Crowd-Out in the Healthy Families Program:

Does it Exist?

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Executive Summary

Researchers from the University of California, San Francisco undertook a study of children's coverage prior to enrollment in Healthy Families. Children with employer-related insurance within 3 months prior to enrolling in the program are ineligible, as a means to discourage employers and families from supplanting private insurance with public insurance. This research was designed to determine the extent to which this phenomenon, called "crowd-out," exists within the Healthy Families program.

Telephone interviews were conducted between April 10 - April 24, 2002 of 57 Spanish-speaking and 468 English-speaking parents and guardians of children newly enrolled in the Healthy Families program. The major findings of this study are:

- Some crowd-out is occurring, but at very low levels (8%);
- When crowd-out does occur, it tends to happen among lower income families and is largely because parents can no longer afford the employment-related coverage for their children. In fact, nearly half (45%) of the families reported that they had been paying more than $50 per month for their child's employment-related coverage;
- Based on this survey, it does not appear that employers are encouraging children to drop coverage and enroll in the Healthy Families Program. None of the respondents indicated that this occurred; and
- The coverage status of parents indicates that children were dropped from employment-related coverage, but parents tend to retain their own employment-related coverage.

RECOMMENDATIONS

These findings suggest that public policy in California should not focus on crowd-out as a phenomenon that affects eligibility for public programs, but rather should identify ways to ensure that children have coverage, whether through employment-related approaches or public programs. Among the policy options is providing assistance to low-income families in their ability to purchase and maintain employment-related insurance. The state could also explore once more the feasibility of implementing the provision in the law establishing the Healthy Families Program, which permits employers to provide premium support for their employees' dependents. Another (though not mutually exclusive) option is the imposition of a financial test with respect to determining if crowd-out occurs. That is, eligibility for publicly subsidized programs should take into account not only whether or not a child recently had previous coverage, but also if that coverage was affordable to the family. Some states have already instituted such policies. For example, Georgia allows "substitution" (or, in other words, does not consider it crowd-out) if previous insurance coverage cost the family more than 5% of the family income.

INTRODUCTION

In response to the lack of health coverage in the United States, Congress enacted the Balanced Budget Act of 1997, which amended the Social Security Act to include Title XXI, the State Children's Health Insurance Program (SCHIP). The goal of SCHIP is to increase access to health care for children whose family incomes are too high to qualify for Medicaid and too low to afford private coverage. The program provides approximately $40 billion in matching funds to states over ten years; California's total SCHIP allotment for the Healthy Families Program amounts to $4.5 billion.

There is concern among some policymakers and program planners that the creation and expansion of publicly subsidized programs may supplant and "crowd-out" private, employment-related insurance, rather than cover uninsured individuals. Concern about crowd-out originally emerged in the early and mid-1990s when policymakers and researchers examining trends in health insurance coverage noted that as Medicaid enrollment rose during the 1980's and 1990's the number and percentage of children covered under private insurance plans declined. This led to speculation that the Medicaid expansions for children may not have extended coverage to previously uninsured children, but rather covered children who already had private insurance.

To date, some research has been conducted on the presence of crowd-out, but the results have been mixed. In a study using data from the Current Population Survey (CPS), Cutler and Gruber found that nearly half of the increase in Medicaid enrollment was offset by a decrease in private insurance coverage.[i] On the other hand, other studies using the same data report significantly less crowd-out. Dubay and Kenney found a crowd-out effect of 12% for children under 11 years of age, and 14% for pregnant women.[ii] Determining the presence and extent of crowd-out is an important policy matter because it has been used extensively in arguments against the expansion of publicly funded health insurance programs. For example, at the national level, crowd-out was a major argument against the establishment of SCHIP, which led to the creation of Healthy Families in California.[iii]

Researchers from the University of California, San Francisco undertook a study of families' coverage prior to their child's enrollment in Healthy Families. In California, children with employment-related insurance within 3 months of applying for Healthy Families coverage are not eligible. This study was conducted to determine the extent to which crowd-out exists within Healthy Families as well as help to demonstrate California's commitment to rigorous monitoring of the issue.

