Addressing Crowd Out

Summary/Definition
In health policy, “crowd out” or “substitution” occurs when public funds substitute private dollars that otherwise would have been spent on health care. It is an inevitable consequence of any effort to subsidize coverage for people in America’s voluntary health care system where individuals and their employers can drop private coverage when better, more affordable public options are available. For example, “crowd out” occurs when the availability of a public subsidy causes:

- Employers to stop offering health coverage to their employees; drop the option for dependent coverage; increase the cost to employees of enrolling in dependent coverage; or be deterred from pursuing efforts to offer coverage in the future.

- Individuals to drop out of employer-based coverage; drop dependent coverage; or decide not to switch jobs to one that offers health benefits.

It is important to highlight that crowd out is not an issue linked only with expansions in publicly-subsidized health insurance programs. To the contrary, it occurs whenever the government takes steps to subsidize coverage, including through the tax code. For example, it is widely believed that offering refundable tax credits to people for the purchase of health insurance in the individual market would generate significant crowd out of employer-based coverage.¹

Framing the Issue
Medicaid and the Children’s Health Insurance Program (CHIP) have a remarkably successful track record of providing coverage to low- and moderate-income children who otherwise would be uninsured.² Opponents of expanding these programs often point to crowd out as a reason not to expand these programs or, in some cases, to argue for cutting them back. However, instead of allowing concerns about crowd out to paralyze efforts to cover millions of uninsured children and families, it is far more constructive to find ways to minimize and address the issue without unnecessarily harming children and their families. Even if it is not possible to entirely eliminate crowd out, it is important to note that public program expansions are an extremely efficient way to expand coverage to more uninsured Americans and have been remarkably successful doing so. As Dr. Jonathon Gruber, one of the leading researchers on crowd out, has said, “I want to emphasize a conclusion that has been consistent throughout my research: public insurance expansions are by far the most cost-effective means of expanding coverage in the U.S. today.”³

Legislative/Regulatory Authority
In general, whenever the federal government seeks to subsidize coverage for those who cannot afford it on their own, the issue of crowd out is raised. In 1997 when Congress was creating CHIP (which expanded coverage for uninsured children with incomes above Medicaid eligibility levels), there was concern that some families would decide to drop private coverage and enroll...
their children in subsidized CHIP coverage. In response, Congress required states to include in their state CHIP plans an explanation of how they would prevent the substitution of public insurance for group health insurance. As the insurance affordability gap for families widens and many states seek to expand CHIP eligibility further up the income scale, crowd out has again risen as a concern among policymakers, including during the 2007 congressional debate over reauthorization of CHIP.

The CHIP law requires states to describe in their state plans the procedures that they will use to ensure that CHIP coverage does not substitute for group-based coverage. It, however, does not specify exactly which procedures a state must use, reflecting a decision that states should have the flexibility to decide which strategies are most effective given their particular economic conditions, health insurance system, and demographics.

In issuing regulations on the crowd out provisions of the CHIP law, the Centers for Medicare and Medicaid Services (CMS; at the time, the Health Care Financing Administration) indicated it would particularly scrutinize anti-crowd out procedures in states with CHIP programs covering children further up the income scale. Specifically, states with coverage between 150 percent and 200 percent of the federal poverty level (FPL), at a minimum, are expected to evaluate the incidence of crowd out and to have detailed plans for how they will respond if their monitoring efforts identify issues. States providing coverage above 200 percent of the FPL are expected to actually implement specific strategies to limit substitution.

In contrast to CHIP, the Medicaid program does not require that people be uninsured to be eligible for Medicaid. In practice, since Medicaid typically serves a lower-income population than CHIP, the people that it serves rarely have private coverage. In those instances when they do, Medicaid “wraps around” it, providing services not covered by the private insurance and keeping cost-sharing obligations to the levels allowed in Medicaid. The private insurance, however, is treated as a third party payor that must cover its share of bills before Medicaid will pay for remaining gaps in coverage.

