Medicaid Expansions and Crowd-Out: Evidence from HIFA Premium Assistance Programs

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Objective. To evaluate the effect of the Oregon and New Mexico Health Insurance Flexibility and Accountability (HIFA) demonstrations. HIFA is an optional state Medicaid expansion targeted at adults and children with incomes below 200 percent of the federal poverty level (FPL). The study has five research questions: What type of health insurance do HIFA enrollees self report in surveys? What are the demographic characteristics of these enrollees? What type of health insurance coverage, if any, did HIFA enrollees have just prior to enrollment in the HIFA program? Among those with prior coverage, what prompted participation in the HIFA program? What type of health insurance, if any, would HIFA enrollees have in the absence of HIFA?

Methods. Data were collected via telephone interviews with a total of 406 enrollees from Oregon and 409 enrollees from New Mexico. The survey was conducted between July 7 and September 20, 2009, for both states. The sample frame for the survey was based on administrative records of adults enrolled in June 2009. After completion of the survey, active enrollment status as of the date the telephone interview was confirmed. Respondents no longer enrolled at the time of the survey (7 cases in NM and 14 in OR) were excluded from the analysis. The final sample size was 794 verified HIFA enrollees.

Results. HIFA enrollees tended to be middle-aged, male, and relatively unhealthy. Employment status varied tremendously from the self-employed to retired to unable to work. HIFA enrollees were reasonably well educated with 80 percent having at least a high school education. Most HIFA enrollees (90 percent) reported being uninsured just prior to participation in HIFA. Of those who were uninsured, most reported having been uninsured for an extended time—a year or more. Most enrollees joined HIFA because they lacked access to health insurance or could not afford insurance on the private market. The overwhelming majority (76 percent) of respondents believed that they would be uninsured in the absence of HIFA, with few considering either an employer plan or private purchase to be a viable option. Over 90 percent of enrollees correctly indicated they had insurance coverage. However, characterization of the type of coverage was problematic, particularly in the absence of the program-specific name.

Conclusions. HIFA enrolled a relatively sick, male, middle-aged population that tended to have been long-term uninsured—the kind of enrollees for which the programs were designed—with little apparent crowd-out of private insurance. The

reported health status coupled with low incomes suggests that individual purchase is unlikely, a sentiment echoed by the respondents. In the absence of HIFA, most enrollees believed they would rejoin the ranks of the uninsured from where they came.

Key Words. Medicaid expansion, crowd-out, HIFA waivers, Medicaid, uninsured

One controversial aspect of the Patient Protection and Affordable Care Act (ACA) of 2010 is the expansion of Medicaid eligibility to a broader group of low-income adults than has traditionally been included; specifically all adults with family incomes below 138 percent of Federal Poverty Guidelines. A primary concern is that the expansion of Medicaid will “crowd-out” private insurance programs. If there is extensive crowd-out, then the expansion simply transfers coverage from the private to public sector, increasing public costs but not affecting net insurance coverage rates (Gruber and Simon 2008). Another concern is that Medicaid programs will suffer from “adverse selection,” enrolling a sicker than anticipated population, with correspondingly higher costs (Kenny and Holahan 2003; Marquis and Long 2003).

There is relatively little research on the effects of Medicaid expansions to low-income adults because, with the exception of pregnant women and new mothers, prior to ACA adults generally have not been eligible for Medicaid. One exception is the Health Insurance Flexibility and Accountability (HIFA) initiative, which extended Medicaid coverage to a variety of typically ineligible populations and explicitly allowed the inclusion of childless adults, offering new opportunities to explore crowd-out.

HIFA is a Section 1115 waiver that permits states to conduct special demonstrations. The policy purpose of the HIFA demonstration was to encourage new comprehensive state approaches to increase the number of insured individuals within Medicaid, the State Children’s Health Insurance Program (SCHIP), and public–private partnerships that include premium assistance programs and development of new health plan products. HIFA targeted individuals with incomes below 200 percent of the federal

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poverty level and allowed states to subsidize private health insurance premiums for either SCHIP or Medicaid enrollees (Zabaza 2003). Subsidies for private health insurance premiums were intended to leverage private funds and overcome the “welfare stigma” associated with public insurance programs.

