Preliminary Assessment of Crowd Out in Louisiana

INSIGHTS FROM THE LOUISIANA HEALTH INSURANCE SURVEY

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Background

Recent expansions of the Medicaid program since the Affordable Care Act have renewed concerns about efficiency of the program. An efficiency measure often cited in these debates is crowd out, which is generally defined as the decrease in private spending caused by an increase in government activity. In the context of healthcare, crowd out could be expressed in terms of dollars spent, but is often measured in terms of the number of individuals with different types of insurance. A seminal paper by Cutler and Gruber (1996) on crowd out in healthcare defined crowd out in two ways. The first was the reduction in private insurance divided by the increase of public insurance, and the second was one minus the decrease in uninsurance divided by the increase in public insurance.

$$(1) \quad Crowd\ Out = \frac{Decrease\ in\ Private\ Insurance}{Increase\ in\ Public\ Insurance}$$

$$(2) \quad Crowd\ Out = 1 - \frac{Decrease\ in\ Uninsurance}{Increase\ in\ Public\ Insurance}$$

Theoretically, these two definitions should produce the same estimate of crowd out, but in practice they do not because of overlap in insurance coverage due to some individuals having both public and private insurance. When this occurs, public insurance serves as a secondary source of coverage and the private coverage typically covers the lion's share of expenses.

In addition, in context of investigations of crowd out for one type of program, some coverage types may not always be relevant. For example, investigations of crowd out associated with Medicaid expansion may focus on changes in private coverage and exclude those with Medicare coverage in order to focus on the effects of changes in public insurance related to Medicaid. The first definition is used in the vast majority of recent research on ACA Medicaid expansions. Estimates of crowd out vary considerably across studies reflecting differences in the particular programs included, differences in target subgroups of the population included as well as improvements to methodology over time.

In Cutler and Gruber (1996), large and significant crowd out was estimated from the historic expansion of public healthcare in the United States. The central estimate of crowd out in this study was 49%. This study and most others from the pre-ACA era, however, focused on expansions for children and programs offering pregnancy-related care for women, which differ in important ways from the populations most impacted by recent Medicaid expansions. For example, the expansions of Medicaid covered by the Cutler and Gruber analysis included individuals with income as high as 185% of the federal poverty level (FPL). These programs had a different focus than the recent post-ACA Medicaid Expansions, which expanded coverage to adults up to 138% FPL. People with higher incomes are more likely to purchase private insurance or have it provided by employers, so expanding public insurance to higher FPL populations increases the risk of crowd out (Kronick & Gilmer, 2002). It is also common for employers to pay a greater share of premiums for their employees than is paid when adding family members, making the relative attractiveness of employer coverage quite different for those directly eligible for coverage through an employer. In addition, preferences related to insurance for children and pregnant women may differ systematically from preferences related to insurance for adults more generally. For these reasons, crowd out can be expected to differ for recent Medicaid expansion programs relative to earlier studies on crowd out.

There have been several studies to date that evaluated potential crowd out from Medicaid expansions in other states. The estimates summarized in Table 1, below, range from small but negative crowd out, suggesting that private coverage actually increased in the period after a Medicaid expansion, to estimates that crowd out could be as high as 42% suggesting that nearly half as many people dropped private insurance as gained public coverage. The models used to assess crowd out are often either difference in differences (DD) or difference in difference in differences (DDD). Each of these approaches compares areas that expanded Medicaid with areas that didn't (one difference) and compares differences across the two groups of states before and after expansions (a second difference). To provide an even more nuanced look at changes in coverage, some researchers have also compared coverage across income groups offering a third difference comparing experiences of newly eligible individuals to those previously eligible, or just outside of the eligibility threshold. The primary data used in this more recent group of crowd out studies were from the Current Population Survey (CPS) and/or the American Community Survey (ACS).

Table 1: Medicaid Crowd Out Studies

Citation	Data	Sample	Crowd Out Type	Estimate	Significant
(Courtemanche, Marton, Ukert, Yelowitz, & Zapata, 2016)	ACS	Adults 18-64 Below 138% of the FPL	Any Private	23%	No
(Frean, Gruber, & Sommers, 2017)	ACS	Population 0-64	Employer Sponsored	-1%	Yes
			Individually Purchased	-2%	Yes
(Kaestner, Garrett, Gangopadhyaya, & Fleming, 2015)	ACS CPS	Adults 22-64 with High School or Less	Any Private	25%	No
		Adults 22-64 Below 300 FPL	Any Private	35%	Yes
(Mas & Leung, 2018)	ACS CPS	Childless Adults 27-64	Any Private	42%	Yes
		Childless Adults 27-64 Below 100 FPL	Any Private	27%	Yes

The first paper to be published following state Medicaid expansions after the passage of the ACA was Kaestner et al. (2015). Their crowd out estimates focused on subsamples of the population so caution is warranted when generalizing the findings to the entire eligible population. One estimate for all parents with a high school education or less suggested crowd out of 25% (though the estimate was not statistically significant) while another estimate for parents below 300% of the FPL suggested crowd out was 35% (and significant at the 95% confidence level).