Data

**Highlights**

It is clear that CHIP is a successful program, but less clear as to how much of an issue crowd out is. Most analyses seem to agree that some crowd out of private coverage does exist when states expand public programs, and that crowd out increases when they expand further up the income scale. But, there are widely varying estimates as to the magnitude of the crowd out effect, in part, because of varying definitions of crowd out and methodologies for estimating it. Despite these challenges, many researchers have investigated the magnitude of crowd out in public programs. The most widely used findings, which are discussed in more detail below, include:

- Data collected in ten states as part of the Congressionally mandated evaluation of CHIP found that very few families—at most one in fifteen families—actually drop affordable private coverage that they already have in order to enroll in CHIP.

- The Congressional Budget Office, relying on a broader definition of crowd out that, for example, considers the response of employers to public expansions, has concluded that
probably for every 100 children who gain coverage as a result of CHIP, there is a corresponding reduction in private coverage of between 25 and 50 children. It, however, assumes that initiatives to reach more uninsured children already eligible for Medicaid results in a reduction in private coverage of 20 children.

**Detailed Discussion of the Data**

Studies on the crowd out effect of CHIP rely on three kinds of data sources: population-based surveys, surveys of CHIP enrollees, and state administrative data based on applications. As a result of different data limitations and methodologies, these studies have shown a wide range of crowd out estimates from zero to 60 percent. Given this wide range of findings, all crowd out estimates should be interpreted with caution.

- **Population-based studies.** One type of crowd out study uses population-based survey data and econometric techniques (which use assumptions to model changes in the behavior of families and employers) to determine the number of CHIP and Medicaid-eligible children who would have had private coverage in the absence of public programs. Due to data limitations, estimates from population-based studies are imprecise and sensitive to assumptions; they also do not account for all the nuances of state-specific factors affecting eligibility determinations or economic conditions affecting insurance coverage.
  - Population-based studies tend to find the greatest amount of crowd out, generally between 20 and 40 percent, but as low as 10 percent and as high as 60 percent.
  - The one study to examine employer behavior in response to CHIP found that CHIP was not associated with an employer’s decision to offer individual or family coverage, but was, however, associated with an increase in the employee contribution/cost.

- **Applicant-based studies.** Other crowd out studies use state administrative data based on applications to measure the percent of CHIP-enrolled children who dropped private coverage or the percent of applications denied because of other coverage. Some states consider dropping of private coverage for certain reasons to be acceptable, and applicant-based studies generally reflect this state perspective, however these studies do not control for other factors, such as changes in employer behaviors.
  - Using applicant-based studies in the first few years of CHIP, Connecticut, New Hampshire, New Jersey, Oregon, and Pennsylvania reported virtually no crowd out; California estimated that four percent of enrollees dropped coverage; and the District of Columbia reported that 15 percent of applicants dropped health insurance within the three months before applying.
  - In 2004, of 34 states reporting, almost all (33 states) found that 15 percent or less of applicants were denied eligibility because they had other coverage, and most (28 states) reported rates of less than 10 percent.
• Of the 23 states with data on applicants who dropped coverage before applying to CHIP, about half (13 states) reported rates of less than 1 percent, and most (20 states) reported rates of less than 6 percent, but one state reported a rate as high as 16 percent.\textsuperscript{14}

- **Enrollee-based studies.**
  Another type of crowd out study surveys parents of children enrolled in CHIP to measure how many CHIP-enrolled children had private coverage before enrollment in CHIP. Enrollee-based studies do not control for employer behavior or account for applicants who were denied CHIP because of other coverage.

