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Participation and crowd out: Assessing the effects of parental Medicaid expansions

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ABSTRACT

In this paper, we examine the effects of recent parental Medicaid eligibility expansions on Medicaid participation and private insurance coverage. We present a new approach for estimating these policy effects that explicitly models the particular policy instrument over which legislators have control–income eligibility thresholds. Our approach circumvents estimation problems stemming from misclassification or measurement error. Moreover, it allows us to assess how the policy effects may vary at different initial threshold levels. Using data from the Survey of Income and Program Participation, we find three main results. First, the eligibility expansions result in significant increases in Medicaid participation; a "typical" expansion increases Medicaid participation by about four percent of baseline coverage rates. Second, the participation effect is larger for lower initial thresholds and the effect decreases as Medicaid thresholds increase. Third, we find no statistically significant evidence of crowd out regardless of initial threshold level.

1. Introduction

While the cash assistance available through the social safety net has been substantially cut since the mid-1990s, the in-kind benefit of public health insurance has seen extensive eligibility expansions over the same period. After some earlier expansions applying primarily to children (starting in the 1980s), the late 1990s saw two major shifts in public health insurance policy. One well-studied shift was the introduction of the State Children's Health Insurance Program (SCHIP), which provided new funding and incentives for states to expand children's eligibility higher into the income distribution. By 1999, almost 95 percent of children in families under 200 percent of the Federal Poverty Guidelines (FPG) were eligible for public health insurance (Broaddus and Ku, 2000). The second, less-studied phenomenon was the gradual expansion of parental Medicaid eligibility, beginning with the delinking of Medicaid from cash assistance in 1996 via the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA).

Expansions in parental eligibility for Medicaid have been primarily a matter of state-driven efforts. While the federal government has mandated minimum eligibility thresholds for children's and pregnant women's coverage over the years, parental eligibility remains a matter of state prerogative, with the caveat that prior to 1996 the state needed to use the same standards for both Medicaid and cash welfare. Since 1996, these parental eligibility thresholds can be set separately from the cash welfare rules; the only requirement is that states may not reduce thresholds from 1996 levels. Thus states have been allowed to maintain their 1996 standards indefinitely or to expand eligibility, and states have made both small and large changes over the last 15 years (e.g., Hamersma, 2012). Some of these expansions have been in the Medicaid program directly (called section 1931) while other states have utilized waivers (section 1115) or have developed state-funded supplemental programs. Our focus in this work will be on any expansions in no-premium public insurance coverage, which includes all Medicaid 1931 expansions as well as some waiver-based or state-funded programs.[1]

Understanding the effects of parental Medicaid expansions is essential for future policy making. First, because of the reach of SCHIP, there is increasingly less room to expand children's

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[1] There is evidence that public insurance programs suffer a significant drop in participation when a premium is required (see Hudman and O'Malley, 2003).

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coverage as a means of improving overall public health.[2] Second, it has been recognized that having healthy parents are more likely to have stable employment, which improves family and child welfare (Rosenbaum and Whittington, 2007). A consistent concern, however, with the expansion of Medicaid eligibility is that it may draw people away from private coverage, thus failing to improve overall rates of health insurance coverage. This phenomenon has been termed "crowd out."

In this paper, we examine the effects of parental Medicaid eligibility expansions on Medicaid participation and private insurance coverage. Relative to the existing literature on both child and adult coverage, we present a new method of estimating policy effects that explicitly models the particular policy instrument over which legislators have control–income eligibility thresholds. Instead of estimating the effect of a marginal individual becoming eligible (which must be multiplied by the approximate number of new individuals made eligible by policy) or the effect of a state simply changing its Medicaid threshold (i.e., using an indicator for a Medicaid expansion), this paper models participation using the eligibility threshold itself. Our results provide estimated effects of raising the Medicaid threshold on participation in Medicaid, private coverage, or any coverage. These results allow us to assess the expected level of crowd out that would be generated by a given change in the Medicaid threshold. We expand on these estimates by allowing the marginal effect of the threshold to vary with its initial level, followed by a series of robustness checks.

In all of our analysis, we find two consistent results. First, Medicaid expansions result in meaningful increases in Medicaid participation in the population. This is in contrast to some of the findings in the literature on children's Medicaid expansions, in which marginal take-up rates for the newly eligible were low (e.g., Card and Shore-Sheppard, 2004). We find that a "typical" Medicaid eligibility expansion increases Medicaid participation by about four percent of baseline coverage rates. When marginal effects are allowed to vary across initial threshold levels, expansions are found to have larger effects when the initial Medicaid threshold is low. Second, we find no statistically significant evidence of crowd out. The changes in insurance rates largely mirror the changes in Medicaid participation, with no significant change in private coverage rates. This is an important result given concerns about crowd out in the children's health insurance programs, estimated to be as high as 60 percent (Gruber and Simon, 2008).