Because HIFA programs were designed by the states, each program is unique. Indeed, states were even allowed to use Federal funds to develop and subsidize privately offered health insurance products that groups or individuals might purchase with a public subsidy, similar to current ACA Medicaid expansion proposals put forward by several states, including Arkansas and Pennsylvania. The HIFA program was associated with a 6.4 percentage point increase in insurance coverage among its target population (Atherly et al. 2012a,b).

To date, evaluations of the impact of Medicaid expansions generally (see reviews by Davidson, Blewett, and Call 2004; Gruber and Simon 2008) and HIFA expansions specifically (Atherly et al. 2012a,b) have focused on large national datasets. These studies have the advantage of large sample sizes that allow relatively robust estimates of change in the rate of uninsurance in expansion states relative to nonexpansion states. The weakness of this approach is that national surveys cannot confirm that a given respondent was actually enrolled in a HIFA program; instead, analysts can only estimate whether the individual was in the eligible income range. Nor do national datasets allow analysts to establish whether respondents in the target population who reported that they were insured in the postimplementation years were uninsured in the preimplementation period. The latter question is of major importance, because the Medicaid expansions will accomplish little if they merely shift enrollees from one form of public coverage to another or, worse for policy purposes, displace private insurance.

The purpose of this paper was to shed light on these ambiguities using data from a survey of people actually enrolled in HIFA premium subsidy programs in New Mexico and Oregon. This paper answers three specific research questions: What type of health insurance coverage, if any, did HIFA enrollees report just prior to enrollment in the HIFA program? What are the characteristics of HIFA program enrollees? And, what type of health insurance, if any, do HIFA enrollees anticipate they would have in the absence of HIFA? Because the HIFA population is similar to the ACA Medicaid expansion population, results from the HIFA expansion provide insight regarding the population that is likely to newly enroll in Medicaid.

METHODS

Selection of Study States

The choice of HIFA states was guided by several considerations. First, we wanted to survey enrollees in one of the larger fully operational programs. This limited us to six HIFA states: Arizona, Illinois, Maine, Michigan, New Mexico, and Oregon. Second, we were interested in demonstrations using premium assistance, because a major premise of HIFA was that private–public partnerships represent a joint solution to expanding access and keeping state costs down; this criterion excluded Arizona. Third, we wanted to select one state following each premium assistance model: (1) subsidizing enrollment in existing public or private health plans (Illinois, Michigan, and Oregon); or (2) offering enrollment in a subsidized state-sponsored plan (Maine and New Mexico).

With respect to the first premium assistance model (subsidizing existing plans), we chose Oregon because of the state's interest in collaborating with our research team combined with their plan's more representative eligibility ranges (adults up to 185 percent the federal poverty level [FPL] vs. childless adults under 35 percent FPL in Michigan). Oregon offers a subsidy for purely private health insurance, either employer sponsored or individual purchase. Consistent with its goals of cost savings, Oregon built on existing programs. Although the state reduced benefits somewhat, it relied more heavily on increased cost-sharing for current enrollees (Coughlin et al. 2006).

With respect to the second group of premium assistance programs (state-sponsored plans), we selected New Mexico. New Mexico's program is an interesting example of a state-sponsored insurance product that represents a private–public partnership. New Mexico created a new commercial insurance product and contracted with managed care organizations to offer the plan to employers with low-income workers. The plan is somewhat less generous than the typical employer-sponsored product in the state and is less generous and includes higher cost-sharing than the state's Medicaid product. New Mexico's demonstration was approved in 2002, but implementation did not begin until July of 2005.

