

*Effective Coverage Expansions for Uninsured Kids and Their Working Parents:
Links to Job-Based Coverage*

May 18, 2001

Conference Transcript: "Crowd-Out Study"

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A Study of Past Public Insurance Expansions and Crowd-Out of Private Coverage

Speakers:

- Susan Marquis, Senior Economist, RAND

Moderator: Joan Henneberry, NGA

(Additional information about the speaker appears at the end of this section.)

Transcript:

MS. HENNEBERRY: My name is Joan Henneberry. I'm the Director of Health Policy at the National Governors' Association Center for Best Practices, and we're very happy to be here and co-hosting this meeting this morning.

The rest of the morning we're going to be focused on the phenomenon known as "crowd-out" or substitution, and is it there, how real is it, how bad is it? And, hopefully, talk about what sorts of policies and program designs you can put in place to minimize or avoid it.

Our first speaker is going to be Susan Marquis, who is a Senior Economist at RAND. And for those of you who are in those pioneer states that did major health insurance and coverage expansions in the '90s, you're very familiar with the work that she and her colleagues at RAND have done. They have been a very important source of data for the states, and she's going to talk to us today about what happened in those states and where crowd-out occurred and where it didn't and give us some of her insights. Susan.

MS. MARQUIS: This is a study that I recently completed with my colleague Steve Long, and as you just heard, it was intended to explore the extent to which some recent public program expansions have, in fact, reduced the number of uninsured and to what extent people who enrolled in the programs dropped or did not purchase private insurance that they might otherwise have purchased.

Crowd-out can occur because people who enroll in the public program drop private insurance, or don't purchase it, because the private coverage is now more expensive than public coverage or its benefits are lesser. But crowd-out can also occur if the availability of public insurance leads some employers, and especially employers with a lot of low-wage earners, to drop insurance, or discourages others from adding insurance, and so reduces access to employer-sponsored coverage. And we tried to look at both decisions from the family's perspective and from the employer's perspective.

There have been a number of previous studies that have tried to estimate crowd-out, and most of these have focused on the crowd-out stemming from the Medicaid eligibility expansions for children and pregnant women. These studies have produced a fairly wide range of estimates of the amount of crowd-out. The largest suggested that about 60 percent of newly eligible

children and pregnant women dropped private insurance, but most of the evidence suggests that crowd-out is somewhat more modest, in the range of about five to 20 percent.

EXISTING LITERATURE	
<ul style="list-style-type: none">• Focus on Medicaid expansions for children and pregnant women• Wide range of estimates:<ul style="list-style-type: none">– Largest estimate: 60 percent of increase in public coverage for eligible population– Preponderance of evidence: 5-20 percent• Some empirical support that crowd-out increases as income eligibility threshold increases• Little evidence that these expansions affected employer decisions	
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These studies also suggest that crowd-out increases as income increases, which is not too surprising since the likelihood of having private insurance increases with income and so the potential for crowd-out is greater, but it does suggest that as public programs move up the income threshold, crowd-out could become an increasing problem.

Very few of these studies looked at the question of whether the eligibility expansions affected employers' decisions to offer insurance, but the few that did look at that found little empirical support for the idea that access to employer-sponsored coverage was adversely affected.

But as I said, most of these previous studies have looked at eligibility expansions for special population groups: children or pregnant women. And since the decision to purchase insurance is often a family decision, it seems likely that crowd-out may differ under broader based programs—those that are open to adults as well as children, and those that aren't restricted to maternity episodes. And so our goal in the study that Steve and I did was to look at the degree of crowd-out under some of these broader based programs, and as I said, we look at the response both from the perspective of families and the decisions of employers.

Our measure of crowd-out is based on changes in insurance status in seven states that introduced fairly broad-based public expansions. They are listed in this chart: Delaware,

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Massachusetts, Minnesota, Oregon, Tennessee, Washington and Vermont. These programs were introduced over the period 1993 to 1997.

EXPANSIONS STUDIED		
DE	4/96	100% FPL
MA	7/97	133% FPL children, unemployed 400% FPL uninsured children, receiving unemployment
MN	1/93	275% FPL families, 175% other
OR	1/94	100% FPL
TN	1/94	400% FPL uninsurable, children under 18, ineligible for other
WA	1/93	200% FPL
VT	10/96	150% FPL, 225% children
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The income eligibility thresholds varied quite substantially across these states, but the common feature of these programs is that, below the income threshold, the program was open to a fairly broad range of the population and not to special population groups. These earlier programs did not coordinate with employer sponsored coverage, however.

Let me just briefly tell you how we measure crowd-out. To look at the responses of families, we used data from the Current Population Survey, which is a large national survey designed to make state as well as national estimates. We looked at changes in insurance status for the low-income eligible population in the seven states before and after the program was introduced. Our before period was '91 to '93 and after '97 to '98.

Other things may have been changing over this period of time as well as the introduction in the new program that would affect insurance status, and so to try to control for that, we look at changes in insurance status for the low-income population in all other states and use this to adjust our measure in the seven expansion states.