  - An analysis of data collected in ten states as part of the Congressionally mandated CHIP evaluation found that among the 28 percent of CHIP enrollees that had private coverage in the six months before enrolling in CHIP, half (14 percent) lost private coverage due to a change in employment or family structure, one quarter (8 percent) cited affordability issues for ending private coverage, meaning that less than seven percent of recent CHIP enrollees had dropped their private coverage for reasons unrelated to affordability or to loss of coverage due to changes in family structure or employment.\textsuperscript{15}

  - Other state-based surveys of CHIP enrollees have found crowd out rates of less than 10 percent.\textsuperscript{16}

**Strategies**
States have several strategies with which to address crowd out in CHIP, but evidence is limited as to their relative effectiveness. More importantly, anti-crowd out policies often work by creating new barriers to enrollment for eligible children or by reducing the affordability and adequacy of public coverage. In light of this, some anti-crowd out strategies carry with them difficult trade-offs and should be avoided unless necessary in the face of concrete evidence of a crowd out issue. To address crowd out, states can:

- **Monitor and evaluate insurance coverage.** Before pursuing aggressive anti-crowd out strategies, states should carefully assess the extent of the crowd out issue that they face. In the past, a number of states have done so by investigating the extent to which families with children drop private coverage to qualify for CHIP and, if so, the reasons for doing so. As noted above, most of these studies have identified minimal crowd out and, as a
result, have led a number of states to actually reduce the length of time for which children must be uninsured before they can enroll in CHIP.

- **Require a “waiting period” of uninsurance.** In the name of minimizing substitution, many states with a separate CHIP program require that children be uninsured for a specified period of time (usually three to six months) before they can be enrolled in coverage—waiting periods are not allowed in CHIP-financed Medicaid expansions except with a waiver. (Download Waiting Periods in Medicaid & CHIP for Children for details on which states have waiting periods.)

States routinely allow exceptions to the “waiting period” for children who lost private coverage for certain reasons, such as a parent lost a job or the private coverage was simply unaffordable. It is not clear how effective waiting periods are in minimizing crowd out. For instance, one study found little evidence that waiting periods reduce crowd out, but another study found an inverse relationship between waiting periods and crowd out, (specifically, they estimate a 50 percent substitution rate with no waiting period and no substitution with a six-month waiting period). Waiting periods clearly can harm children by requiring them to go without coverage for longer than necessary. In combination with minimal state-based evidence of a crowd out problem, many states have reduced or eliminated the waiting period since CHIP was first implemented.

For more on waiting periods, download Snapshot: Public Coverage Waiting Periods for Children.

- **Make public coverage more comparable to private coverage.** To make CHIP coverage less attractive relative to private coverage, and therefore reduce the incentive for insured families to move their children into the more attractive CHIP program, states may impose cost sharing (e.g., premium and co-payments) or limit benefits within federal standards. The majority of states with coverage above 200 percent of the FPL charge premiums and/or co-payments. But, premiums and cost sharing need to be used judiciously, if at all at lower income levels, because states can make coverage unaffordable for the low- and moderate-income uninsured children they are hoping to serve. Similarly, states with separate CHIP programs can make their benefits more comparable to the narrower packages often offered by private companies, but in doing so need to be careful so that they do not prevent children from getting needed services.

- **Create a premium assistance program.** To discourage privately-insured families from dropping their coverage in favor of Medicaid/CHIP, states may be able assist these families with the cost of purchasing dependent coverage. In pursuing premium assistance options, however, it is important to ensure that the private coverage being subsidized with taxpayer dollars 1) offers a range of benefits that children need comparable to what they would receive in the public program (either alone or in combination with supplemental benefits provided by the public program), and 2) is cost-effective. Particularly in states that cover only lower-income children where private coverage is less common and, when available, more expensive to subsidize, some states have found that premium assistance programs are not worth the cost. And, while premium assistance programs may help families retain private coverage, they can carry their own version of a crowd out risk. If
the state is subsidizing an employee’s share of the cost of dependent coverage, some employers may reduce their own contribution with the knowledge that the state will help to pay it. (See Premium Assistance Resources.)