Sample Design

The sample frame for the survey was based on state administrative records of adults with a telephone number in the state files (98.4 percent and 99.8 percent of the NM and OR cases, respectively, had telephone numbers available) enrolled in June 2009. Due to inactive numbers and failure to locate enrollees

using directories, the actual proportion of numbers available to attempt interviews was approximately 75 percent in NM and 84 percent in OR. The survey was conducted by the same survey vendor in both states between July 7 and September 20, 2009.

Our power analysis suggested that we needed approximately 400 survey enrollees in each state: ultimately, surveys were completed by 409 HIFA enrollees from NM and 406 from OR. Because it is possible that enrollees may have discontinued enrollment after the sample was drawn, state agency staff later confirmed active enrollment status on the date the telephone interview was completed. Enrollees no longer enrolled at the time of the survey (7 cases in NM and 14 in OR) were excluded from the analysis. The analysis reported here is based on the 794 verified HIFA enrollees. (The HIFA enrollee was asked for by name to complete the interview; a knowledgeable adult could respond if the enrollee was unavailable.)

The response rate for the total study was 20 percent using the most conservative calculation (completed over total sample released) and 26 percent using the response rate calculation that excludes sample with bad phone numbers, disconnects, and ineligible sample. The response rates were comparable in both states. The response rate was lower than witnessed in some other studies (Call et al. 2008). However, recent research indicates that lower response rates are not necessarily associated with greater response bias because surveys with high and low response rates demonstrate similar levels of absolute bias (Groves 2006).

Using demographic data within the sample frame from each state, we compared characteristics of those who were sampled and responded to the survey with those who did not respond. Respondents and nonrespondents were similar on gender, race, employment status, citizenship, and subsidy level, and significantly different on only one dimension: age. Respondents were older than nonrespondents by about 1 year in NM and approximately 4 years in OR. Although these differences reach statistical significance, we believe they are not sufficiently different in substantive terms to raise concerns about biased representation of the HIFA population in the survey results.

Survey Methodology

The telephone survey was designed to be comparable to the Behavioral Risk Factor Surveillance System (BRFSS) and Current Population Survey (CPS) national surveys—combining aspects of the BRFSS and CPS health insurance question series—yet not fully representing either. Specifically, the BRFSS

includes only one health insurance question that does not specify the type of coverage, whereas the CPS specifies type of coverage held but does so with (1) a prior calendar year reference period that impedes recall and (2) placement at the end of a long survey, increasing the likelihood of item nonresponse (Call, Davern, and Blewett 2007). Therefore, we begin with the one question item from BRFSS that asks about current coverage of any type. Those reporting no coverage receive the CPS verification questions. Those reporting coverage receive a CPS-like series that asks about specific types of coverage. Finally, at the end of the CPS coverage type series, we included a question specifically asking about the HIFA program by name (State Coverage Insurance in NM; Family Health Insurance Assistance Program in OR) to assess HIFA enrollees' reporting accuracy.

The HIFA survey mimicked the BRFSS beginning with questions about health status, followed by expanded CPS-like health insurance coverage section, and ending with BRFSS demographics. In addition, questions were created to measure self-reports of health insurance coverage prior to enrollment in HIFA, circumstances surrounding enrollment in HIFA, and perceptions of the likelihood of having health insurance in the absence of the HIFA program.

Analysis Strategy

Our approach to answering the research questions includes a series of univariate and bivariate descriptive statistics. We report the result for the overall HIFA population and separately for each state program. Data are weighted to account for unequal probabilities of selection across HIFA sampling strata within the two participating states. Overall numbers are averages of the results of the two state-level weighted results.

RESULTS

For both states, the results show a middle-aged population (mean age of 47.3 years) that is somewhat unhealthy (Table 1). Overall, enrollees report 7 days of poor physical and 7 days of poor mental health in the past 30 days. About 33 percent of NM enrollees self-rate their health as "fair or poor" as compared to 23 percent of OR enrollees.