METHODOLOGY

Sample Selection

The Managed Risk Medical Insurance Board (MRMIB), the agency that administers Healthy Families, provided the contact data based on a random sample of 3,000 recent enrollees (i.e., children who enrolled within 60 days of the date the sample was drawn). MRMIB provided names and contact information for 1,500 enrollees above 200 percent of the poverty level, and 1,500 enrollees below the

poverty level. (This reflects an over-sampling of the higher income group to ensure that they were adequately represented in the final sample.) Only English and Spanish speakers were interviewed. The sample was reduced by excluding those whose Healthy Families coverage began more than two months before the data pull, enrollees who did not have phone numbers, duplicates from households (based on a sort of parents' names and addresses) and individuals who indicated that they did not want to be called (by returning a self-addressed, stamped post card sent to each potential subject for this purpose). The final sample-frame included 1,958 enrollees at or above 200 percent of poverty and 1,042 enrollees below 200 percent of poverty.

Data Collection

Parents and guardians of enrolled children were contacted initially by mail to inform them about the study and to request their participation. The mailing, written in both English and Spanish, included a letter of introduction, a study information sheet, and a self-addressed, stamped postcard that individuals could return if they did not want to participate in the study. In addition, a $10 incentive was promised to those respondents who completed the telephone interview and was subsequently mailed to the respondents).

The researchers developed a telephone survey instrument to assess the extent and nature of crowd-out among newly enrolled participants in California's Healthy Families Program. The instrument was based on validated surveys designed to elicit similar information, and on the feedback from program administrators to ensure inclusion of pertinent policy and program questions. Corey, Canapary, and Galanis Research (CC&G), a San Francisco survey research firm, phoned parents and guardians to request their consent to participate in the study and conduct the interview. English-speaking interviewers made all initial calls on the randomly drawn sample. Interviews were conducted with qualified respondents if possible. This includes respondents who spoke English well enough to do the interview. If a Spanish-speaking respondent was unable to do the interview in English, he/she was called back by a bilingual (Spanish/English) interviewer. CC&G conducted the telephone survey using a computer assisted telephone interview (CATI) format. Telephone calls were made 3 weeks after the letters were mailed to potential participants. The sample of individuals randomly selected to be called was 783. In total, 525 interviews were completed. This represents an overall completion rate of 67% (525 divided by 783). The (See Tables 5 and 6 in the appendix.)

RESULTS

Characteristics of Enrollees

Of the total 525 interviews with families who participated in the survey, 468 were in English and 57 interviews were conducted in Spanish. As Table 1 illustrates, the majority of the children in the sample are Hispanic (63 percent), while whites comprise the next largest group at 25 percent. Asians

and African Americans each make up four percent of the total sample, and the remaining three percent belong to other ethnic groups. This distribution is somewhat different than that of current Healthy Families enrollees. (Sixty-seven percent of current enrollees are Latino, 16% are White, 13% are Asian, 3% are African American and less than 1% are of other ethnicities.) Sixty-four percent of interviewed families have one working adult in the household and a mean household income of $32,100. The average family size is four.

