums. Of those employers who believed that businesses have a responsibility to contribute towards health premiums, many stated that employers should contribute less for families than for individual employees. Also cited are a number of studies that find employees' shares of health premiums and contribution amounts have risen over time. As a result, in 1993 more than 29 million employees could not provide employer-sponsored coverage for their families. While the percentage of working-age adults with private insurance coverage decreased at a nominal pace, the number of insured children declined more significantly. GAO concludes that a decline in employer-sponsored coverage will increase the number of uninsured Americans and will shift a greater proportion of health care spending onto public programs.

Crowding Out: How Big a Problem?

Holahan, J. Crowding Out: How Big A Problem? Health Affairs 16:1:204-206. January/ February 1997.

The author comments on the implications of recent findings that Medicaid expansions have resulted in crowding out of private insurance. He points out that, assuming Cutler and Gruber's and Dubay and Kenney's results, while almost 20% of new Medicaid enrollees would have been insured by private plans in the absence of the expansions, 80% of new enrollees would have been uninsured in the absence of those expansions. Further, Medicaid enrolled 9 million beneficiaries between 1988 and 1993, mostly in families with income below poverty who were unlikely to have had access to employer coverage. Without Medicaid, the number of uninsured would likely have risen dramatically. He points out that 1) Employer-sponsored coverage had been declining for all income groups since the 1970s and had continued to drop in the late eighties. Those declines were likely to have been due to reasons other than crowd-out, such as increasing premium costs, and probably would have occurred in the absence of the Medicaid expansions. 2) Crowding out did not significantly increase the cost of the Medicaid program. He calculates that about 1% of Medicaid spending could be attributed to crowd out. 3) Crowd-out was not a significant factor in the surge in Medicaid spending during the same period. He estimates Medicaid spending on children and pregnant women was only a small share of total spending and attributes the

rising costs primarily to increasing enrollment of AFDC and disabled beneficiaries, rising disproportionate share payments, increased utilization, and growth in inflation. Holahan suggests that crowd out may be minimized by requiring sliding scale premiums or by subsidizing the purchase of employer-sponsored coverage for modest-income employees but may not ever be completely avoided and such program could be costly.

Finding Practical Solutions to "Crowding Out"

Curtis R, Merlis M, Page A. Finding Practical Solutions to Crowding Out. Health Affairs 16:1:201-203. January/February 1997.

In this article, Curtis, Merlis, and Page describe the administrative difficulties confronted by states implementing a Medicaid law that requires them to provide financial support towards the coverage of Medicaid-eligible employees when employer-sponsored coverage was available and when it was cost-effective for states to do so. (In 1997, the provision was amended to become an option for states instead of a mandate.) The authors argue that the widespread implementation of such programs might have reduced much of the crowding out that was observed while Medicaid eligibility was undergoing the expansions of the late 1980s and 1990. Since most private coverage requires families to contribute to premiums, financial incentives exist for those families to discontinue their private coverage in order to enroll their children in Medicaid. To minimize the substitution of Medicaid for private coverage, Medicaid programs could have changed those financial incentives by providing a subsidy toward employer-sponsored coverage rather than provide Medicaid benefits directly. States found, however, a number of barriers to effectively administering such programs. Some of those barriers included a) difficulty determining the availability of coverage of applicants, b) assessing cost-effectiveness of the private coverage, c) problems enrolling beneficiaries after the annual open enrollment period has ended, and d) providing wraparound coverage. The article provides practical solutions to some of those impediments and encourages policies to improve the fit of public and private coverage.

Medicaid Eligibility Policy and the Crowding-Out Effect: Did Women and Children Drop Private Health Insurance to Enroll in Medicaid?

The Center for Studying Health System Change. **Medicaid Eligibility Policy and the Crowding-Out Effect: Did Women and Children Drop Private Health Insurance to Enroll in Medicaid?** Issue Brief No. 3. October 1996.

Based on a crowd-out seminar sponsored by the Center for Studying Health System Change, this issue brief describes the differences and similarities of two studies that received widespread attention among health care reformers and children's health advocates: The Cutler-Gruber study and the Dubay-Kenney study. Cutler and Gruber, using 1987 through 1992 CPS, attempted to separate crowding out from secular trends in employer coverage via regression analysis. The authors concluded that about 50% of the increase in Medicaid coverage associated with the eligibility expansions was offset by a reduction in private insurance coverage. Dubay and Kenney estimated the extent of crowd out over the 1988 to 1993 period. They controlled for secular trends in employer-sponsored coverage by comparing changes in private coverage for Medicaid-eligible children with changes in a control group of men aged 18 to 44. They found that while crowd-out was not a significant problem among the poor population, it became increasingly problematic among less poor populations, and that overall, 14% of the increase in Medicaid enrollment for

pregnant women and 12% in children was attributable to crowd-out. While the two studies appear to be very different, CSHSC points out that they are not necessarily inconsistent. The estimates differ because Cutler and Gruber considered only those children who were eligible for the Medicaid expansions whereas Dubay and Kenney focused on the entire Medicaid population of children under age 11 as well as pregnant women. Further, Cutler and Gruber examined the extent of crowding out by taking into account the indirect effects of the eligibility of other family members whereas Kenney and Dubay did not. Both

studies agree that crowd-out occurred as Medicaid eligibility was broadened. The Center for Studying Health System Change suggests that in order to ensure that uninsured children receive coverage, states could offer subsidies to modest-income employees to purchase private insurance or could introduce income-based fees for Medicaid services to enrollees with higher incomes.

Medicaid Crowd Out and the Inverse Truman Bind

Swartz K. Medicaid Crowd Out and the Inverse Truman Bind. *Inquiry* 33:5-8. Spring 1996.

This article cautions that a careful analysis of the complex causes of declining private health insurance coverage must be done before it can be concluded that publicly funded health care coverage for children and pregnant women will create a public policy problem. Dr. Swartz questions whether the simultaneous expansion of Medicaid coverage and the decline in private health insurance coverage confirm the hypothesis that Medicaid expansions have crowded out private insurance coverage. She argues that crowding out is hard to identify, and harder to measure. The author points out that crowd-out can co-exist with normal job turnover. Without measuring macroeconomic fluctuation, which varies dramatically by region, it is difficult to determine the portion of the decline attributable to crowd-out. To test the crowd-out hypothesis, she recommends following states over a set of years, while controlling for macroeconomic variation for each year cautioning that careful consideration of the particular experiences of each state is essential. While the Current Population Survey (CPS) is the best there is, she points out that very small sample sizes for many states can compromise the analysis. Finally, she proposes erring on the side of targeting a public policy too broadly rather than too narrowly - particularly when the costs of covering children are small and the net societal savings in terms of lower costs for premature and low birth-weight babies can be large.