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Changes in
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findings brief

Safety Net "Crowding Out" Private Health Insurance for Childless Adults

Because so many low-income children are eligible for either Medicaid or the State Children's Health Insurance Program, even when they access safety-net providers, the doctors can usually get them enrolled in the appropriate program.

The health care safety net—which includes public hospitals, community health centers, local clinics, and some primary health care physicians—is "crowding out" (replacing) other insurance options for unmarried childless adults nationally, according to new research by Anthony Lo Sasso, Ph.D., and colleagues at Northwestern University.

The researchers examined the effect of uncompensated care provided by clinics and hospitals on insurance coverage for two groups: children under age 14, and unmarried childless adults age 18–64. They found that the adults with good access to safety-net services were less likely to have health care insurance.

"Some of these people may think, 'I'm young. I'm healthy. I have better things than health insurance to spend my money on,'" says Lo Sasso. "And they know that the safety net will be there if they become ill or injured and need care."

However, the researchers only found weak evidence that children are being crowded out of private or public insurance coverage. Children in need of health care services typically have more insurance options than do adults, particularly public insurance coverage. "Also, because so many low-income children are eligible for either Medicaid or the State Children's Health Insurance Program (SCHIP)," he says, "even when they access safety-net providers, the doctors can usually get them enrolled in the appropriate program."

Background

The safety net consists of a patchwork of providers that is supported by a diverse and often haphazard array of funding mechanisms. Although their funding may be uncertain from year to year, or administration to administration, safety-net providers generally offer a combination of comprehensive medical care and enabling services, such as language translation and transportation, which target the needs of those likely to require safety-net health care.

Federal grants to federally qualified health centers (FQHCs) grew steadily throughout the 1990s, from about $550 million in 1990 to $925 million in 1999.[1] FQHCs have also been on President Bush's health care agenda for the past few years.

"The safety net clearly has a purpose and a place in the American health care system," says Lo Sasso. "But it is not without risks." It is an informal, uncoordinated system of care whose continued existence is not guar-

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anteed, he says, and many argue that it is stretched thin even today. Indeed, between 1990 and 1998, FQHCs witnessed a 60 percent increase in the number of uninsured patients.[2]

Meanwhile, in the 1990s, expansions in Medicaid and the creation of SCHIP allowed many individuals who were covered under private insurance to be eligible for public programs. The premiums for public coverage were more affordable than for private, and, in some cases, the health care delivered may have been better—leading many to speculate that public coverage was crowding out private. Because so many low-income people continue to be uninsured despite the expansions in program eligibility, however, the researchers wanted to identify alternative reasons for why take-up of private insurance is so low for these groups.

"We knew that substitution was occurring within public programs," says Lo Sasso, "but very few studies had really examined whether the safety net may also be playing a crowd-out role."

FQHCs provide a substantial amount of uncompensated care. Overall uncompensated care provided by FQHCs increased from about $450 million in 1990 to nearly $700 million in 2000 (see Figure 1). Hospitals also provide a large amount of uncompensated care annually. Hospital uncompensated care increased from just under $19 billion in 1990 to nearly $21 billion in 2000 (see Figure 2).

Figure 1: FQHC Uncompensated Care, 1990–2000 (Y2000 in Real Dollars)

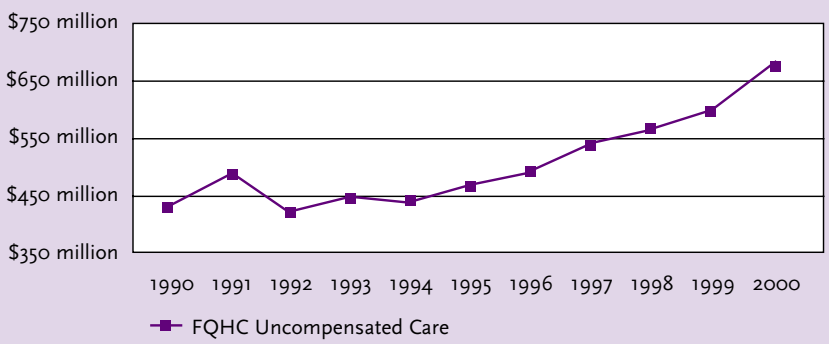
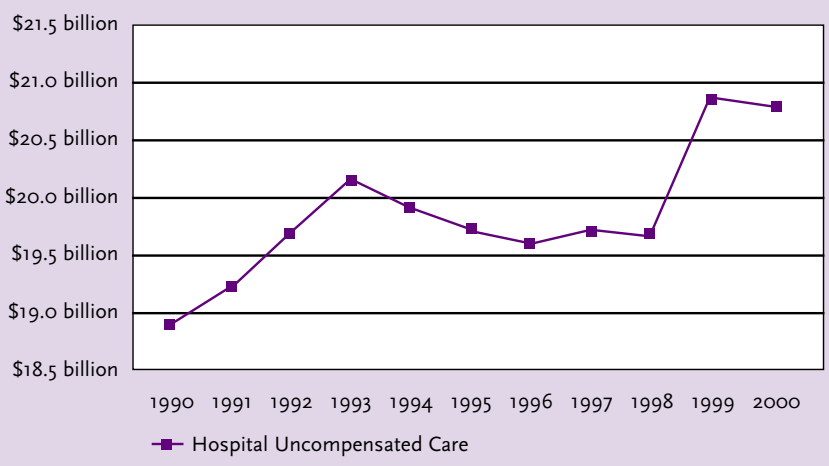


