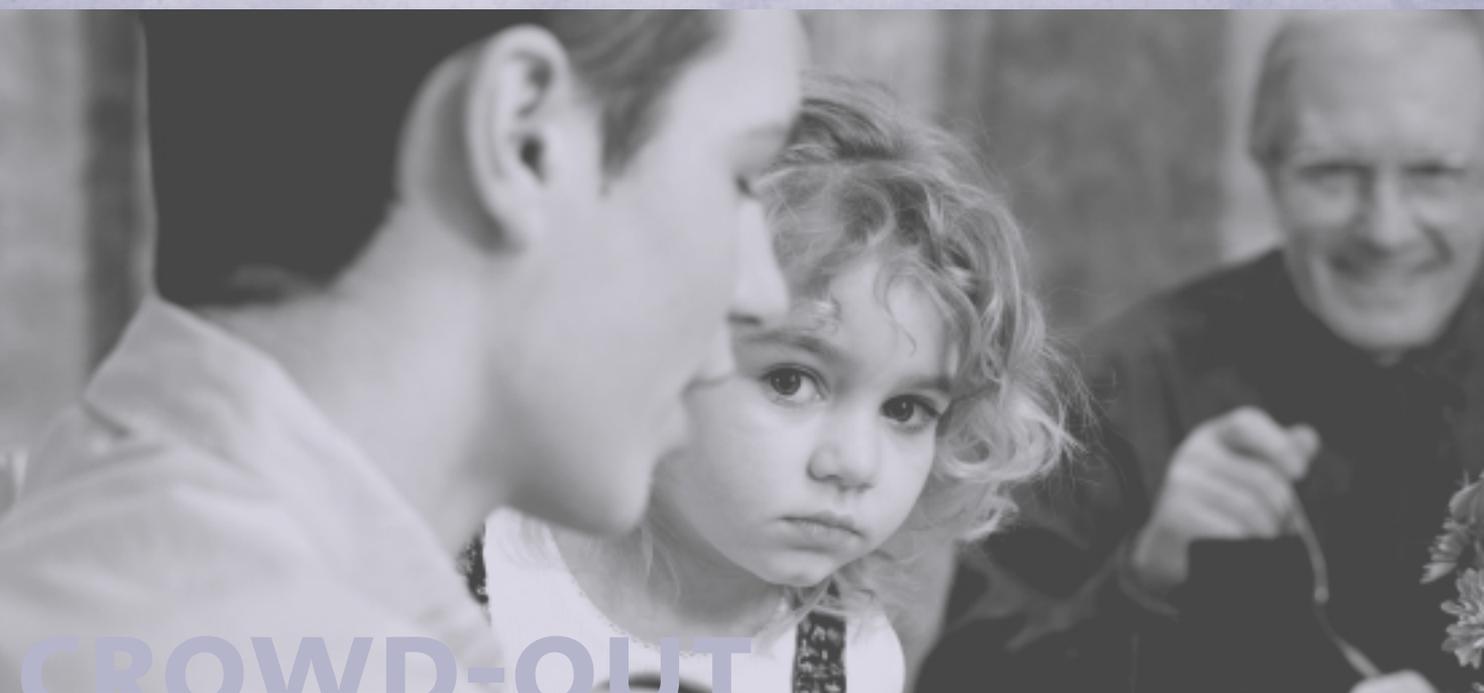


CROWD-OUT



# Understanding the Dynamics of “Crowd-out”:

Defining Public/Private Coverage Substitution for Policy and Research

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# Foreword

Crowd-out—the substitution of public for private insurance—is a complicated issue that in recent years has become increasingly relevant to state and federal policymakers. The policy and politics of crowd-out entered the spotlight during the Medicaid expansions of the 1980s, and the 1997 enactment of the State Children’s Health Insurance Program (SCHIP) focused renewed attention on the issue. Now, as states use their SCHIP funds to expand eligibility to include more, higher-income children and their families, policymakers are hungrier than ever for answers about how often crowd-out occurs and how much of it is acceptable in public programs.

For many policymakers, one of the most challenging aspects of expanding public insurance programs is striking the right balance between “take-up” and “crowd-out.” On the one hand, their goal is to increase the number of eligible Americans covered by public insurance. On the other, they do not want to cast a net so wide that public resources “crowd out” coverage that people already have in the employer-based system.

Unfortunately, there are no perfect data to steer policymakers toward a clear, “correct” course of action. Estimates on the extent to which crowd-out occurs vary greatly, with some studies suggesting it accounts for about 15 percent of new Medicaid enrollment and others putting the figure as high as 50 percent. Limited data and methodological differences in the way coverage substitutions are defined and measured make it impossible to know which calculation is most accurate.

Assessing the policy implications of crowd-out is not straightforward either. Although policymakers tend to think of coverage substitution in negative terms—associating it with the misuse of limited public resources—the fact is that the costs of crowd-out have important benefits. For example, low-income workers who choose to substitute public coverage for their private insurance often do so because the public program provides access to continuous, comprehensive health care (including preventive services) that they could not otherwise afford.

Moreover, in some cases, the “cure” for crowd-out may be worse than the disease. Policies that deny coverage to people who have been privately insured in the past often leave many currently uninsured without health care, including those who have lost jobs or been dropped from an employer’s plan because public funds became available.

Today, many states are finding that they can do more to help the nation’s uninsured and underinsured by working with the private sector than without them. Oregon and Massachusetts, for example, are reimbursing firms for purchasing employer-based coverage. Maryland and Wisconsin are pursuing private coverage buy-in programs that subsidize premiums for employees who cannot afford their portions of employer-based plans. Other states are considering offering tax breaks to employers that sponsor insurance or are organizing purchasing co-ops to help small businesses negotiate for affordable benefits packages.

This report provides a framework for researchers and policymakers as they navigate through the complex maze of issues raised by coverage substitutions. It is a synthesis of information presented at a meeting held by The Robert Wood Johnson Foundation’s *Changes in Health Care Financing and Organization* (HCFO) program. The meeting brought together stakeholders to discuss how to define, measure, and analyze crowd-out, and identified salient questions for future research to address as policymakers design the next generation of coverage expansions.