• **Restrict changes to employer benefits.** Because crowd out can occur if employers change their benefit offerings, one strategy states can use is to prohibit employers from changing their insurance benefit offerings or contributions, especially based on wage level or job classification. For example, California has made it an unfair labor practice for employers to refer employees to CHIP when the employer offers dependent coverage or for employers to change the employee cost sharing for such coverage. Due to federal laws regulating certain private insurers (i.e., ERISA), there are limits to which states can use this strategy, but it provides states with a way to minimize crowd out that does not harm beneficiaries.

**Issues to Consider**

In responding to concerns about crowd out, a few specific issues to consider include:

• **Many lower-income families do not have any access to employer-based coverage.** Some employers, usually concentrated among certain industries and smaller firm sizes, do not offer coverage, and some employers may not offer coverage for a worker’s dependents (e.g., they might cover the employee, but not a spouse or children). For instance, 53 percent of low-income children live in families where at least one employed parent is offered health insurance through an employer, compared to 91 percent of higher-income children. Even if an employer does generally offer coverage, not all employees, especially part-time, seasonal, or new employees, are eligible for that coverage. Many of the employment characteristics that affect access to private coverage for low-income families also do so for moderate-income families.

• **Families may have legitimate reasons for foregoing private coverage.** Some families may have valid reasons, or a “good cause”, for not taking advantage of private coverage, and states may decided that they, therefore, should not be subject to anti-crowd out policies. For instance, some families may find their private coverage to be unaffordable (i.e., when private coverage costs more than five or ten percent of a family’s income). Several states acknowledge this and exempt such children from their uninsured waiting periods.

• **Not all crowd out needs to be considered inherently problematic.** More broadly, the reality that private coverage is not always affordable and of high quality (e.g., some private plans impose high deductibles or fail to cover services critical for children, such as vision, hearing, mental health, and dental care) illustrates that not all substitution needs to be considered inherently problematic. For example, allowing an uninsured child into CHIP whose low-income parents otherwise would need to spend 20 percent of their income on health care costs may offer much needed help to the family, perhaps allowing them to improve and stabilize their living situation. It also should be noted that researchers, in general, have opted not to treat the dropping of individual coverage in response to government subsidies as substitution because the individual coverage market can be highly unstable and/or expensive. In some other contexts, substitution has been
widely acknowledged and accepted. For example, Congress adopted the Medicare Part D drug benefit fully aware that most seniors already had private drug coverage through retiree health plans or other sources. One early study estimated that up to a quarter of seniors with private drug coverage would drop coverage to enroll in Part D. Instead of imposing a waiting period or higher premiums to discourage crowd out, the federal government opted to maximize participation in Part D while offering employers financial incentives to continue providing drug coverage through their retiree plans.

- **The price of anti-crowd out strategies can be high.** Strategies to reduce crowd out, such as waiting periods, can cause children to remain uninsured or delay their enrollment in coverage. Research has shown that uninsured children generally have less access to medical care, especially primary care, and as a result may receive more costly care in emergency rooms or may altogether delay or forgo care necessary for their healthy development. Delayed or forgone care of uninsured children can have adverse effects on their health and can make treatments more costly when a child is able to obtain coverage or secure medical services. Any policy that leaves children uninsured in an effort to minimize crowd out should be considered in the context of the health consequences and financial costs associated with limited access to health care.

### State Experiences

**Illinois:** When Illinois first designed its CHIP program, called KidCare, the state imposed a three-month waiting period as an anti-crowd out strategy. However, there was a concern, primarily among Republican state legislators, that a waiting period would create an inequity for low-income families who had “done the right thing” by purchasing private health insurance. In response to this concern, the state created a state-funded premium assistance program, called KidCare Rebate, to help families pay for private premiums and deter them from dropping private coverage for CHIP. In 2006, when Illinois was designing its universal children’s coverage program, called All Kids, crowd out was again a concern since children in families with income up to 300 percent of the FPL are eligible for subsidies under the program. The state employed three anti-crowd out strategies:

1. Retention of the premium assistance (“Rebate”) program for low-income families;
2. A 12-month waiting period for children in families with income above 200 percent of the FPL, with exceptions (e.g., underinsured children and children who lost private coverage due to a job loss are exempt from the waiting period); and
3. Cost sharing that is comparable to commercial plans, with premium and copayment amounts based on family income.