Table 1: Profile of Survey Participants

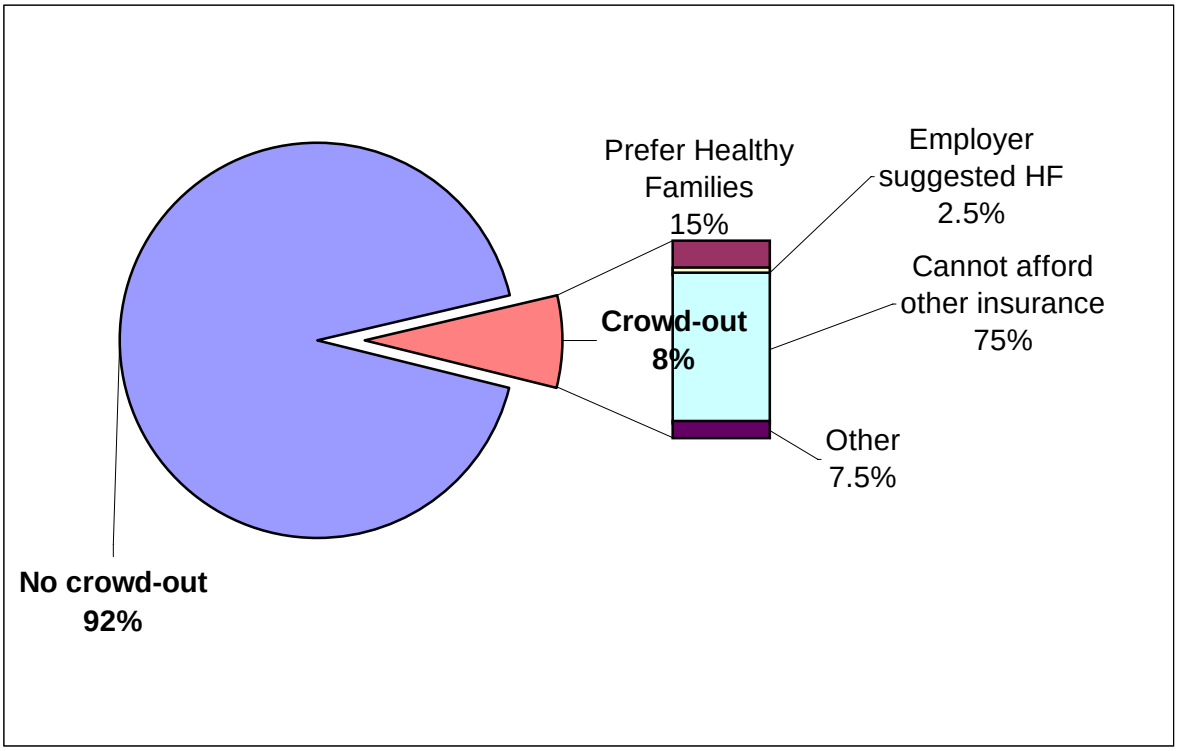
Demographic Characteristics	All Respondents		English-Speaking Respondents		Spanish-Speaking Respondents	
	Number	Percent (n=525)	Number	Percent (n=525)	Number	Percent (n=525)
Total	525	100%	468	89%	57	11%
Race/Ethnicity						
Hispanic/Latino	332	63.2%	275	52%	57	11%
White	132	25.1%	132	25%	0	0%
Asian	22	4.2%	22	5%	0	0%
African American	22	4.2%	22	5%	0	0%
Other	17	3.2%	17	4%	0	0%
Family Income						
100-199% FPL	363	69%	320	61%	43	8%
200-250% FPL	162	31%	148	28%	14	3%
Household Type						
Single parent	125	24%	121	23%	4	1%
Dual parent	400	76%	347	66%	53	10%
Full- or Part-Time Employed Adults in Household						
None	29	6%	27	5%	2	0.4%
1	334	64%	301	57%	33	6%
2	162	30%	140	27%	22	4%
Family Size						
2	47	9%	45	9%	2	0.4%
3	138	26%	126	24%	12	2%
4	174	33%	157	30%	17	3%
5	108	21%	90	17%	18	3%
6 or more	58	11%	50	10%	8	2%

The Presence of Crowd-Out in Healthy Families

We estimate crowd-out in the Healthy Families Program to be 8%. (Figure 1) That is, only 8% of the sample had previous insurance within the three months prior to enrolling in Healthy Families and dropped that insurance for reasons that constitute crowd-out. These reasons include families who had access to employment-related coverage but dropped it because the employment coverage was unaffordable (n=30), who preferred Healthy Families (n=6), whose employer suggested enrollment in Healthy Families (n=1), and who dropped it for other reasons (n=3). (The percentage of children

exhibiting crowd-out may actually be might be lower if the "other" category of reasons for dropping previous health insurance is excluded from the numerator. However, because we cannot know with certainty whether or not these reasons fall within the definition of crowd-out, we included them.) (See the appendix for demographic characteristics of the crowd-out group compared to the non-crowd-out group.)

Figure 1: Estimate of Crowd-Out in California's Healthy Families Program



Crowd-out represents a small portion of enrollment. When crowd-out occurs, it is because the family can no longer afford employer coverage.

