



Robert Wood Johnson Foundation

Revisiting crowd-out

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SUMMARY OF KEY FINDINGS

- > Some level of crowd-out will always occur with public program expansions. There is a wide range of estimates of crowd-out with lower estimates for low-income children (0 to 15 percent) and higher rates for higher-income children and longer-term enrollees (35 to 50 percent).
- > Anti-crowd-out measures such as waiting periods and increased premiums discourage the uninsured as well as privately insured from enrolling in health care programs.
- > Other approaches to limiting crowd-out include incentives for employers to offer affordable coverage to low-wage populations to help maintain the role of the private sector in providing health insurance coverage.

THE SYNTHESIS PROJECT

NEW INSIGHTS FROM RESEARCH RESULTS

UPDATE

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This document is an update of a previous Synthesis Report available at www.policysynthesis.org

The objective of public-supported health care programs, including the State Children's Health Insurance Program (SCHIP) and Medicaid, is to increase access to affordable quality health insurance for low-income individuals and families while minimizing the displacement of private health insurance coverage (12, 15). Substitution of public for private coverage is often referred to as "crowd-out" in the sense that expanded public programs may "crowd-out" the role of private health insurance coverage for similar individuals and families.

The debate about how to define and measure crowd-out is gaining recent attention with discussions in the Congress about the reauthorization of SCHIP and the extent to which states may expand eligibility beyond low-income children, currently defined as 200 percent of the Federal Poverty Level (FPL) or \$41,300 for a family of four (22).

This brief provides an update to a previous synthesis of the literature on the impact of public program expansions and estimates of substitution. Our initial synthesis and policy brief (see www.policysynthesis.org) were published in 2004 and a thorough discussion of the policy issues and research evidence are available in those reports (6, 23). The key findings of that early report included the following:

- While some crowd-out occurs with almost any public program expansion, there is still disagreement about how much crowd-out occurs at different levels of expansions. Estimates of crowd-out vary greatly depending on the target population studied, the methods and data used, the time frame and the specific public program expansion.
- The potential for crowd-out is greater for families with incomes above 200 percent of the federal poverty level, who are more likely than poorer families to have private health insurance coverage.
- Crowd-out may also be higher if entire families enroll together in a public program than if just one member of the family enrolls.
- Rates of crowd-out are likely to change over time, influenced by changes in the economy, labor market conditions, characteristics of private coverage and attitudes toward public coverage.

Since the earlier report was released, several additional studies have been published and the debate over the incidence of and factors contributing to crowd-out continues. This brief provides an update to that initial synthesis of the literature and highlights more recent findings on crowd-out.

What is crowd-out?

As a concept, public program substitution, or crowd-out, occurs when individuals are enrolled in a public program when they would have had some form of private insurance (employer-sponsored insurance or private non-group insurance) if the public program were not available. There are several ways in which crowd-out can occur:

- Individuals or families that have private health insurance coverage may simply drop their coverage to enroll in an available public program.

- Employers either reduce existing health insurance benefits and/or increase premiums and out-of-pocket costs, which may provide enough incentive for individuals or families to drop coverage and enroll in the public program.
- An employer might decide to not offer any benefits given the existence of public programs that provide the needed coverage for its employees (8).

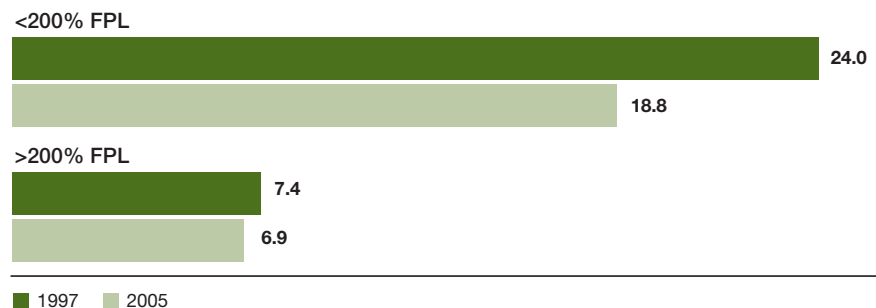
In all cases, the public program has essentially “crowded-out” private health insurance that would have existed without the availability of a public program. The key issue in estimating crowd-out is the extent to which enrollment in SCHIP is directly offset by reductions in private coverage.