In the end, deciding whether—and how much—crowd-out is acceptable in public programs boils down to making a value judgment. Considering crowd-out forces us to examine the fundamental purpose of public insurance programs. Although this report does not offer easy answers for policymakers, it helps them ask the right questions.



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Program Director

# Introduction

While the question of how to deal with America's growing uninsured problem makes headlines daily, designing and implementing policies that will provide health care coverage to the uninsured are enormous tasks fraught with political and practical challenges. High on that list of challenges is how to use finite public resources to provide cost-effective coverage to the most people. Is that challenge being met, however, when public dollars are used by low-income children and families with access to private coverage? There are many reasons why a family might forgo private health coverage to enroll in a publicly funded program, but the phenomenon of substituting publicly funded insurance coverage for privately paid coverage has been labeled as "crowd-out."<sup>1</sup>

Though simple on its surface, crowd-out raises many questions, including: 1) how much crowd-out is acceptable in a public program; 2) what policy measures are effective at controlling crowd-out; 3) are all rationales for substituting public for private coverage equal when determining a program's cost-effectiveness; and 4) how might policymakers rank the priorities of efficiency and equity to improve health status? These questions came up in the 1980s with Medicaid expansions, and more recently with the State Children's Health Insurance Program (SCHIP). They are now taking on a new significance as states look toward the next generation of SCHIP. Many states either have begun, or are considering, using SCHIP funds for family coverage by expanding eligibility levels for parents. In addition, some states have applied for and received waivers to use SCHIP resources to subsidize employer-sponsored insurance (ESI). Granted, these mechanisms illustrate SCHIP's ability to respond to today's uninsured population, but they also add to the complexity associated with monitoring crowd-out.

While the flexibility inherent in SCHIP's authorizing legislation makes it somewhat easier for states to target their policies toward a greater proportion of the working uninsured, there is a catch: the higher the SCHIP eligibility climbs, the greater the possibility of interaction between the public and private insurance markets, the greater the potential for, and the more difficult it will be to measure, crowd-out.

The objective of this report is to help policymakers understand the complex questions inherent in expanding subsidized health insurance coverage to people with incomes above Medicaid eligibility levels. For instance, should policymakers be concerned when private insurance is dropped for public coverage and better benefits? Should a program strive to offer more affordable and stable insurance in addition to expanding rates of insurance coverage? What role does outreach play in increasing enrollment in the targeted program and other programs? At what point does the administrative cost of keeping children who are or could be privately insured from enrolling in the program exceed the cost of allowing them to enroll? And finally, do we measure SCHIP's success by the total number of children it has covered, or by how many previously uninsured children it has covered?

States are now feeling pressure from two sides. Though they want to refine both their SCHIP plans as well as other policies for covering uninsured parents, children, and childless adults, they are also facing new and greater budgetary pressures than in most of the last decade. As the consequences of policy decisions become ever more costly, research that can inform policymakers on public program expansions and coverage substitution dynamics may be helpful in the program design process. In the following pages, this report will:

- Describe variations in behavior that may or may not be considered crowd-out;
- Summarize the seminal research on the subject, paying particular attention to how research has defined crowd-out and how these definitions have affected the estimates;
- Explore program design and its implications for achieving policy goals;
- Illustrate the difficulties of estimating crowd-out; and
- Suggest questions—and the data that may be used to answer them—about coverage and insurance substitution for researchers to consider as they inform the policy process.

<sup>1</sup> Defined by the Agency for Healthcare Research and Quality (AHRQ) as "a phenomenon whereby new public programs or expansions of existing public programs designed to extend coverage to the uninsured prompt some families with privately insured persons to drop their private coverage and take advantage of the expanded public subsidy."

## Not All Substitution Should Be Seen as Crowd-out: Clarifying Terminology and Perception

When the SCHIP program was first signed into law in 1997, analysts estimated that it would lead to individuals dropping out of private insurance programs to enroll in the (presumably less expensive) public program.<sup>2</sup> There was also the concern, though not as widely studied, that employers who offered private group coverage and employed a high percentage of low-income workers would either drop their insurance offerings or make them more expensive to encourage their workers to enroll in the public program. The argument is that a public program not effectively using finite public resources could result in fewer improvements in overall health status and access to care, providing the lesson that sometimes the most well-intentioned public policy may create perverse incentives and ultimately undermine the goal of that policy. But whether one perceives insurance substitution—and the implications such substitution could have on public resources and private markets—as the result of such perverse incentives depends on two measures: the perceived goal of the public program, and the magnitude of the substitution taking place. Analysts tend to agree that the question is not if substitution or crowd-out is taking place as a result of publicly subsidized health coverage, but rather how much substitution is acceptable.

Furthermore, are the drawbacks of broadly defining a program preferable to the drawbacks of targeting a program too narrowly and not allowing it to achieve its goals?<sup>3</sup>

In policy circles, crowd-out has a distinctively negative connotation and implies wasting precious public resources. There can be a number of different factors, however, motivating low-income families to choose public coverage over private

coverage. Furthermore, within the private coverage arena, there may be different motivations and outcomes depending on whether one is enrolled in group or non-group coverage. The following scenarios help illustrate the incentives behind certain coverage substitutions, demonstrating that the crowd-out label may be applied to several behaviors that do not constitute direct coverage substitution.

**Substituting Public Coverage for Non-group Coverage:** A parent drops his or her dependent's enrollment in an individual private coverage plan to enroll in SCHIP. Studies indicate that a high percentage of families who purchase non-group coverage do so because they have children with special needs. If the premiums and copayments associated with this coverage

**As the consequences of policy decisions become ever more costly, the importance of research that can inform policymakers on public program expansions and coverage substitution dynamics may be helpful in the program design process.**

are prohibitive—which is more likely than not—should it be considered crowd-out when the family signs up for less expensive (and perhaps more comprehensive) SCHIP benefits?