So what we're assuming is that what happened elsewhere is what would have happened in these seven states had they not introduced the program. Some of you may be familiar with this as a difference-in-differences estimate. This assumes that the effect of time is the same everywhere, and if there are some state-specific effects of time, then our measure could still be biased. And so, to try to estimate the state-specific effects, we look at a population that's not

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eligible for the program—in this case, people with moderate income—and look at the change in insurance status for the moderate income in expansion states and the other states. And this difference is our estimate of the time effects that are specific to the expansion states, and we also adjust for that.

Our way of estimating crowd-out from the employer's perspective is pretty similar, except here our data come from two large national surveys of employers, the National Employer Health Insurance Survey, which collected information about the employment-based system in 1993 and represents our pre-expansion period, and the 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey, which represents our post period.

And we look at changes in employer offer rates and changes in employee take-up rates before and after the expansion, again adjusting for the effect of time based on changes in non-expansion states. Since all employers have some low-wage workers, we can't identify a set of employers that we can *a priori* say were not affected by these public insurance expansions, and so we don't have a state-specific time adjustment. But we do believe that it's likely that the expansions would affect small employers more than large employers, and especially small employers with low-wage workers, and so we do look at those groups separately.

And here are our results.

Editor's note: The preliminary results that Dr. Marquis presented at the conference have been submitted for publication in a scholarly journal. Therefore, the specific results cannot be reproduced here at the present time, for two reasons. First, submission of an article to a journal requires that the author agree not to publish the information elsewhere prior to its publication in the journal. Second, the journal's peer-review process may lead to revision of the original analysis; thus, the findings cannot be considered final until they are published. Once the findings have been published (assuming they are not significantly changed from what was originally presented), we will re-issue a complete transcript of Dr. Marquis' presentation with the results included. Dr. Marquis has, however, kindly given us permission to include her summary conclusions at this time, which she is confident will not change. What follows is the conclusion of Dr. Marquis' presentation, along with the question-and-answer session.

MS. MARQUIS: So, to summarize, we found fairly substantial substitution of public insurance for private insurance in the seven states that we studied. Some small employers do seem to drop coverage, but overall, changes in take-up rates seem to be a bigger factor leading to crowd-out.

There are a couple of cautions in trying to generalize our results for these seven states, however. First of all, these seven states were among the states that had the lowest uninsured rates and the highest privately insured rates, even before the expansion. And so they were states where the potential for crowd-out was high, and so similar results might not occur if we were to look at other areas.

CONCLUSIONS, I

- **Substantial substitution of public insurance for private insurance occurred**
- **Some small employers drop coverage, but changes in take-up a bigger factor**
- **Some caveats:**
 - **States may have been self-selected**
 - **Other changes (e.g. welfare policies) may be a factor**
 - **Short time to adjust**
 - **Limited efforts to prevent crowd-out**

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Also, as I mentioned, there were a number of other changes occurring over the period, such as changes in welfare policy, that might have affected results; and though we tried to control for them, our adjustments may have not been adequate.

Our post period was soon after many of these programs were introduced, and so they had a short time to adjust. Over a longer term, results may have been somewhat different. And, finally, results might also have been different with stronger efforts introduced and enforced to try to prevent crowd-out.

Nonetheless, our study did suggest that these programs had a pretty limited effect on the number of uninsured in these states, although they may have decreased periods of transitory uninsurance and they may have improved generosity of coverage or decreased premiums, and so welfare overall for the low-income population was probably improved.

On the other hand, there is other evidence that also suggests that a large number of eligible people remain uninsured, even when they are able to enroll in fairly generous public insurance programs. For example, in another study that I just completed with Steve, we found that about a third of adults eligible for the Washington basic health plan, who said they knew of the plan, had heard of the plan, still remained uninsured. And so the challenge to policymakers really is to try to find new ways to attract the uninsured and yet not disrupt private markets and crowd out private insurance.

CONCLUSIONS, II

- **Programs had limited effect on uninsured**
- **Although may have decreased number of those with transitory uninsurance**
- **May have improved generosity of coverage, or lowered out-of-pocket costs**
- **But, other evidence that many remain uninsured even with generous public programs**
 - **Almost 1/3 of eligible adults who know about WA Basic Health Plan remain uninsured**
- **Challenge: find ways to attract the uninsured and not disrupt private markets**

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MS. HENNEBERRY: Thank you very much. I think we have time for a couple of questions. Yes?

AUDIENCE PARTICIPANT: I just was curious. I take it from what you said, the explanation about Oregon—they said that their uninsured rate was ten percent, and it sounds like what you're primarily saying is, before their program began, it probably wasn't much different than ten percent, since that sounds so much better than the national average now. Is that what you were saying?

MS. MARQUIS: Yes. That's part of what I'm saying. That's right.

MS. HENNEBERRY: Leighton.