Who cares about crowd-out and why?

The goal of SCHIP and other public program expansions is to increase health insurance coverage to those who currently do not have insurance. When crowd-out occurs, scarce resources are used to cover people in public programs who already have or would have had private health insurance coverage. Public programs, in essence, replace private coverage leading to limited impact on rates of uninsurance. This reflects a shift in the distribution from private to public coverage which results in no change in levels of uninsurance. State and national policy-makers are concerned about crowd-out because it limits the impact of public coverage expansions on the low-income uninsured. Others are concerned about the extent to which tax-supported public health insurance covers children and their parents who could otherwise purchase coverage in the private health insurance market.

Since the passage of SCHIP, the share of low-income (<200% FPL) children who are uninsured dropped by 5.2 percentage points, representing 2.3 million newly insured low-income children (Figure 1). Clearly the program is hitting its mark. The question remains: how many newly-enrolled public program participants were truly uninsured, and how many were previously or would have been enrolled in private—primarily employer-sponsored—insurance in the absence of SCHIP.

Figure 1. Percent of U.S. children who are uninsured by poverty level, 1997 and 2005



Source: 1998 and 2006 Current Population Survey Annual Social and Economic Supplement (Age 0–18)

Note 1: The 2006 CPS was re-released in March 2007; this analysis is based on the original release to keep the comparison across time as similar as possible.

Note 2: The addition of an insurance verification question to the CPS in 2000 results in more people reporting that they have health insurance compared to earlier years. In order to make the data comparable over time, data from the 1998 CPS were imputed to simulate the impact of having a verification question. The hotdeck imputation procedure was implemented in Stata/SE 9.

How much crowd-out is there?

Crowd-out exists but continues to be difficult to measure. Consistent with the previous review of the literature, the newer studies that we reviewed show wide variation in the estimates of the crowd-out of private insurance by public coverage programs. Recent estimates of substitution range broadly, with several studies showing virtually no or very limited crowd-out (11, 20) to as much as 60 percent from public program expansions such as SCHIP (9). In general, studies look at the percentage decline of private coverage over a period of time that can be attributed directly to a percentage increase in public program enrollment (e.g., crowd-out estimates express the percent decline in private insurance due to public program displacement). The estimates vary based on the data used, the years examined, whether the focus is on children or adults, the modeling technique and the assumptions made. Even seemingly minor changes in the assumptions can significantly alter the estimates of crowd-out (13). In addition, the high-end estimate noted here used a different method to define crowd-out, making direct comparisons across studies difficult. We highlight a few studies here for reference.

A Congressionally mandated evaluation of SCHIP, conducted by Mathematica Policy Research and the Urban Institute, used case studies and surveys of SCHIP enrollees and disenrollees in ten states. This study provides two estimates of crowd-out; one for recently enrolled SCHIP beneficiaries and one for enrollees enrolled for five months or more. Of those recently enrolled, 28 percent of SCHIP enrollees in the ten states studied had private insurance six months before enrolling in SCHIP. However, half of those with prior private coverage lost their coverage involuntarily—they were no longer eligible due to job change or change in family structure. An additional eight percent dropped coverage citing affordability of private coverage as the reason. The authors estimate crowd-out of seven to 15 percent for the newly enrolled depending on whether affordability is considered as an indicator of crowd-out (24). When affordability is not categorized as substitution, crowd-out estimates were ten percent or less in all ten states. The upper bound estimate of crowd-out for children enrolled in SCHIP for five months or longer was 36 percent.