**Substituting Public Coverage for Group Coverage:** In the group market the issues are somewhat more complicated, given the interaction between employees' and employers'

<sup>2</sup> Though a public program, states are mandated to charge SCHIP enrollees whose income is above a certain level of poverty a premium to enroll in the program. This is designed to: a) reduce crowd-out, and b) make SCHIP mimic private insurance and thereby reduce the stigmatization that some say occurs in the Medicaid program.

<sup>3</sup> "The View from Here: Medicaid Crowd-out and the Inverse Truman Bind," by Kathy Schwartz, *Inquiry*, Spring 1996.

decision-making behavior. For example, most would agree that a low-wage employee who drops his/her high-premium, employer-sponsored dependent coverage to enroll in a SCHIP program that offers greater benefits at a lesser cost is not contributing to crowd-out. However, if an employer with many employees whose incomes make their families eligible for SCHIP decides to stop offering dependent coverage (or ESI altogether), the likelihood increases that public resources might be spent on people who may not need them.

**Benefit-driven Substitutions:** Setting aside the group vs. non-group market dynamics, there is the underlying issue of how a private benefits package may motivate enrollment in a

#### **Maintaining Child's Enrollment in Public Coverage After Change in Employment:**

One of the characteristics of the Medicaid-eligible, and to some extent the SCHIP-eligible, population is relatively unstable employment. Thus, it is not uncommon for a child who is enrolled in a public program to have access to private group coverage for various periods. Given the instability of that access, however, it would make sense both from an economic and from a public health perspective to allow that child to remain enrolled in a public program rather than risking bouts of uninsurance. Are the periods during which the child is enrolled in a public program, but the family has access to group coverage, to be considered crowd-out?

Many such scenarios occur daily, making the design of a public insurance program that targets the uninsured a difficult task. Understanding why coverage shifts occur becomes all the more important for policymakers, health advocates, and employers.

Finally, some additional terms may be helpful insofar as they guide policy decisions. Substitution initiated by an individual can be categorized

as “opt-out,” since it is the individual choosing to leave a privately subsidized plan to enroll in a publicly subsidized plan. Conversely, when an employer ceases to offer group coverage (for employees and/or their dependents), or raises cost-sharing to unaffordable levels knowing their employees may be eligible for public coverage, the behavior may be labeled “push-out.” In considering these behaviors, the motivations behind them, and solutions for increasing insurance rates, policymakers must weigh important financial and political considerations.

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**Questions on the effectiveness of publicly funded coverage must take into account the avenues by which outreach efforts are being made to bring eligible individuals into the system.**

public program. Take, for example, a pregnant woman who drops a catastrophic private plan that does not include pregnancy and delivery benefits to enroll in public coverage. If the private coverage required a woman to pay for pregnancy and delivery benefits out-of-pocket, there is a chance she would not get the necessary prenatal care, or she would get it through a publicly funded health care source. The same would likely be true of the delivery. Either way, there will be high public costs, particularly if she forgoes prenatal visits due to associated costs. If she chooses instead to enroll in public coverage, would her actions be measured as crowd-out?

## Strategies for Limiting Crowd-out

To maximize limited public resources, the crowd-out limiting strategy needs to be appropriate to the behavior it is trying to control. Each policy option carries with it specific incentives for either the employer or the individual, and the strengths and weaknesses of these strategies rest upon pushing the correct buttons. Policymakers need to be mindful of whose behavior will be affected by the various incentives and of the impact those strategies will have on other facets of the health care market, both public and private. Two broad categories of strategies that motivate the substitution decision have been identified for dealing with potential substitution: direct and indirect.<sup>4</sup> Direct strategies attempt to motivate enrollee behavior (“opt out”) by making the public program appear less attractive to the target population. These strategies, which would be written into a state’s program plan, may include eligibility restrictions based on current insurance status or time spent uninsured, and/or mandatory premium contributions. Indirect strategies seek to motivate employers either to begin or continue offering accessible and affordable benefits for families and dependents, thereby making private insurance purchases an attractive option for those eligible for public insurance (limiting “push out”). These indirect strategies include subsidizing employees to make premiums for group coverage more affordable (e.g., Maryland); establishing purchasing cooperatives for small businesses so they can provide their employees with coverage; reimbursing firms for their purchase of employer-sponsored coverage (e.g., Oregon and Massachusetts); and establishing an employer tax credit that would encourage employers to offer benefits to their employees or allow employers to deduct the cost of premium payments.<sup>5</sup>

There are trade-offs associated with each type of strategy. Direct interventions are more commonly used and have an evaluated track record, so it is easier for policymakers to determine the probable effects of their use. In addition, administrative data collected via these interventions may ultimately be helpful in studying coverage expansions and their effects on the health care system. However, both the administrative costs and the public health costs associated with restricting a program based on insurance status can be prohibitively high.

There are a number of benefits to designing a program that uses indirect interventions, foremost among them the fact that they may be more successful in achieving expanded coverage and introducing more people into the employer-based, private system. Yet, given the high uninsurance rate, justifying the use of public funds for employer subsidies to make coverage more affordable for those who arguably already have financial access to insurance could be politically difficult. There are at least two sides to the debate: is it fair to those who do not have access to private coverage to spend public funds in order to shore up systems that are only available to those above a certain income with access to private coverage? Or is it smart health policy for the government to support the private employer-based market and improve systems of private coverage for the working uninsured? Beyond ESI subsidization are strategies that involve tax incentives for small businesses or businesses that employ a majority of low-wage workers to offer group coverage, and subsidization of individual insurance purchases. Again, these may be politically risky, but could achieve success in expanding coverage.

<sup>4</sup> “Examining Substitution: State Strategies to Limit Crowd-out in the Era of Children’s Health Insurance,” by Anna Fallieras, Mary Jo O’Brien, Susanna Ginsburg, and Amy Westpfahl of the Lewin Group for the Office of Health Policy of the Office of the Assistant Secretary for Planning and Evaluation, United States Department of Health and Human Services, December 9, 1997. (<http://aspe.hhs.gov/health/reports/hinsubst/front.htm>)

<sup>5</sup> Ibid.