Crowd-Out by Family Income

When considering family income, lower income children were more likely than higher income children to have had prior insurance that constitutes crowd-out. Specifically, 68% of all children exhibiting crowd-out had incomes between 100% and 199% of the federal poverty level. (Table 2) At first blush, this finding appears counterintuitive since children in higher incomes are more likely to have employment-related insurance. However, the most frequently cited reason for ending their employment-related insurance was that the family could not afford it (75%). Moreover, lower income parents were most likely to report not being able to afford the insurance (45% for lower income families versus 30% of higher income families.) This is corroborated by responses to a follow-up question of families who indicated they preferred Healthy Families. When asked why they preferred Healthy

Families, five of the six crowd-out families said they preferred it because the program is "less expensive." (Not shown.)

Table 2: Crowd-Out Related Reasons for Ending Employment-Related Insurance Coverage, 0-3 Months Prior to Enrollment in Healthy Families

Reasons for ending employment-related insurance coverage	Total		100% to 199% of FPL		200% to 250% of FPL	
	Number	Percent (n=40)	Number	Percent (n=40)	Number	Percent (n=40)
Prefer Healthy Families	6	15%	5	13%	1	2%
Employer suggested enrollment of child in Healthy Families	1	2%	1	2%	0	0%
Cannot afford other insurance	30	75%	18	45%	12	30%
Other	3	8%	3	8%	0	0%
Total	40	100%	27	68%	13	32%

Cost of Employment-related Coverage: Crowd-Out versus Non-Crowd-Out Groups

The cost of previous coverage among children exhibiting crowd-out varied greatly and ranged from less than $10 per month to more than $75. (Table 3) More than a quarter (27%) of the crowd-out group reported that they paid more than $75 per month for their child's coverage. Only 13% of the crowd-out group indicated that they paid $10 or less per month for previous coverage. These high costs among the crowd-out group likely explain that they dropped previous coverage because they couldn't afford it.

Table 3: Cost of Previous Coverage

Cost of Previous Coverage	Crowd-Out Group	
	Number	Percent (n=40)
$10 or less per month	5	13%
$11-$25 per month	1	3%
$26-$50 per month	7	17%
$51-$75 per month	7	18%
More than $75 per month	11	27%
Other	8	18%
Don't Know	1	3%
Total	40	100%

Parent's Insurance Status: Respondents (typically parents or guardians of enrolled children) were asked about their own insurance status. (Table 4) Of the 27 crowd-out parents with current insurance, 25 had private insurance through an employer or union. This suggests that parents of the crowd-out group of children may have dropped only dependent coverage and retained their own coverage.

Table 4: Respondent/Parents' Insurance Status

Respondent/Parents' Insurance Status	Crowd-Out	
	Number	Percent (N=40)
Currently insured	27	68%
Currently uninsured	12	30%
Don't know	1	2%
Total	40	100%

DISCUSSION AND RECOMMENDATIONS

This study was undertaken to determine the extent to which crowd-out, the substituting of employment-based health insurance with public health insurance – exists within the Healthy Families program. Based on survey responses of parents of newly enrolled children, we learned that there is some extent of crowd-out in the program: 8% of newly enrolled children had employment-related insurance within the previous three months that is not considered legitimate. (This figure might be actually lower if the "other" category of reasons for dropping previous health insurance is excluded from the numerator. However, because we cannot know with certainty whether or not these reasons fall within the definition of crowd-out, we included them to ensure the most conservative interpretation.) Other states have found varying degrees of employment-related insurance prior to enrollment in public programs. Eleven percent of children in Florida's Healthy Kids program[iv] and 3.5% of respondents to a 1995 survey of the MinnesotaCare program indicated that they gave up employment-related insurance to enroll in the state program.[v] (Note that these analyses of the experiences in other states are not directly analogous to this analysis due to different definitions and different timeframes under study. In addition, the Minnesota program measured previous coverage among both adults and children.)