Shortly thereafter, another paper was published on the topic by Courtemanche et al. (2016), which found a rate of crowd out of 23% in the population below 138% of the FPL, though the estimate was not statistically significant. This paper looked separately at crowd out for employer sponsored and individually purchased insurance and found changes across the two sources to be roughly equivalent but neither change was significant. Another paper was published in 2018 by Leung and Mas focusing on childless adults. This subgroup of the population may have unique preferences toward insurance and so

the estimate should not be generalized. However, within this group, Leung and Mas estimated crowd out to be 42% and statistically significant.

A more recent crowd out paper by Frean et al. (2017) emphasized that prior studies had failed to account for the effect of premium subsidies, which come in the form of tax credits. Frean et al. (2017) found no evidence of crowd out once that effect was taken into consideration. The argument is that previous research did not consider the effects from premium subsidies available to people from 100-138% of FPL that were present in all states as of 2014 and are still present in states yet to expand Medicaid. These subsidies disappear in states that expand Medicaid and premium subsidies subsequently begin at 139% of the FPL. Failing to account for this change can be said to overstate the effect of crowd out related to Medicaid eligibility because the subsidy in comparison areas and time periods increases private coverage for this group (between 91% and 96% of premiums are covered by the subsidy according to 2019 estimates by the Henry J Kaiser Family Foundation, 2019).

Estimates of crowd out by Frean et al. (2017) are small and negative at 1% and 2% for individual coverage and employer coverage, respectively. In other words, after controlling more carefully for other provisions of the ACA including the premium subsidies, the authors find that private insurance coverage actually went up slightly in areas that expanded Medicaid. While the analysis does not control for all ACA-related provisions as carefully as Frean et al. (2017), Leung and Mas (2018) consider an assessment of crowd out only among those below the poverty level, which excludes those ever eligible for subsidies and sidesteps the potential bias of failing to account for that effect. This group had significantly lower crowd out of 27% relative to their overall estimate of 42%, which suggests that accounting for the premium subsidy and the real factors influencing specific groups can lead to substantially different implications for crowd out.

Louisiana Health Insurance Survey and Crowd Out

While an in-depth study of crowd out in Louisiana has not yet been completed, data from the Louisiana Health Insurance Survey (LHIS) can shed light on the order of magnitude of any crowd out following Louisiana's expansion of the Medicaid program in 2016. Comparisons of coverage from the 2015 and 2017 LHIS provide before and after snapshots of coverage and establish some basic intuition about the potential extent of crowd out. Table 2 summarizes the types of insurance for adults under 138% of FPL in Louisiana in each year as well as the difference between the two estimated percentages and a test of whether the percentages are significantly different between the two years. While 25.8% more of these individuals were covered by Medicaid after the expansion and 21.1% fewer people were uninsured, changes for private insurance types were relatively small. Among private insurance types, the only coverage type with a significant change for this group was former employer insurance, which typically involves paying costly COBRA premiums to maintain coverage after losing a job. When faced with the alternative of continuing COBRA premiums, or opting for Medicaid, it is understandable that the largest relative changes might be for this type of coverage.

Table 2: Insurance Types for Adults Under 138% of the FPL

Coverage Type	2015	2017	Change
Medicaid	23.9%	49.7%	25.8%***
Medicare	10.1%	14.3%	4.3%***
Employer	20.1%	19.6%	-0.5%
Former Employer	5.3%	3.4%	-1.9%***
Direct Purchased	6.9%	7.3%	0.3%
Out of Household	2.7%	2.5%	-0.2%
Military	3.7%	3.0%	-0.7%
Uninsured	36.5%	15.3%	-21.1%***

Note: *** indicates significance at the .01 level, ** indicates significance at the .05 level, * indicates significance at the .10 level.

In the months since the release of the 2017 LHIS, data from the 2017 American Community Survey (ACS) have become available. When comparing estimates between the LHIS and ACS, it important to keep in mind that the ACS does not benefit from the methodological advantages of the LHIS related to customized question wording for Louisiana-specific programs and the Medicaid bias adjustment, which produces more accurate estimates of coverage among those potentially eligible for Medicaid. However, ACS data do provide a useful check of the findings from the LHIS. Table 3 provides a similar set of comparisons to Table 2, but using the broader insurance categories provided by the ACS. Among adults below 138% FPL, Medicaid coverage increased by 19.8% while 13.2% fewer individuals in this group are uninsured. ACS estimates suggest a slightly larger drop in private insurance than LHIS, but it is important to recall that the Medicaid bias adjustment in the LHIS leads to a reclassification of some with private insurance to Medicaid based on survey responses for those known to be on Medicaid.