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The question is: where should finite resources be spent? Are they best spent by covering those who could not access coverage, or would they be better spent enrolling more eligible individuals, even if it means including some individuals who theoretically have access to private coverage? Are crowd-out limiting strategies worth the administrative effort and the possible public health costs? And finally, how does the issue of equity within the un- and underinsured population play into these questions?

### **Making the Connection: Ensuring the Policy Strategy Matches the Programmatic Goal**

At the core of the crowd-out debate is whether finite public resources are being used to provide services to certain individuals (in this case, those with access to private coverage) at the expense of others (those without access). However, an examination of current insurance rate statistics makes it clear that outreach, rather than crowd-out, may have a more significant effect on the uninsurance rates. According to the most recent data (1999) there were 10.8 million uninsured children living in the United States, down from 11.9 million in 1998.<sup>6</sup> Without downplaying the success of this decline, the fact remains that 6 million of those still uninsured are eligible for Medicaid and/or SCHIP.<sup>7</sup> There is no doubt that a large deter-

minant of how well a public program meets its goals is inherent in the success of its outreach efforts. Thus, within the context of crowd-out, it would be presumptive to question the effectiveness of publicly funded coverage without taking into account the extent to which outreach efforts were made to bring eligible individuals into the system. While it is arguably important to design programs that limit crowd-out, policymakers need to support outreach and enrollment activities that, as evidenced by the dropping number of uninsured, help ensure that programmatic goals are met.

There is a question about the potential ripple effects of outreach on the interaction between public and private coverage following enrollment and the building up of public program caseloads: if an individual's or family's first entry into health care coverage is through a public program, what will happen when that person or family has access to employer coverage? Will they take that coverage, or continue to be covered by a public program where they incur less out-of-pocket expense? Thus, the implications of outreach, like those of the programs themselves, are more complex than they appear on the surface.

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## **Estimating Crowd-out for Policymaking Purposes: Pitfalls and Priorities**

State legislatures and members of the research community put a great deal of effort into estimating the crowd-out effects of publicly funded coverage expansions. At the federal level, the SCHIP statute requires that states develop their SCHIP plans with crowd-out-limiting strategies in mind. Furthering this effort, HCFA mandates that states include some means of measuring (and limiting) the percentage of children enrolling in SCHIP who were previously covered privately. Many in the research and policy communities have learned, however, that determining the existence of a causal relationship between the public program and changes in insurance enrollment is not as straightforward as it sounds. This is further complicated by the fact that many low-income families frequently experience transitions in insurance status, moving from uninsured to Medicaid-covered to SCHIP-covered. As policymakers look for evidence of what strategies work and do not work for providing the most benefits to the most needy (whether defined by income or by current insurance status), researchers are trying to estimate the impact not only of insurance expansion policies, but also of crowd-out-limiting strategies, to understand better their impact on both public health care financing and on public health itself.

### **Estimation Difficulties**

There are rarely perfect data available for studying any issue, and crowd-out is no exception. Up to the last few years, the data have centered on Medicaid expansions. This precludes researchers' abilities to examine some of the more complex lingering questions, namely the effects of premium costs, benefits, provider networks, etc., on public/private coverage substitution.

In today's rapidly changing environment, where states are experiencing budget pressures unlike any they have known for

the last five years, measuring the effects of public program expansions on crowd-out are especially relevant. But for utility's sake, these estimates must be able to account for a number of difficult-to-measure variables: whether individuals or families moved directly from private insurance into Medicaid; whether these individuals intentionally disenrolled from private coverage, or lost that insurance through a change of employment, loss of income, or other factors; whether families have had consistent coverage over a 12-month period; and finally, whether the benefits offered through Medicaid or SCHIP were broader, more stable, and more affordable than those provided through private means.

### **Evaluating the Effects of Coverage Expansion Programs: What Are the Appropriate Data?**

The predominant data sources for studies done in the late 1980s to mid-1990s were Medicaid administrative and claims data, the Current Population Survey (CPS), the National Longitudinal Survey of Youth (NLSY), and the Survey of Income and Program Participation (SIPP). In recent years, however, more detailed data collection efforts have ensued due to recognition that the traditional data sources left gaps in what could be evaluated. In addition to the question of what type of data will meet researchers' needs—survey data, administrative data, claims, case study data, or a combination of any or all—there is debate over whether the best data for studying this issue is to be found at the federal, state, or community levels. Finally, there are the issues of what it will cost to produce the best data sets for studying crowd-out, how the need for reliable and informative estimates can be balanced with that cost, and whether the time needed to produce these data will cancel out their effectiveness.

<sup>6</sup> Children's Defense Fund, "Key Facts: Children's Health Coverage in 1999." [www.childrensdefensefund.org/health-start-chip-keyfacts.htm](http://www.childrensdefensefund.org/health-start-chip-keyfacts.htm).

<sup>7</sup> Children's Defense Fund, "Unspent 1998 Federal CHIP Funding." [www.childrensdefensefund.org/health\\_articles\\_98chipfund.htm](http://www.childrensdefensefund.org/health_articles_98chipfund.htm)

The following section informs this debate by examining the:

- data sampling area (state or national);
- type of data (survey, administrative, or case study); and
- collection timeframe (cross-sectional or longitudinal).

Following this discussion is a description of data currently available that may be useful in charting a path toward evaluating the second generation of coverage expansion initiatives and their effect on decreasing uninsurance rates and improving health status for low-income populations.

### The Data Debate: National vs. State

There are a number of difficulties in using population data to assign some level of causality between a policy intervention and consumer or employer behavior. Estimates produced using state-level samples may not be generalizable to a national population, and vice versa. The myriad variables—regulatory, demographic, economic, and social—make producing low-cost, quick-turnaround estimates of the percentage of privately covered individuals choosing public coverage a daunting task. Currently, researchers can use a number of national surveys to conduct these studies, including the Current Population Survey (CPS), the Medical Expenditure Panel Survey (MEPS), the Community Tracking Study (CTS), the National Survey of America's Families (NSAF), and the 1993 National Employer Health Interview Survey (NEHIS). State-specific data are available through states' Medicaid enrollment and claims data and their HCFA-mandated SCHIP evaluations, the Urban Institute's Assessing the New Federalism project, and other state agencies that either are involved in overseeing health coverage programs or might have complementary data to study the issues pertaining to enrollee behavior in those programs.