Although the findings from this study are within the range of Florida's experiences (and higher than that of Minnesota), several distinctions between the periods when the studies were conducted and the circumstances of the states are important to note. First, this study was conducted at a time when the California economy was on a steep decline with no concomitant reduction either in the high cost of living in the state for families or tough financial conditions for businesses. At the same time, the cost of

health care has increased, leading to higher premiums for families as well as reductions in dependent coverage provided by employers. In addition, this study's time frame covered the period in which most employees were given the opportunity to change their employment-related insurance plans through the end-of-year open enrollment period (a period when increases in employee contributions are introduced). Together, these factors may have contributed to employers dropping health insurance coverage and/or families electing to drop coverage, circumstances that were not present during the periods when the other studies were conducted.

More important, this study demonstrates that the unaffordability of previous health insurance was the single most important reason for crowd-out in the Healthy Families Program. Seventy five percent of the parents whose children had health insurance in the three months prior to enrollment in Healthy Families for reasons that constitute crowd-out reported that they dropped that prior coverage because it was unaffordable. This finding is further supported by the predominance of crowd-out among lower income families and the far higher costs of previous coverage among the crowd-out group. Of all parents whose children exhibited crowd-out, 68% were in this lower income group and 45% of these reported that they dropped previous coverage because they could not afford it. Further, nearly half (45%) of the crowd-out group paid more than $50 per month for their children's coverage under the previous coverage.

These findings throw into question whether crowd-out really exists in California, even at low levels such as 8%. To the extent that the vast majority of these low income families dropped relatively expensive employment-related insurance and enrolled their children in Healthy Families for financial reasons, it is arguable that this is not crowd-out but a sound financial decision, affording families a degree of discretionary income to address other family needs. This suggests that public policy in California should not focus on crowd-out as a phenomenon that influences eligibility rules for public programs, but rather should identify ways to ensure that children have coverage, whether through employment-related approaches or public programs.

We recommend three policy options for the State of California (which are not mutually exclusive):

- Assist low-income families financially in purchasing and maintaining employment-related insurance;
- Explore the feasibility of implementing the voucher provision in the law establishing the Healthy Families Program that permits employers to obtain subsidized premium support for their employees' dependents; and
- Impose a financial test when determining if crowd-out occurs.

With this third option, eligibility for publicly subsidized programs would take into account not only whether or not a child recently had previous coverage, but also if that coverage was affordable to the family. Some states have already instituted such policies. For example, Georgia allows “substitution” (in other words, does not consider it crowd-out) if previous insurance coverage cost the family more than 5% of the family income. In this study, the proportion of annual premiums of prior employment-related insurance to annual incomes of parents suggests that no fewer than (and likely more than) 10 percent of the children in the crowd-out group would be permitted to substitute coverage if Georgia’s criterion were applied to California. (Note that in this calculation, respondents’ premium costs were calculated at the *lowest* amount in a range when respondents were unable to offer a specific cost per month. California would also need to take into account such factors as family size, number of children, and allowable deductions in this calculation, which would presumably decrease the number of children in the crowd-out group.)

California should consider these policy options given the apparent burden of high health care costs on low-income families – to the extent that it exists at all. Parents need options for health insurance coverage for their children and Healthy Families appears to be a reasonable option for low-income families. This is true even for the few families that previously had employment-related but expensive coverage and other financial demands on their relatively low income.

Appendix

Table 5: Crowd-Out Survey Fieldwork Information and Sample Disposition

Field interviewing for the 2002 Crowd-Out Survey was conducted by telephone from April 10 - April 24, 2002. All fieldwork was done at the offices of Corey, Canapary & Galanis Research (CC&G) in San Francisco. Interviewing was conducted in English and Spanish. In total, 525 interviews were completed with Healthy Family program enrollees. The sample of individuals randomly selected to be called was 783. This represents an overall completion rate of 67% (525 divided by 783). The table, which follows, details the disposition of the sample.

