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The effect of the state children's health insurance program on health insurance coverage

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Abstract

This paper presents the first national estimates of the effects of the SCHIP expansions on insurance coverage. Using CPS data on insurance coverage during the years 1996–2000, we estimate instrumental variables regressions of insurance coverage. Our regression results imply that 9% of children meeting income eligibility standards for SCHIP gained public insurance. While low, our estimates indicate that states were more successful in enrolling children in SCHIP than they were with prior Medicaid expansions that were focused on children just above the poverty line. Crowd-out of private health insurance was estimated to be nearly 50%, which is in line with estimates for the Medicaid expansions of the early 1990s. In addition, state anti-crowd-out provisions in the form of waiting periods were found to significantly affect both take-up and crowd-out.
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1. Introduction

The State Children's Health Insurance Program (SCHIP) was signed into law as part of Title XXI of the 1997 Balanced Budget Act. The goal of the legislation was to increase the insurance coverage of children in the United States by extending eligibility for public insurance to children in families earning too much to qualify for Medicaid yet earning too little to afford private health insurance. Touted as the largest expansion in health insurance

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since the enactment of Medicaid in 1965, the SCHIP legislation apportioned more than $40 billion in federal matching funds over 10 years beginning in fiscal year 1998. States are allowed to use these funds to expand Medicaid eligibility, to develop new insurance programs, and increase outreach for children already eligible for public coverage.

The efficacy and cost of public insurance expansions depend critically on two factors: program take-up and the possible substitution from private to public coverage, i.e., "crowd-out". A number of recent studies find low take-up rates for individuals who became eligible for public insurance through the Medicaid expansions of the late 1980s and early 1990s (Cutler and Gruber, 1996; Dubay and Kenney, 1997; Shore-Sheppard, 1997; Yazici and Kaestner, 2000; Blumberg et al., 2000; Ham and Shore-Sheppard, 2001; Card and Shore-Sheppard, 2003).[1] Previous studies also suggest that the Medicaid expansions contributed to a decline in private insurance, though the estimated magnitude of this effect varies considerably.

Low take-up might be an even greater problem for SCHIP as many of the families made eligible for the program had little prior experience with public insurance programs and, therefore, may lack good information about the program. Negative perceptions of the quality of public health insurance and stigma related to public assistance also represent potentially serious barriers to enrollment. Evidence from the Medicaid expansions suggests that take-up falls as coverage is extended to relatively higher income families. For example, Currie and Gruber (1996) find that take-up was higher among women who gained eligibility from expansions that were targeted at families in poverty than for those who gained coverage from broader expansions. Similarly, Card and Shore-Sheppard (2003) find that expansions targeting children under the federal poverty line (FPL) led to a 10–15% increase in Medicaid coverage, whereas legislation extending eligibility to children with incomes up to 133% of the FPL had essentially no effect.

Since private insurance coverage increases with income, crowd-out is potentially a greater problem for SCHIP than for prior expansions of public insurance. However, in response to research showing large crowd-out effects for Medicaid, SCHIP programs were designed with explicit mechanisms intended to keep newly eligible families from dropping private coverage in favor of public insurance. Thus, whether crowd-out is more or less of a problem in the case of SCHIP as compared to the earlier Medicaid expansions is an empirical question.[2]

Because the program is relatively new, research on the effects of SCHIP is quite limited. Two recent studies present evidence on trends in insurance coverage for children in the early years of SCHIP implementation (Zuckerman et al., 2001; Rosenbach et al., 2001). They show that the percent insured fell slightly for children in families with incomes above 200% of FPL, while remaining relatively constant for lower income children who were more likely to be affected by SCHIP. Since coverage had been falling previously for children in the SCHIP target population (incomes between 100 and 200% of the FPL), this suggests a

[1] Low take-up is not unique to health insurance, but is a problem with most public programs. See Remler et al. (2001) for a recent review.

[2] The anti-crowd-out provisions of SCHIP may seem to render this question moot. However, research on legislation designed to prevent the substitution of Medicare for private insurance by workers over the age of 65 suggests that those rules were largely ineffective (Glied and Stabile, 2001). Even if SCHIP was implemented in a way to limit direct transitions from private to public insurance, crowd-out can still occur if the program inhibits transitions from uninsurance or public insurance to private coverage.

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