Although national-level data lack relevant state-level variables, many argue that there are still important issues that they can address. This becomes particularly important when one considers the time and expense involved in collecting multiple state-level data through surveys or administrative files. Relying solely on national samples, however, may well leave information gaps. Each state has to deal with many political and policy-related issues that are likely not accounted for in data based on a national sample. On the other hand, there is a recognition of how valuable it can be to conduct studies using

national data, given the need for assessing national trends that go beyond local, state, or regional differences. Perhaps the most daunting issue in using national-level data is confidentiality. Even the best, most comprehensive national data sets, such as the MEPS, are beset by confidentiality restrictions that may limit their feasibility for answering current questions.

### Cross-sectional vs. Longitudinal Data

There is some debate over the merits of studying substitution using data that illustrate one point in time, versus studying changes in the same population over a period of time. Equally important to whether one uses national or state-specific data is the need for data that allow researchers and policymakers to establish a “counterfactual,” or what would have happened to the population in question had a policy intervention not been implemented. Longitudinal data sources and models are considered more adept at extracting the predictors of substitution behavior and can answer more questions about health care utilization, access, and costs before and after implementation of and/or enrollment in a public program. Due to its national sample and its ability to be used longitudinally to some extent, the CPS is one of the most widely used data sets for studies of crowd-out. There are, however, three factors that preclude its efficacy in certain situations: 1) changes were made to the CPS population weights, questions, and survey methods in 1990, and every year following since 1993; 2) the questions are “generic” in nature, meaning they do not provide detailed information on local- and/or state-specific differences; and 3) the meaning of the questions tend to change subtly depending on the order in which they are asked. On a positive note, \$10 million was spent in FY 2000 to institute a number of improvements that would address the noted weaknesses prior to the next fielding. Among these improvements will be an increased sample size and a decreased standard error. One goal is to make estimates of children's insurance participation more reliable.

### Selected Data Resources Currently Available

**National Survey of America's Families (Urban Institute):** Data from the large-scale, National Survey of America's Families (NSAF), part of the Urban Institute's Assessing the New Federalism (ANF) project, includes national and state-specific information for 13 states on insurance status, health status, access, etc. The first round of data was collected before 1997, when SCHIP was implemented, and the second round was collected in 1999.

These data may enable researchers to: 1) describe changes in levels of private coverage and public coverage; 2) compare states that implemented large Medicaid expansions to those with smaller expansions; and 3) compare stand-alone SCHIP programs to Medicaid expansions. The ANF project also enables examination of questions on how the uninsured behave in light of availability of new public programs, and to a limited degree, on how employers behave vis-a-vis publicly funded programs. One limitation of these data is that while they can account for who had employer-sponsored insurance, there is no information on premiums charged to employees for their insurance or for dependent coverage.

**The Robert Wood Johnson Foundation's Employer and Family Health Insurance Surveys (RAND):** The Robert Wood Johnson Foundation's (RWJF) Employer and Family Health Insurance Surveys were first conducted in 1993 in 10 states. The employer survey collected baseline employer data including information about the employer, including firm size and industry; the workers at the business, such as the wage distribution; and health insurance benefits offered by the employer, such as employers' premium contributions. The household survey collected data on insurance status, health status, and health care use. In 1997, RWJF sponsored a national survey of employers, collecting information similar to that obtained in the 1993 survey. Data from these surveys is available from the Inter-University Consortium for Political and Social Research (ICPSR) at the University of Michigan.

**Medical Expenditure Panel Survey (AHRQ):** The 1996 Medical Expenditure Panel Survey (MEPS) collected data on employer contributions to premiums, premium costs, and benefit design through two sources: the MEPS Household Component, linked to household respondents' employers, and the MEPS Insurance Component, a nationally representative survey of establishments. The household component of the survey includes data on demographic characteristics, health conditions, health status, use of medical care services, charges

# A New Resource for States

With support from The Robert Wood Johnson Foundation, the University of Minnesota's School of Public Health now operates a research unit called the State Health Access Data Assistance Center (SHADAC), designed to assist states in collecting data on the uninsured. Led by Principal Investigator Lynn A. Blewett and Co-Principal Investigator Kathleen Call, SHADAC works with states to develop and implement household and employer surveys, and can assist states in their efforts to analyze the prevalence of crowd-out in the private market. SHADAC helps states collect data that can be effectively put to use in developing state health policy. For more information, visit <http://www.shadac.org/>.

and payments, access to care, satisfaction with care, health insurance coverage, income, and employment. MEPS data can be used to answer questions regarding household health insurance status, private insurance, and employer behavior.

**National Longitudinal Study of Youth (Bureau of Labor Statistics):** The National Longitudinal Survey of Youth (NLSY) is a nationally representative sample of mothers born between 1957 and 1965. However, it is not a nationally representative sample of children, so findings using the NLSY may not be generalizable to the broader population of children in the United States.<sup>8</sup> It contains information on health insurance for each child in the sample, but there are only three choices of insurance coverage: private, Medicaid, or no coverage. Medicaid eligibility can be imputed using family wage income.

<sup>8</sup> Yazici, EY and R. Kaestner, “Medicaid Expansions and the Crowding Out of Private Health Insurance Among Children.” *Inquiry*, Spring 2000.