Figure 2: Hospital Uncompensated Care, 1990–2000 (Y2000 in Real Dollars)



Methods and Findings

The researchers sought to answer the following questions:

- How do the structure and characteristics of the health care safety net affect employees' decisions to accept employer-offered health insurance?
- How do these characteristics affect decisions to accept employer-offered insurance for their families, particularly their children?
- How do these characteristics affect employers' decisions to offer health insurance and characteristics of that coverage?

The researchers used data from the March Current Population Survey (CPS) Annual Demographic File to measure health insurance coverage over the years 1990 to 2000. The CPS data were combined with detailed measures on health care facilities to examine the link between safety-net characteristics and private health insurance coverage. The researchers' primary safety-net measures included total hospital uncompensated care derived from the American Hospital Association's annual survey of hospitals and uncompensated care provided by FQHCs.

Their results provide mixed evidence on the extent of crowd out; hospital uncompensated care does not appear to crowd out coverage for children or adults, while health center uncompensated care appears to crowd out private coverage for childless adults. "Less crowd out for hospital uncompensated care may be plausible," says Lo Sasso, "given that most hospital uncompensated care pays for big-ticket items rather than more routine care that individuals may think of when making coverage decisions."

Getting Around Insurance

According to Lo Sasso, low-income people frequently believe that they can avoid the need for health insurance by using free clinics or public hospitals. Employer-provided health insurance is likely to have greater costs than Medicaid or safety-net care, both in terms of premiums and out-of-pocket costs, such as deductibles and co-payments. Therefore, a dependable safety net may result in workers accepting employment without health insurance, or declining coverage offered by their employers because of the cost.

Moreover, for many workers in low-wage jobs, private insurance isn't offered by their employer. When it is offered, premiums and deductibles often make it cost-prohibitive. Buying coverage in the individual insurance market is similarly expensive. Evidence from the Survey of Income and Program Participation suggests that among people who lose health insurance coverage, 60 percent indicated that the reason is that insurance is too expensive.

From the employers' perspective, the presence of a safety net may affect their decision to offer coverage. They may come to rely on the safety net as a substitute to provide care for their low-income workers—which saves them money. Small employers in a particular area may in turn choose not to offer health insurance to workers because of the availability of safety-net health care services.

In ongoing research, Lo Sasso and colleagues will take a closer look at the employer side of the equation through the insurance component of the Medical Expenditure Panel Survey. Are employers backing away from offering insurance in communities where a strong safety net is in place? And how is a "strong" safety net defined? The researchers hope to understand the extent to which the presence of a safety net will affect employers' decisions to offer insurance and what plans they might offer.

Conclusion

For many policymakers, one of the most challenging aspects of safety-net care is striking the right balance between promoting appropriate take up of safety-net services and preventing crowd out of other coverage options. On the one hand, the goal and the role of safety-net institutions

is to provide health care access to low-income Americans who cannot afford coverage through other vehicles. On the other, however, a rich safety net may induce people with access to other types of insurance to forgo it for a seemingly "free" program.

"Our analysis provides a unified framework bringing together privately offered insurance characteristics, Medicaid eligibility, and characteristics of the local safety net to better explain and understand the health insurance decisions of firms and individuals," says Lo Sasso. "We hope policymakers will use the information to craft policies and provide incentives to providers to minimize distortions in the private market while still providing care to those truly in need."

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Endnotes

1 Source: National Association of Community Health Centers, 1999.

2 Source: Bureau of Primary Health Care, 1990, 1998.

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