MR. KU: I guess I have less a question but more a comment. I think it's a great paper and a good contribution to the literature, but I've looked at other studies that deal with expansions for adults, and I'm aware of two other papers that are published. I had a little simple thing related to TennCare in the HCFC review recently. Nicole Lorry had something in JAMA a couple of years ago about MinnesotaCare. I know Rick Kronick and Todd Gilmore have a paper that's in progress—I've heard testimony about it out in California at the California Senate. And basically, the conclusions of all the other three papers are going the other way, saying that the public expansions that included adults led to reductions in uninsurance. There was little or marginal crowd-out. I'm not exactly sure why there are disagreements between the sources, but I guess the main point I want to have made is, the evidence in this area is really quite mixed. And, you know, you mentioned before the children's literature was sort of mixed for a long time

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period, and there have been different results that have been coming out, and I think at this point, there is an evolving consensus that there is some but limited crowd-out for kids. I think it's a little early to reach any particularly strong conclusion that crowd-out is making all these programs of public expansions essentially ineffective. So just—

MS. HENNEBERRY: Do you want to respond to that?

MS. MARQUIS: I'll have to take a look at some of these other programs. Minnesota was one of the states we studied, and while I didn't report any of our state-specific results separately because they're less reliable, we actually found pretty consistent results in these Current Population Survey data and employer data across all the states. But it would be interesting to take a look at the different methods. And I think part of the point I wanted to make wasn't necessarily that crowd-out had rendered these programs ineffective, but there do seem to be a large share of uninsured people who, for reasons that I think we don't understand at all, aren't attracted into public programs, and subsidies aren't the only answer, and I think we haven't found the answer.

MS. HENNEBERRY: Tricia.

MS. LEDDY: I'm wondering whether in your study you controlled for the erosion of employer-based coverage which occurred in many states through the late '90? Although it's going on an upswing now, up until '99 it was going down. It seems from your data that you assumed that people are going from private coverage into public coverage, and yet some other data that we looked at in our state suggests that people are going from—that through erosion of employer-based coverage, people that are going into public coverage are, indeed, uninsured and that the people that are adding to the uninsured rate, making it [stay] the same, is due to the erosion of the employer-based coverage. So it's that employers were dropping coverage and adding people to the uninsured, so that, in fact, the uninsured rate would have been higher if we had not done an expansion.

MS. MARQUIS: We controlled for this to a limited extent in that we looked at the erosion that was occurring in the states other than the seven states and tried to make an adjustment for that, but to the extent that the degree of erosion differed across the various areas, we didn't have a good way to control for that. But there is some limited control.

MS. HENNEBERRY: We'll take one more question over here. Yes?

AUDIENCE PARTICIPANT: Yes. I'm from Delaware. We're one of the seven states that were studied. We've been tracking the uninsured for quite some time, and one of the things that we looked at is also the population growth, because we have a fairly light population growth, and we've actually concluded that between the Medicaid Standard and our SCHIP program, that had we not put those things in place, that another 35,000 adults would have been insured that have some kind of insurance now. I don't know that it's—that not only is there erosion, but when there is a population growth impact going in too, so I'm just wondering how that all played into your calculations?

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MS. MARQUIS: Well, again, we tried to control to some extent for changes over time using other states, and so what we're saying is, relative to what was happening in other states shifting to public programs, we're finding an increase in public programs, but no change in the uninsured in these seven states on average, and we're looking at rates, and so there is an adjustment for population growth in doing that.

MS. HENNEBERRY: Okay. We'll let John have the last question.

DR. SANTA: I know in Oregon one of the things we've been impressed with makes us believe that all of this information may be correct, it depends on the question you ask and how you define uninsurance.

MS. MARQUIS: Right.

DR. SANTA: Today we're covering 350,000 people. Over a year, we know that we'll provide benefits to 550,000 people. Over five years, we know that a million of the 3.5 million Oregonians will get [public] benefits at some time using—enormous amount of this churn. And we now know from some of the disenrollment information that the biggest reason for that is people's incomes do go up a little bit. They do get employed. They get a raise. They work more hours. So they are going back and forth between private and public coverage. Just enormous amount of dynamics going on there. So it kind of depends on the question you're asking and how you're evaluating uninsurance and what's going on. Just a very dynamic picture.

MS. MARQUIS: Which is consistent with our hypotheses about this increase in the dual coverage, which is, really it's there is less uninsurance in a transitory sense, and we just can't detect that.

DR. SANTA: Yes. I would just close with—in one of our counties, we were stunned to see that, over a five-year period, almost half the people in the county at some point in time got benefits from the Oregon Health Plan. Forty-eight (48) percent got benefits for at least six months from the Oregon Health Plan over a five-year period of time. Just stunning.

About the Speaker

Susan Marquis, Ph.D. is a Senior Economist at RAND in Washington, DC. Her current research focuses on employment-based insurance, state health care reforms, and Medicaid eligibility expansions. During 25 years in the RAND Health Sciences Program, Dr. Marquis has directed many projects to study the effects of health care financing on patient access and provider behavior. She has also participated in designing and implementing evaluations of innovative financing arrangements. She has served on advisory and technical panels for HCFA, the Agency for Health Care Policy and Research, the Physician Payment Review Commission, the National Institutes of Health, and The Robert Wood Johnson Foundation. Dr. Marquis received her Ph.D. in Economics from the University of Michigan.