Sharon Long and her colleagues (2006) using data from the National Survey of American Families (NASF) between 1997 and 2002 found significant variation in estimates of crowd-out both within and across four states. The authors concluded that the lack of uniformity across states makes it difficult to generalize crowd-out estimates from one state to another. The degree of crowd-out depends on state characteristics including the benefits and costs of private health insurance coverage, the level of eligibility for the public program, the length of waiting periods and other unique state policies regarding the private and public health insurance programs (14).

Two additional studies using data from the Current Population Survey found results quite similar to one another. Bansak and Raphael (2006) (1) estimated crowd-out for SCHIP-eligible children between 1998 and 2002 at 25 to 33 percent, and Busch and Duchovny (2005) looking at low-income parents between 1996 and 2002 estimated crowd-out at 24 percent (4).

Using a different data source, the Medical Expenditure Survey (MEPS), Hudson, Selden and Bantnin (2005) looked at children under 18 years of age between 1996 and 2002, and found a significant decrease in uninsurance for children associated with increases in enrollment for both SCHIP and Medicaid. Their estimates of crowd-out were between 42 and 49 percent but the authors suggested that these findings were not conclusive, as some model specifications resulted in no significant crowd-out effects while others showed a significant impact on private coverage (13).

Clearly there is wide variation in estimates and it is difficult to summarize the results using any one estimate of crowd-out even for a given target population such as children or adults. The Congressional Budget Office, in its summary of the research on the substitution effects of SCHIP on children, concluded that between 25 to 50 percent of the reduction in private coverage among children is a result of the increase in public program coverage (5).

What is the impact of anti-crowd-out measures?

There is evidence that anti-crowd-out measures work but involve trade-offs. States have used two main strategies to limit crowd-out in SCHIP: (1) establishing waiting periods between when a person has had private insurance and when s/he is eligible for public programs; and (2) introducing cost-sharing—primarily in the form of premiums—to reduce the difference between public and private cost-sharing requirements. In 2006, 35 states had implemented waiting periods. Of these the most common was six months (16 states) followed by three months (11 states) and four or less months (7 states). Only one state had a waiting period of 12 months and 16 states had no waiting periods (5).

Studies concur that waiting periods consistently reduce take-up rates of public coverage, with potentially greater impact on the uninsured than on privately covered children. Bansak and Raphael (2006) estimated that anti-crowd-out efforts explain roughly one-quarter of the cross-state variation in take-up rates for SCHIP eligible children(1). Research indicates that waiting periods and other anti-crowd-out provisions may lower take-up by the uninsured faster than they lower crowd-out of private insurance (they are not associated with increased private enrollment) (1, 9). New administrative policies to require year-long waiting periods for SCHIP should consider the impact of lower take-up rates for both currently insured individuals and the low-income uninsured. That is, they may limit the ability of SCHIP to effectively enroll low-income populations.

Introducing or increasing public insurance premiums for near-poor children will discourage crowd-out of private insurance, but will also lower coverage rates (9, 10). Research indicates that raising public premiums reduces enrollment in public programs, with some children who forgo public coverage having private coverage and others being uninsured. Those in the lowest income groups are the most sensitive to public premiums, are least likely to have access to private coverage and, therefore, are at greatest risk of remaining uninsured (17).

Family and higher income coverage increases the potential for crowd-out. As eligibility levels for public programs are expanded to cover higher incomes, the possibility of substitution increases. At 300 percent of FPL crowd-out may be as high as 50 percent (15). Expanding eligibility to higher income levels may have the effect of increasing participation in public programs when private coverage is available.

There is evidence that crowd-out is also associated with family eligibility. In their working paper Gruber and Simon (2007) found that the estimated crowd-out ranges from 61 to 68 percent when an entire family is eligible for public programs; about twice that estimated for individuals (9). This is due to the fact that parents may be more likely to enroll their children in public programs if they themselves or the child's siblings are also eligible (11). Again, the high-end estimate noted here used a different method to define crowd-out, making direct comparisons across studies difficult.