The paper proceeds as follows. In the next section, we describe the relevant background literature. In Section 3, we describe our data sources. In Section 4, we review previous methods and present our preferred method of assessing the impact of the Medicaid expansions. In Section 5, we report out main results, followed by robustness checks and falsification tests in Section 6. Section 7 offers conclusions and health policy implications.

2. Literature review

Our analysis of the effects of parental Medicaid expansions on adult coverage draws from and integrates two streams of literature on participation responses to Medicaid expansions. The first stream examines Medicaid expansions during the late 1980s and early 1990s, which primarily affected children's eligibility. These early expansions have been well-researched, with the seminal paper indicating substantial and statistically significant crowd out of private coverage (Cutler and Gruber, 1996) and a number of subsequent papers indicating small or statistically insignificant crowd out (Card and Shore-Sheppard, 2004; Dubay and Kenney, 1996; Ham and Shore-Sheppard, 2005; Shore-Sheppard, 2008; Yazici and Kaestner, 2000).[3] While the focus of these papers is the effect of children's Medicaid eligibility on children's coverage, we draw on some key methodological contributions of the literature.

Cutler and Gruber (1996) use annual data from 1988 to 1993 Current Population Survey (CPS) to examine the impact of Medicaid eligibility on different types of health insurance coverage (Medicaid, private, or uninsured). Cutler and Gruber point out that Medicaid eligibility is potentially endogenous to private insurance coverage because eligibility depends upon wages, which are likely correlated with other (non-insurance) benefits that are unobserved and therefore in the error term. To address this endogeneity, they construct an instrument that uses exogenous variation in Medicaid expansions by year, state, and age. Using two-stage least squares, they estimate a significant positive relationship between Medicaid eligibility and Medicaid participation, but a significant negative relationship between children's eligibility and children's private insurance coverage; their results imply that as much as 50 percent of the increase in Medicaid participation could be the result of crowd out from private coverage.

However, as Cutler and Gruber (1996) point out, one potential weakness of using the CPS (or, more generally, annual data) to study the effects of Medicaid expansions is that Medicaid eligibility is, in reality, determined on a monthly, not annual, basis. Therefore, annual data cannot account for mid-year changes in eligibility status arising from either mid-year changes in family circumstances or mid-year changes in eligibility criteria. To address this concern, Ham and Shore-Sheppard (2005) re-examine Cutler and Gruber (1996) using monthly data from the Survey of Income and Program Participation (SIPP). Using the same specification as Cutler and Gruber, they find little evidence of crowd-out resulting from the early Medicaid expansions. They provide evidence that attributes this difference in results in part to the difference in annual versus monthly recall period.

Card and Shore-Sheppard (2004) use a regression-discontinuity design to assess the participation effects of the same children's eligibility expansions. They find that an expansion from 100 percent to 133 percent of FPG had little effect on Medicaid participation for children (so that the lack of crowd out appears to be rooted in a general absence of policy response). While this child expansion occurred over 20 years ago, even by 2007 only 10 states had parental thresholds above 100 percent FPG. This brings up an important concern regarding possible heterogeneity in policy responses related to the initial threshold level, which we address in this work.

The second stream of literature influencing our work involves assessments of the recent parental Medicaid expansions, starting in the mid-1990s when welfare reform officially delinked Medicaid from cash welfare. The most relevant literature for our purposes focuses on the effects of parental expansions on parental coverage.[4]

[2] For instance, when President George W. Bush faced SCHIP reauthorization in 2007, he was reticent to allow states to expand eligibility above 250 percent of FPG if they had not already covered at least 95 percent of the currently eligible children, and wanted to require states to demonstrate that crowd out was not a problem (see further details at http://www.kff.org/medicaid/upload/7675.pdf).

[3] Shore-Sheppard (2008) provides a particularly helpful discussion and analysis of the reasons for sensitivity of the Cutler and Gruber (1996) results. Note that there are also more recent studies on crowd out for children related to the State Children's Health Insurance Program (SCHIP) which began in 1997 (e.g., Bansak and Raphael, 2006; Gruber and Simon, 2008; LoSasso and Buchmueller, 2004); however, the methodological contributions we draw upon are from the earlier literature.

[4] There is a distinct literature examining the cross-effects of parental Medicaid expansions on *children's* coverage (e.g., Dubay and Kenney, 2003; Ku and Broaddus, 2000; Lambrew, 2001).