Enrollees in NM had lower levels of education than enrollees in OR; 52 and 39 percent, respectively, had a high school degree or less. OR enrollees

Table 1: Health Status and Sociodemographic Characteristics of HIFA Enrollees ($N = 794$)

	<i>Overall</i>	<i>New Mexico (n = 402)</i>	<i>Oregon (n = 392)</i>
Age: Mean (standard error)	47.3 (0.78)	46.8 (0.94)	47.7 (0.63)
Days of physical limitation in past 30 days: Mean (standard error)	7.1 (0.76)	7.9 (0.90)	6.3 (0.62)
Days of mental limitation in past 30 days: Mean (standard error)	7.2 (0.73)	7.4 (0.71)	7.1 (0.76)
Self-rated health (%)*			
Excellent	11	8	15
Very good	28	23	33
Good	33	36	29
Fair	21	26	16
Poor	7	7	7
Female	76	74	78
Education (%)*			
Less than high school	13	21	6
High school graduate or GED	32	32	33
Completed some college	36	34	38
College graduate or above	18	13	23
Marital status (%)*			
Married	45	35	54
Living with partner	7	7	7
Divorced/widowed/separated	28	32	23
Never married	19	24	14
Employment status (%)*			
Employed for wages	39	39	39
Self-employed	9	9	9
Out of work more than 1 year	17	17	16
Out of work less than 1 year	6	6	5
Homemaker	9	8	9
Student	6	6	6
Retired	6	6	6
Unable to work	9	9	9

*Do not sum to 100% due to missing data (1% or less) or rounding error.

Source: HIFA Enrollee Survey.

are more likely to be married or living with a partner (62 percent) than is true of NM enrollees (42 percent). Approximately 39 percent of HIFA enrollees report being employed for wages, followed by self-employed (9 percent). Just over half of HIFA enrollees in both states are out of the workforce (including homemakers, students, retirees, and those who are unable to work).

Only 9 percent of enrollees reported having health insurance immediately prior to HIFA enrollment, suggesting a relatively small crowding out effect (Table 2). Prior to joining HIFA programs, a large share of enrollees

Table 2: Insurance Prior to HIFA and Projections of Insurance in the Absence of HIFA (*N* = 794)

	<i>Overall (%)</i>	<i>New Mexico (%)</i>	<i>Oregon (%)</i>
Time from prior insurance to HIFA enrollment			
Insured prior to HIFA enrollment	9	9	9
Uninsured prior to HIFA enrollment			
Less than 3 months	5	7	2
3–6 months	6	5	7
6–12 months	4	4	4
More than 12 months	64	59	69
Never previously insured	13	16	9
Total	100	100	100
Insurance coverage HIFA enrollees expect in the absence of HIFA			
None	79	75	84
Medicare	4	4	1
Medicaid	1	2	1
Other public	5	5	5
Private	3	4	1
Don't know	5	6	4

Source: HIFA Enrollee Survey.

had been without health insurance for more than a year (59 percent in NM and 69 percent in OR) or had never had health insurance (16 percent in NM and 9 percent in OR).

We also asked HIFA enrollees what type of insurance they think they would have had, if any, in the absence of HIFA (Table 2). Overall, almost 80 percent of enrollees reported that in the absence of HIFA, they expected they would have no insurance coverage (75 percent of NM and 84 percent of OR enrollees). Combining Medicare, Medicaid, Tri Care, VA Coverage, Indian Health Services (IHS), and “other,” approximately 11 percent of enrollees reported they would likely qualify for alternative public coverage or access to care through IHS. Only 3 percent anticipated they might have private coverage through their own or a family member’s employer/union or through a private self-purchased policy. Finally, approximately 5 percent of enrollees reported they did not know what coverage they would have in the absence of HIFA.