What about the role of employers and employer-sponsored insurance?

There is substantial evidence of the decline in employer-sponsored insurance (ESI) for adults as well as for their dependents. Data from the Current Population Survey show a decline in the percent of the population covered by ESI from 63.9 to 59.7 percent between 1999 and 2006 (21).

Until the past few years, children's health insurance coverage has remained relatively stable while uninsurance for adults continued to increase. The maintenance of coverage for children was largely a result of SCHIP and Medicaid serving as a safety net. A new release of health insurance coverage estimates from the Census Bureau, however, shows a significant increase in the number of children without health insurance from eight million in 2005 to 8.7 million in 2006, representing 11.7 percent of all children. For children living in households with incomes below the poverty line, 19.3 percent were uninsured in 2006 (7). The reasons for this trend are not clear. It may be that SCHIP programs have enrolled the easy-to-reach populations or that states have limited enrollment given the capped funding for SCHIP grants.

It is important to note that crowd-out can occur based on employers' as well as employees' behaviors. The estimated drop in employer-based coverage may result from employer decisions to change their health benefit packages, dropping benefits or making them more expensive or less attractive, or from employee decisions to opt out of private coverage for new public programs (3, 18).

There is evidence that some employers do pay attention to policy decisions around public insurance but that the impact on their health benefit decisions is relatively small (18). One study suggests that employers are as likely to offer coverage as before the public program expansion, including offering dependent coverage, but have raised employee contributions for family coverage. Take-up of any coverage generally, and family coverage specifically, has, however, dropped in these establishments (3).

It appears that declines in offers by employers play a smaller role in the reduction of ESI than decreases in employee take-up (and by implication, substitution of ESI for lower cost public coverage) (3, 18). Sustained increases in private insurance premiums will continue to create enrollment pressures on state insurance programs for children.

How does public program enrollment affect access to care?

There is limited evidence to suggest that some children with public program coverage—as opposed to private coverage—may be better off. Lower out-of-pocket costs are often available through public coverage and may improve access to care and the standard of living for low-income families (1).

Kenney (2007) found that children enrolled in SCHIP had improved access to care including reported reductions in unmet health care needs, increased use of preventive care and increased likelihood of having a regular source of care (16). Blewett et al. (2004) found that young children (up to 36 months) enrolled in either Medicaid or SCHIP for a full year were significantly more likely to be up-to-date in two series of recommended vaccines compared with children with private full-year coverage (2).

Conclusions

There will always be some level of crowd-out with any public program expansion and measuring it with precision will always be difficult. A general midpoint of the studies reviewed indicated an overall substitution effect of 25 to 50 percent with lower rates of substitution for low-income children (0 to 15 percent) and higher rates for higher-income children and longer-term enrollees (35 to 50 percent).

There is greater potential for crowd-out for public programs with higher income eligibility, as well as sibling and family eligibility. Yet the trade off is that children are more likely to be insured and use health services appropriately if the whole family is covered than if parents lack coverage.

Adding anti-crowd-out measures such as longer waiting periods or increased premiums discourage the uninsured as well as the privately insured from enrolling in existing programs. There are currently 8.7 million uninsured children (7), 69 percent of whom are currently eligible for public programs (15). In addition, 91 percent of children covered by SCHIP live in families with incomes at or below 200 percent (19).

Employers also play a role in decisions regarding private health coverage. There is clear evidence of erosion in employer-sponsored health insurance coverage and a significant increase in adult rates of uninsurance and more recently uninsurance rates for children. Policy-makers are eager for solutions, but anti-crowd-out measures do not appear to be an effective way to increase private coverage. Instead, policy-makers may want to focus on cost containment and public-private partnerships to maintain private coverage and make it more affordable to employers and employees (10).

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