# A Research Agenda for the Next Generation of Coverage Expansions

One of the main goals of exploring crowd-out is to gain greater insight into how policies and their implementation strategies affect behavior among those with a stake in the policy. In the case of SCHIP, stakeholders span the realm from low-income children and families, providers, employers, state public health and Medicaid staff, and federal and state policymakers. At a working meeting held by The Robert Wood Johnson Foundation's *Changes in Health Care Financing and Organization* (HCFO) initiative, researchers, policymakers, and health care and children's advocates discussed a research agenda for furthering the field's knowledge of crowd-out issues. These ideas may enable health care analysts to evaluate current policies, and design new ones that will reach more of the uninsured. The following is a compilation of the questions that were considered the most crucial to study.

## Defining and Measuring Crowd-out

- Should the purpose of a public program (e.g., increasing insurance rates; providing more affordable and consistent coverage; improving benefits) be taken into account when measuring substitution rates, so as to not penalize programs that will ultimately improve public health and lower the public cost of providing health care? If so, how can we define and measure crowd-out to exclude insurance substitutions made to improve accessibility and affordability?
- To what extent should the definition of crowd-out depend on what type of private insurance was dropped, as opposed to why it was dropped?

- How can the research describing the effects of Medicaid expansions on disenrollment from private coverage inform policymakers who are trying to estimate the effects of SCHIP plans on disenrollment from private coverage?
- How will differences in administration of SCHIP (as a stand-alone program vs. a Medicaid expansion) affect enrollment, utilization, and crowd-out, and how will those differences affect state and federal policy?

## Methodological Issues

- Given that all 50 states have now implemented a SCHIP program, how can researchers compare the level of uninsurance post-SCHIP to what the uninsurance rate would be in the absence of SCHIP? Even if fewer states had implemented SCHIP to date, how would researchers control for the myriad socioeconomic, demographic, and other environmental differences necessary for establishing the counterfactual of what would have happened in the absence of a public program?
- Is there any way to measure "spillover" effects, and thereby account for instances where an entire family drops private coverage because one or more members are eligible for public insurance?
- Where does outreach fit in to the current research methodology? Can the impact and effectiveness of specific outreach efforts be measured? Can researchers estimate enrollment rates among targeted populations?

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State legislatures and members of the research community are putting a great deal of effort into estimating the crowd-out effects of public coverage expansions.

## Describing Consumer and Employer Behavior

- What role do benefits, premiums, co-payment rates, and choice of provider play in the decision to drop private coverage and enroll in public coverage? If an individual can get the same benefits in a public plan as in a private plan, do lower out-of-pocket costs create an incentive for enrollment in the public program? Which plays a larger role in consumer decision making to leave a private plan for a public one: premium costs or choice of provider?
- Who is enrolling in public insurance programs? What can policymakers learn from data on individuals' and families' prior insurance status (e.g., uninsured, individual, small or large group) and employment status (e.g., individuals who drop employer-sponsored insurance because of layoffs or other job loss, rather than financial incentives spurred by the public subsidy)?
- Can researchers measure employment status changes of adults enrolled in public programs (and parents of children enrolled in SCHIP programs) to more accurately describe the impetus behind transitions from private to public coverage?

- How do changes in the employer contribution to premiums affect enrollment into SCHIP as a substitute for purchasing more expensive private coverage?
- How do people behave during waiting periods? Do they delay obtaining care, thereby enrolling with poorer health status than they had when first applying? Do they rely on public safety-net services to receive care, thereby costing the state more money than if they had enrolled when first applying?
- How do co-payments affect the level of utilization of care under public programs?
- How will policies aimed at limiting crowd-out, both direct and indirect, affect employer behavior? Will employers drop dependent coverage but not alter their employer-sponsored insurance for their employees? Or will they cut benefits from the coverage offered to their employees?
- What effects do state-level insurance regulations and policies have on firm-level behavior? Furthermore, how will those policies affect state and federal budgets in terms of providing public resources for health insurance coverage? How do public insurance programs affect the stability and options available in the small-group market?

# Advancing the Field on Issues of Insurance Substitution and Crowd-out

It comes as no revelation that the need to align policy goals with existing political realities does not always make for easy policymaking. When it comes to health care and health coverage, the question is how to make insurance coverage accessible and affordable while recognizing the need for equitable and efficient use of public funds. In addition, policymakers and researchers must deal with a number of other variables, including benefits, premiums, co-payments, deductibles, state and federal regulations,

what policymakers are trying to accomplish in their coverage expansion programs.

Since the mid-1990s, following the failure of the Health Security Act to institute major reforms in the system, policymakers have relied upon incremental coverage expansion initiatives for discrete populations, using a combination of federal and state funding. Along with the additional freedom and flexibility that initiatives such as SCHIP offer state policymakers, however, comes a responsibility to delve deeper

into the question of how implementation of new programs affects existing systems and constituencies.

To that end, this report offers guidance for policymakers on how to think about crowd-out in the coming years and to researchers on how to build the field through research that answers questions policymakers have about public program implementation. By taking the time to examine why

individuals and families make insurance transitions, and how employers and the market respond to policy interventions aimed at helping individuals and families, researchers and policymakers can all better understand the needs of our country's uninsured and how to best meet those needs given inevitable policy, political, and financial constraints.

and tax treatments and incentives that define the country's care delivery and coverage system. Consequently, defining, researching, and predicting crowd-out and its causes become complex, yet necessary, exercises in the era of insurance expansions for the un- and underinsured. What is acceptable or problematic about crowd-out depends on

CROWD-OUT

**The question is how to make insurance coverage accessible and affordable while recognizing the need for equitable and efficient use of public funds.**

## Appendix: Literature Review

One place to start developing a definition of crowd-out for policymakers, administrators, and researchers alike is the existing literature, much of which estimates the crowd-out effects of the Medicaid expansions mandated by OBRA 88 and OBRA 89.<sup>1</sup> These expansions enabled researchers to use various pre-post methods to estimate how new eligibility requirements would affect a less poor population. Despite these natural experiments, developing a research methodology to measure crowd-out directly remains a challenge. One clear obstacle is the difficulty in establishing a counterfactual. One option for doing so is to compare Medicaid populations across states. However, given the state-specific nature of Medicaid eligibility, this method is still imperfect. While some data are available on the prior insurance status of individuals and families who enrolled in Medicaid between 1988 and 1992, there is no information on why shifts in insurance status took place.