Sample Available

	Number
Total sample (names/numbers) provided by UCSF	3,000
Respondents who sent back postcards indicating they not be called for the project	-115
Total sample (names/numbers) available	2,885
Sample (names/numbers) attempted by CC&G	783

Table 6: Disposition of Sample by Language

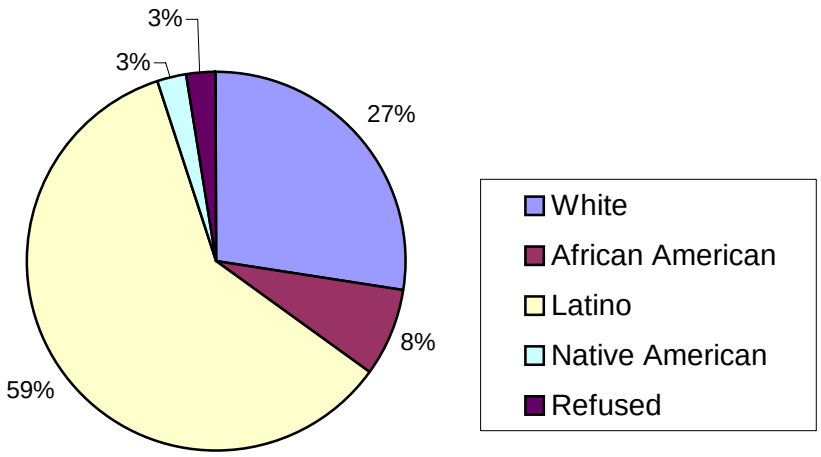
	English	Spanish	Total
Completes	*468*	*57*	*525*
DISQUALIFIED			
Child not enrolled in Health Families	5	1	6
Child not enrolled in Healthy Families during study timeframe	2	1	3
No Eligible Respondent	21	5	26
Language Barrier	7	-	7
Fax Number	2	-	2
Answering Machine/No Answer/Busy	69	22	91
Not At Home/Call Back	15	11	26
Disconnected/Wrong Number	63	-	63
QUALIFIED			
Respondent terminated call	1	0	1
Respondent refused to participate	29	4	33
	682	101	783

**In most cases, these respondents were called at least 4 times.*

Characteristics of Families: Crowd-Out versus Non-Crowd-Out Groups

Race and Ethnicity: The vast majority of children in the crowd-out group identified as Latino (59%). (Figure 2) Another 27% were White, 8% African American and 3% Native American. This distribution is essentially equivalent to that of the group for which there was no evidence of crowd-out. (Not shown.)

Figure 2: Race and Ethnicity of Children in the Crowd-Out Group (n = 40)



Family Income: The distribution of income as a percentage of the Federal Poverty Level was largely equivalent between the two groups. (Table 7) Approximately two-thirds of each group had incomes between 100% and 199% of the poverty level and one-third had incomes between 200% and 250% of the poverty level.

Table 7: Income as a Percentage of the Federal Poverty Level

Income Level	Crowd-Out		Non-Crowd-Out	
	Number	Percent (n=40)	Number	Percent (n=485)
100% to 199% of FPL	26	65%	335	69%
200% to 250% of FPL	14	35%	148	31%
Missing data	-	-	2	0%
Total	40	100%	485	100%

Parents' Employment Status: Generally equivalent proportions of parents had at least one parent who worked full time, though the crowd-out group was slightly more likely to have at least one parent employed full time. (Table 9)

Table 8: Parents' Employment Status

Employment Status	Crowd-Out		Non-Crowd-Out	
	Number	Percent (n=40)	Number	Percent (n=485)
At least one parent employed full time	34	85%	398	82%
1 parent employed part time	1	2%	35	7%
2 parents employed part time	0	0%	30	7%
No parent employed	5	13%	22	4%
Total	40	100%	485	100%

[i] Cutler D, and Gruber J. The Effect of Medicaid Expansions on Public Insurance, Private Insurance, and Redistribution. *American Economic Review.* Volume 86, No. 2. 1996.
[ii] Dubay L, and Kenney G. Revisiting the Issues: The Effects of Medicaid Expansions on Insurance Coverage of Children. *The Future of Children.* Volume 6, No. 1. 1996.
[iii] Hearne. Coordinating Children's Coverage Expansions with Employer-Sponsored Coverage. Washington, DC: Institute for Health Policy Solutions.
[iv] Institute for Child Health Policy. Florida KidCare Program Evaluation Report. University of Florida. January 2000.
[v] Call KT, Lurie N, Jonk Y, Feldman R, Finch MD. Who is still uninsured in Minnesota? *JAMA.* 1997;278:1191-1195.