**Pennsylvania:** When Pennsylvania implemented its expansion of CHIP coverage to 300 percent of the FPL in early 2007, it imposed a requirement that children be uninsured for six months before enrolling in coverage (with exemptions for good cause reasons for losing private coverage). In response to the concerns of pediatricians and child health advocates, the state opted to exempt children under the age of two from the six-month uninsured waiting period. The rationale for the exemption was that it is possible to change the trajectory of a child’s life if they receive preventive care and screenings for developmental and physical issues in the first few years.
years of life. For example, it was pointed out that it is sometimes possible to improve outcomes for children with autism if the condition is identified and treated at a very young age.

**Other States:** Since originally implementing their CHIP programs, a number of other states have reduced their waiting periods, usually in response to their experience with crowd out. For example, since they implemented their CHIP programs, Arizona, Connecticut, Montana, New Jersey, New Mexico, and Virginia have reduced the length of their waiting period, and Iowa, Kansas, Louisiana, Mississippi, North Carolina, and Rhode Island have completely eliminated their waiting period.²⁷

**Resources**

*Waiting Periods in Medicaid & CHIP for Children*

Center for Children and Families, May 30, 2007
This memo provides key points on CHIP and private coverage.

This report outlines the design and financing structure of CHIP and synthesizes findings on the effect of the program on children’s health coverage. The findings indicate that CHIP has contributed to a decline in the uninsured rate of low-income children, CHIP’s target population, and concludes that crowd-out of private coverage under CHIP is most likely between 25 and 50% of the increase in public coverage.

Crowd-out estimates range from near zero to 60%, depending on the population studied and the methodology used, and are higher-income children. Recent efforts to reduce crowd-out, such as waiting periods and higher premiums, have been shown to discourage enrollment in public programs by both the privately-insured and the uninsured. The brief also discusses the role of the availability and affordability of employer-sponsored insurance in maintaining private coverage.

Prepared for the Centers for Medicare and Medicaid Services (CMS) as part of the Congressionally mandated evaluation of CHIP, this report reviews the research on crowd out after 10 years of experience with CHIP and presents new data collected as part of the larger evaluation.

**Substitution of SCHIP for Private Coverage: Results from a 2002 Evaluation in 10 States**, Health Affairs, April 2007
This article examines the extent to which enrollees in CHIP have dropped private insurance to enroll in public coverage. The analysis shows that only 28% of CHIP enrollees had private coverage in the six months prior to enrolling in the program. About half of these enrollees lost
private coverage involuntarily, implying that 14% of all CHIP enrollees had private coverage that they could have retained, but many report it is unaffordable.

**Who's Counting? What is Crowd-Out, How Big is It, and Does it Matter for SCHIP?**, Alliance for Health Reform, August 2007
As Congress debated CHIP reauthorization in 2007, there was much discussion on the crowd-out effects of CHIP. This briefing in August 2007, provided an overview of the issue in the context of the current debate.

**Endnotes**

1. For example, see J. Gruber, “The Cost and Coverage Impact of the President’s Health Insurance Budget Proposals,” Center on Budget and Policy Priorities (February 15, 2006).
4. Section 2102(b)(3)(C) of the Social Security Act.
5. Letter from Sally Richardson, Director of the Center for Medicaid and State Operations at the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services), to State Health Officials, (February 13, 1998).
14. Ibid.
15. op. cit. (7).

17 op. cit. (11).

18 op. cit. (10).


20 See the California SCHIP state plan.


27 op. cit. (20).