### Cross-sectional, Longitudinal, and Case-study Data

In addition to characterizing the literature according to the programs that were evaluated, it can be organized by the type of data used: cross-sectional, longitudinal, or case-study. Cross-sectional studies estimate crowd-out by examining the changes in insurance status of specific populations following Medicaid coverage expansions. By comparing changes in insurance coverage of Medicaid-eligible populations before and after a coverage expansion to that of similarly situated non-eligible individuals, studies using cross-sectional data estimated the share of new entrants into the program who appeared to substitute Medicaid for that private coverage. The major weakness of cross-sectional studies is that they are unable to observe actual movement from one insurance state to another at the individual level and thus, they do not provide information on how or why these shifts take place. That is, a cross-sectional analysis would be unable to detect the difference between a concurrent shift of different individuals from private coverage to uninsurance and from uninsurance to Medicaid, and the direct movement of a single individual from private coverage to Medicaid.

<sup>1</sup> Both the 1988 and 1989 Congressional Omnibus Budgetary Reconciliation Acts (OBRA) mandated that, by 1992, all states cover pregnant women and children under the age of 6 up to 133 percent of poverty, with the option of expanding coverage up to 185 percent of poverty.

Longitudinal studies estimate crowd-out by examining the insurance status of the same individuals over a period of time following a Medicaid coverage expansion. This type of analysis may provide deeper insights into how changes in Medicaid eligibility are related to insurance status changes, and the situational shifts that go along with them. There are, however, drawbacks to using longitudinal data sets for such evaluations. First, the size of the sample available in a longitudinal survey is likely to decrease as additional cohorts are added to the survey. Longitudinal surveys also are less likely to include state-specific information, making it less likely that estimate results could be compared across states.

Researchers examining crowd-out from the employer perspective take a slightly different approach. Studies using qualitative case-studies or firm-level insurance data have evaluated the employer response to Medicaid expansion programs. Rather than examining enrollment in Medicaid directly, these analyses examine the private insurance climate during periods when Medicaid eligibility was expanded. While this type of analysis does not provide a direct measure of crowd-out, these studies provide interesting information about whether employers are more likely to withdraw insurance coverage of employee dependents when a publicly financed alternative (e.g., SCHIP) is available.

Following are selected studies that demonstrate how each of these methods were put into practice and the results that followed. Although fundamentally different in their approach, each poses the question: at what point does measurable crowd-out suggest ineffective policy design?

### Studies Using Cross-sectional Data

A study by David Cutler and Jonathan Gruber published by the Quarterly Journal of Economics in 1996 has become one of the benchmarks of the crowd-out literature. Using CPS data from 1988 to 1993, they took advantage of within- and across-state variability of Medicaid eligibility before and after the 1988 and 1989 OBRA mandates to study changes in insurance status for the newly eligible population of women and children. Cutler and Gruber's study described three ways of estimating how many individuals might substitute public for private insurance: 1) the decrease in private insurance coverage as a share of the persons who became eligible for Medicaid after the expansions; 2) the decrease in private coverage as a share of total Medicaid enrollment increases; and 3) the percentage decline of private coverage over a period of time that can be attributed to Medicaid enrollment.

Using the first measure, they estimated the likelihood of crowd-out resulting from a coverage expansion to be 50 percent. The second measure, which counts all new Medicaid enrollees (those who were eligible before AND after the expansion), comes

in much lower at 22 percent, ostensibly because new enrollees in traditional Medicaid were not likely to have had private insurance prior to enrolling. Finally, when measuring direct substitution of Medicaid for private coverage, the researchers arrive at a crowd-out estimate of 15 percent. This much lower estimate of crowd-out implies that levels of private coverage during the study period were affected by factors other than Medicaid expansions. The researchers suggest that a variety of factors, Medicaid being only one of them, contributed to the shift away from private to public insurance between 1987 and 1992.

Also in 1996, Lisa Dubay and Genevieve Kenney used CPS data to estimate the crowd-out effects of Medicaid expansions by analyzing changes in the probability of having Medicaid or private insurance coverage between 1988 and 1993. Unlike Cutler and Gruber or Lara Shore-Sheppard (see below), Dubay and Kenney focused on two different populations: children from families with incomes below 100 percent of poverty, and children from families with incomes between 100 and 133 percent of poverty. The control group consisted of men ages 18 to 44 in each of those populations. The researchers estimated that of the total population who enrolled in Medicaid during the study period, 14 percent of pregnant women and 17 percent of children had been eligible for private insurance. However, the crowd-out estimates were higher when it came to enrollees with incomes above 100 percent of the poverty level: 45 percent of pregnant women and 21 percent of children who became eligible for Medicaid following the expansion dropped their private coverage to enroll in the program.

In 1997, using methods nearly identical to the 1996 Cutler-Gruber study, Lara Shore Sheppard used CPS data from 1988, 1993, and 1996 to make similar crowd-out estimates, again based on the Medicaid expansions. Defining crowd-out as the reduction in private insurance coverage due to Medicaid expansions for low-income women and children, Shore-Sheppard arrived at an estimate of 15 percent for the period 1988-1993, and 30 percent for 1988-1996. The author suggests that increased enrollment in Medicaid expansion programs and larger declines in private coverage relative to new Medicaid enrollment explain the increased crowd-out effect for the 1993-1996 period.

Though it did not use the CPS, another notable study that examined cross-sectional data was conducted by Elizabeth Shenkman, et al in 1999. Shenkman and colleagues randomly selected 930 families whose children were enrolled in the Florida Healthy Kids program (Florida's SCHIP) in 1998 and surveyed them on their children's insurance coverage before enrolling in the program, including the parent/guardian's access to employer-based dependent coverage. Of the final sample of 653 children, 26 percent had access to employer-sponsored insurance (ESI), but only 5 percent had



been enrolled in this coverage before entering Healthy Kids. They also found that on average, enrollment in employer-based dependent coverage required a premium payment of 13 percent of their income, which for low-income workers could be prohibitively expensive. They conclude that while substitution of state-subsidized health coverage for accessible private coverage may result in fewer improvements to health care access and health status among low-income children, some degree of substitution must be expected given the economic burden of purchasing ESI.