Table 3: ACS Insurance Types for Adults Under 138% of the FPL

Coverage Type	2015	2017	Change
Medicaid	32%	51%	19.8%
Medicare	10%	10%	0.4%
Employer	24%	21%	-3.1%
Direct Purchase	10%	9%	-0.6%
Uninsured	33%	20%	-13.2%

A consistent pattern across the LHIS and ACS is that the increase in Medicaid coverage is greater than the net decrease across other coverage types suggesting that part of the increase in Medicaid enrollment is attributable to individuals who may have held onto their private coverage and taken up Medicaid as a secondary source of coverage. According to the LHIS, dual coverage with Medicaid and a second type of coverage has risen from 4% to 10% between 2015 to 2017, an increase of 6%. To further illustrate trends in dual enrollment, Table 4 shows types of coverage among adults enrolled in Medicaid in 2015 and 2017 as well as the change over time. The largest increase in dual coverage holders is among those purchasing insurance directly and the increase is statistically significant. In addition, employer coverage appears to have increased, but the effect is only marginally significant. These data suggest that rather than simply dropping private coverage after enrolling in Medicaid, some of those

new enrollees have maintained that coverage while enrolling in Medicaid as a secondary source of coverage. Relative to aggregate measures of crowd out that focus on enrollment numbers, this pattern suggests that crowd out measures based on spending would show smaller adjustments.

Table 4: Dual Enrollment among Medicaid Enrollees

Coverage Type	2015	2017	Change
Medicaid	100%	100%	-
Medicare	14%	15%	0.8%
Employer	2%	3%	1.3%*
Former Employer	1%	1%	0.4%
Direct Purchased	1%	4%	2.1%***
Out of Household	2%	1%	-0.8%*
Military	1%	1%	-0.1%

Note: *** indicates significance at the .01 level, ** indicates significance at the .05 level, * indicates significance at the .10 level.

To investigate employer coverage more closely, Table 5 presents eligibility for employer coverage among adults below 138% of the FPL. The first row of the table summarizes responses to a direct question about eligibility for insurance through an adult's own job while the second row of the table includes eligibility for all adults to access employer coverage of any sort including family or spousal coverage through another adult in the household. While employer offers for working adults in this group have gone down when looking at coverage from each individual's own employer, it appears as though those individuals have largely been able to maintain access to employer coverage through family or spousal coverage. However, it should be noted that family coverage often require a higher share of premiums paid by the covered individual relative to self only coverage.

Table 5: Percent of Adults Below 138% FPL who are Eligible for Employer Coverage

	2015	2017	Change
Self Only	14%	10%	-3.9%***
Self or Family	29%	29%	-0.5%

Note: *** indicates significance at the .01 level, ** indicates significance at the .05 level, * indicates significance at the .10 level.

Table 6 further divides the rows from Table 5 to show the percent actually covered by employer insurance, Medicaid, or are uninsured. There is significant increase in the Medicaid population in both the "self only" and "self or family" groups, and there is a significant decrease in the percent uninsured for both groups. Employer coverage does see a sizeable decrease in the self only category, which indicates that fewer people in this income group may be taking insurance from their own job, but the change is not significant and the stability in self or family coverage suggests that the decrease in take up from employees own jobs is largely offset by access to family or spousal coverage.

Table 6: Coverage Types Among Adults Below 138% FPL and Eligible for Employer Coverage

	2015	2017	Change
Self Only			
Medicaid	10%	34%	23.9%***
Employer	65%	60%	-5.1%
Uninsured	14%	7%	-7.6%***
Self or Family			
Medicaid	9%	24%	15.5%***
Employer	68%	68%	-0.6%
Uninsured	15%	7%	-8.0%***

Note: *** indicates significance at the .01 level, ** indicates significance at the .05 level, * indicates significance at the .10 level. Coverage types may not add to 100% within each group and year because of other insurance types not shown on this table, dual coverage and rounding.

To provide additional perspective on the prevalence of these types of coverage relative to the overall Medicaid program, the same types of coverage shown in Table 6 are shown again in Table 7, but the number of individuals under 138% FPL and eligible for employer coverage and selecting each type of coverage is divided by the entire adult Medicaid eligible population. The relative importance of employer coverage is similar, but the figures illustrate that individuals eligible for both employer coverage and Medicaid make up a relatively small portion of the overall Medicaid eligible population.

Table 7: Coverage Types Among Adults Below 138% FPL

	2015	2017	Change
Self Only			
Medicaid	1%	3%	2.1%***
Employer	9%	6%	-3.0%***
Uninsured	2%	1%	-1.3%***
Self or Family			
Medicaid	3%	7%	4.4%***
Employer	20%	20%	-0.5%
Uninsured	4%	2%	-2.4%***

Note: *** indicates significance at the .01 level, ** indicates significance at the .05 level, * indicates significance at the .10 level.

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