We also examined the previous source of insurance coverage for the 9 percent of the survey enrollees who had insurance coverage prior to enrolling in HIFA (Table 3). Just over 30 percent of previously insured enrollees reported having had some type of public insurance (other public, Medicaid, Medicare, and VA Health Care), 21 percent refused or did not know what type

Table 3: Type of Insurance Held Prior to HIFA by Those with Prior Insurance ($N = 71$)

	<i>Percent</i>
Other public	31
No response/Do not know	21
Other	17
Employer/Union provided (policyholder)	14
Employer/Union provided (as dependent)	11
Privately purchased (policyholder)	6
Total	100.0

Source: HIFA Enrollee Survey.

of coverage they had, 17 percent reported “other” and could not be classified. Interestingly, the “crowd-out” from public programs covered a wide variety of programs. However, the large number reporting they had “other public” (25 percent) suggests that enrollees may not fully understand what type of coverage they had. Finally, approximately 31 percent reported private insurance coverage—the more traditional insurance “crowd-out.” This suggests HIFA resulted in nearly equal displacement of private and public insurance among the small group that had prior coverage.

DISCUSSION

There are several conclusions that can be drawn from these results. HIFA enrollees tended to be middle-aged, female, and relatively unhealthy as reflected in days limited by physical and mental issues and by self-rated health. HIFA enrollees represented a broad spectrum of different types of individuals in terms of work status from self-employed to retired to unable to work. HIFA enrollees also tended to be reasonably well educated—particularly in OR—with upwards of 80 percent having at least a high school education.

Most HIFA enrollees (91 percent) reported being uninsured prior to participation in HIFA. Of those who were uninsured, most reported having been uninsured for an extended time—a year or more. This is consistent with the result that most enrollees joined HIFA because they lacked access to health insurance or could not afford insurance on the private market. Given the health of the enrollees, private insurance, if obtainable, likely would have been extremely expensive. Consistent with that, the overwhelming majority (79 percent) of enrollees believed that they would be uninsured in the absence

of HIFA, with few considering either an employer plan or private purchase to be a viable option. In the absence of HIFA, most enrollees believed they would rejoin the ranks of the uninsured.

With reference to the ACA, the policy implications of these results are mixed. First, our results have interesting implications for data and methods in research on coverage expansions. As noted earlier, previous evaluations of the HIFA expansions for adult populations (Atherly et al. 2012b) have the advantage of large sample sizes but—as they are based on CPS data and not true panel data—can only estimate whether the individual was in the eligible HIFA income range and had prior insurance. Our survey results, by contrast, are based on a much smaller sample for only two states without controls, but these results drawn from verified HIFA enrollees, who provide information on their own prior insurance status, are akin to true panel data. The estimates from the two sources of data are different as are the measures of coverage in the surveys.

- In the CPS-based studies, we estimated that across all HIFA states, 42 percent of HIFA enrollees had no insurance coverage in the previous calendar year.
- In our survey of two states, 59–69 percent of the survey enrollees had been without insurance for more than a year, while overall 91 percent of the enrollees had no coverage immediately prior to HIFA enrollment.

Obviously, the CPS-based estimates are closer to our NM–OR survey responses for being uninsured more than a year, but they still are quite different from each other. Granting that the survey responses are only from two states, estimating eligibility and preexpansion insurance status from large datasets that do not elicit such information directly may understate the effects of the expansions.

Second, we find that the enrollees in the program tended to be not only older but also relatively sick, suggesting that the cost per enrollee of the ACA expansions may be greater than expected. Experience is now starting to accumulate in ACA expansions to test this, but our results are a caution.

Finally, we find that crowding out was a relatively minor issue for the population that enrolled in the OR and NM Medicaid expansions. Not only were relatively few enrollees previously insured but also most enrollees had been uninsured for a year or more. These results are suggestive for the ACA, but only that, given all the differences between HIFA and the ACA in terms of program design, eligible populations, and other factors. For example, HIFA

childless adult populations in NM and OR were in an income range of 0–200 percent FPL (NM) and 100–185 percent FPL (OR) who in both cases were not eligible for Medicaid. By contrast, the ACA extends Medicaid to childless adults in states that opt for it to 133 percent FPL, and as high as 400 percent FPL for subsidized coverage. Further research studies on crowd-out in ACA will clarify whether the ACA experience is similar to HIFA.

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SUPPORTING INFORMATION

Additional supporting information may be found in the online version of this article:

Appendix SA1: Author Matrix.