### Studies Using Longitudinal Data

In 1998 Kenneth Thorpe and Curtis Florence used the National Longitudinal Survey of Youth (NLSY) to examine changes between 1990 and 1994, during which time enrollment in private coverage was declining for many reasons not necessarily related to the Medicaid expansions. Thorpe and Florence looked at: 1) increases in Medicaid enrollment among low-income children, stratified by previous health insurance status; 2) health insurance status of parents with Medicaid-enrolled children; and 3) shifts in employment status by parents who were covered under ESI, after their child switched from ESI to Medicaid. They found that the majority of new Medicaid enrollees were uninsured during the year prior to their enrollment and only 16 percent of newly enrolled children in Medicaid had access to private insurance through a parent at the time of their enrollment. The study notes that the major factor driving new enrollees into Medicaid during the early 1990s was the loss of private insurance due to a recession and subsequent high unemployment rates.

In 1999, Linda Blumberg, Lisa Dubay, and Steve Norton released a study that used the Survey of Income and Program Participation (SIPP) panel data starting from 1990 to examine the movement of children from private insurance into Medicaid during the early 1990s. The study compared changes in insurance status for children in poor or near-poor families for two populations of children: ages 1 through 6, and ages 7 through 11. The older children were not eligible for Medicaid under the expansion and were used as a control. The authors report that 23 percent of the movement into Medicaid from private coverage was due to crowd-out. They found no evidence, however, of substitution among those who were already uninsured. When all movement into Medicaid was considered, the crowd-out estimate was lowered to 4 percent.

Finally, in 2000 Esel Yazici and Robert Kaestner used the NLSY to track changes in insurance status over a four-year period following the implementation of Medicaid expansions in 1988. Estimates were made using a treatment group of children who became eligible because of the expansions, with a control group of children who were either always eligible or never eligible before and after the expansions occurred. Defining crowd-out as “the percentage increase in Medicaid enrollment that could be attributed to children who would have had private insurance,” Yazici and Kaestner estimated the crowd-out effects based on four different types of eligibility status:

1) eligible for Medicaid before and after the expansions; 2) became eligible due to the expansions; 3) became eligible due to family loss of income; and 4) never eligible for Medicaid (even in the cases of loss of income). Their estimates ranged from 0 to 33.2 percent, but on average they found that 18.9 percent of Medicaid enrollment during that four-year period came from children who would have been insured in the absence of the Medicaid program.

### The Case-study Approach

Jack Meyer and colleagues at the Economic and Social Research Institute (ESRI) in 1999 collected data from employers and employees on how much they knew about SCHIP, and their perspectives on how SCHIP might affect their benefits. They found that 19 percent of employers surveyed would consider dropping dependent coverage to provide financial relief, and/or to provide parents with an incentive to enroll their children in what may be better coverage under SCHIP. The study also found that employers with low-wage workers are the most likely to drop dependent coverage. Since a number of employees in such firms are likely to have difficulty affording their share of the premium, a transfer to SCHIP in these cases may be considered a helpful rather than a harmful development. The study goes on to say that the percentage of employers who would consider dropping coverage dropped significantly when they were told that their employees’ children would face a waiting period before becoming eligible for SCHIP coverage. Among the study’s conclusions was that employers are genuinely concerned about their employees’ welfare, and that these concerns should be taken into account when designing policies that discourage “push-out” by employers.

Using a combination of CPS and firm-level data supplied by the Health Insurance Association of America and KPMG/Peat Marwick, Shore-Sheppard, Thomas Buchmueller, and Gail Jensen (1998) examined how firms and employees responded to Medicaid expansions. The researchers found that Medicaid expansions did not result in firms dropping health insurance coverage altogether, nor did they affect the portion of the insurance premium workers were required to pay. While there was a small indirect relationship between a firm’s percentage of Medicaid-eligible workers and the employer’s provision of dependent coverage, the researchers note that among the firms sampled in the CPS that provided employer-sponsored insurance, a small fraction did not offer dependent coverage. Thus, while the estimate was statistically significant, the market impact of this estimate must be taken within the context of the labor market characteristics of the CPS sample. The findings of this study suggests that employees did not lose access to private group insurance as a result of Medicaid expansions. Thus, while Medicaid enrollment increases during the late 1980s probably included Medicaid-eligible workers who could have taken up private coverage, it appears that the impetus for the substitution was made on the part of the employee, rather than the employer.





Controversy over crowd-out analyses stems from widely divergent estimates reported by different studies. For instance, the cross-sectional study by Cutler and Gruber published in 1996 has thus far elicited the highest crowd-out estimate, finding that for every two people who enrolled in the Medicaid program, one person dropped his/her private coverage.<sup>3</sup> Conversely, the longitudinal study by Blumberg, Dubay, and Norton in 1999 reported that crowd-out only accounted for 23 percent of people who moved to Medicaid from private coverage. Of the total movement into the Medicaid program, both from private coverage and from the uninsured, only 4 percent was attributable to crowd-out. Obviously, some of this difference has to do with how crowd-out is defined, what population is used to develop a counterfactual, what type of data are used, and what controls are included in the equation.

In the end, these findings suggest that a reasonable estimate for crowd-out falls somewhere between the two poles. However, it is critical to recognize that none of the above studies take into account the benefits covered under private and public insurance plans, or other non-cost based reasons individuals may have sought public insurance over a private option. Despite the disparity among studies' findings, each advanced the field's understand of the effects of coverage expansions.

<sup>3</sup> Not all of those who dropped private coverage enrolled in Medicaid. See "Expansions in Public Health Insurance and Crowd-out: What the Evidence Says," by Lisa Dubay. Kaiser Family Foundation web site ([www.kff.org/content/1999/19991112m/dubay.pdf](http://www.kff.org/content/1999/19991112m/dubay.pdf)).

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