



Health insurance and the consumer bankruptcy decision: Evidence from expansions of Medicaid[☆]

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ABSTRACT

Anecdotal evidence and several observational studies suggest that out-of-pocket medical costs are pivotal in a large fraction of consumer bankruptcy decisions. In this paper, we assess the contribution of medical costs to household bankruptcy risk by exploiting plausibly exogenous variation in publicly provided health insurance. Using cross-state variation in Medicaid expansions from 1992 to 2004, we find that a 10 percentage point increase in Medicaid eligibility reduces personal bankruptcies by 8%, with no evidence that business bankruptcies are similarly affected. We interpret our findings with a model in which health insurance imperfectly substitutes for other forms of financial protection, and we use the model to present simple calibration results which illustrate how our reduced-form parameter estimate affects the optimal level of health insurance benefits. We conclude with calculations which suggest that out-of-pocket medical costs are pivotal in roughly 26% of personal bankruptcies among low-income households.

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1. Introduction

Bankruptcy protection is a legal procedure designed to forgive debtors their debt. It was once undertaken by few debtors, but has become common over the past few decades (Zywicki, 2005). In the 1990s, the number of personal bankruptcies in the United States rose by more than 78% (see Fig. 1). By the end of the decade, more than 1% of American households were declaring bankruptcy in any given year. Stavins (2000) estimates that 8.5% of American households have ever filed for bankruptcy.

This increase in bankruptcies has motivated research on factors that induce households to declare bankruptcy. One such factor is the burden of out-of-pocket medical costs. Several researchers have argued that a large fraction of consumer bankruptcies are driven by the high cost of health care. This conjecture has been widely publicized and has also motivated legislation to prevent “medical

bankruptcies.” For instance, a bill proposed in Congress, “The Medical Bankruptcy Fairness Act of 2008,” would have lowered penalties on debtors forced to declare bankruptcy because of medical bills.

Currently, there exists little credible evidence regarding the relative importance of medical costs in the decision to declare bankruptcy. The few studies that have pursued such evidence rely primarily on interviews with individuals who have recently filed for bankruptcy. Such interviews are unlikely to isolate whether bankruptcy filers who experienced high medical costs would have still declared bankruptcy in the absence of any medical costs.

In this paper, we use plausibly exogenous variation in publicly provided health insurance to examine the effect of medical costs on bankruptcy risk. Specifically, we exploit state-level expansions in Medicaid eligibility during the 1990s.¹ In our preferred specification, we find that a 10 percentage-point increase in eligibility for Medicaid reduces personal bankruptcies by 8%.

We test the robustness of these main findings in several ways. First, we document the results of a simple falsification test: business bankruptcies are not similarly affected by Medicaid expansions. Second, we present the results of a variety of alternative specifications which

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¹ The variation we exploit stems from both Medicaid expansions and the State Children's Health Insurance Program (SCHIP). For simplicity, we refer to both Medicaid and SCHIP simply as “Medicaid,” even though SCHIP provides health insurance to children through programs that are – in many states – distinct from Medicaid.

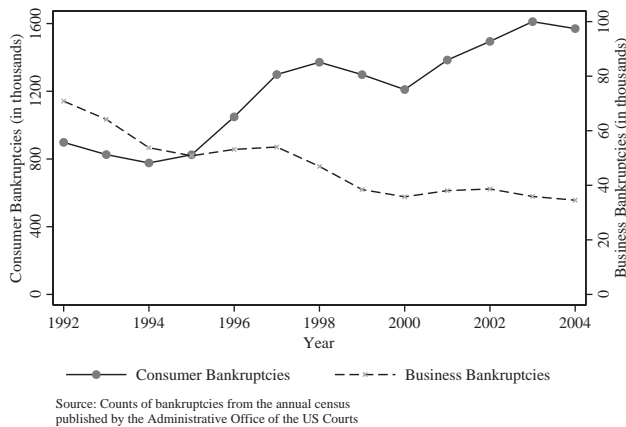


Fig. 1. National trend in bankruptcies.

control for other determinants of consumer bankruptcies. Finally, we construct a database of bankruptcies based on the dockets of bankruptcy courts, and we compile counts of bankruptcies by zip code. This database allows us to test whether Medicaid expansions – which primarily affected households with children – affected certain zip codes rather than others. We find that Medicaid expansions disproportionately reduced bankruptcies in zip codes in which children are a large share of the population as well as zip codes with a large share of low-income households. In general, all of these exercises confirm our main findings.

The empirical results suggest a robust interaction between Medicaid and the consumer bankruptcy system. To explore the welfare implications of this interaction, we construct a simple theoretical model in which health insurance is an imperfect substitute for other forms of financial protection. We calibrate this model and find that the optimal health insurance benefit rate is between 14 and 24% lower than would be suggested by a model which ignores the generosity of the bankruptcy system and the imperfect substitutability between health insurance and consumer bankruptcy. While the calibrations are extremely stylized, they qualitatively demonstrate the likely substantive importance of the interaction between bankruptcy and Medicaid.

The remainder of the paper proceeds as follows. The subsequent section discusses the state of research on personal bankruptcy. Section 3 describes Medicaid expansions, the data, and our empirical strategy. Section 4 presents our main results and robustness tests. Section 5 explores patterns in households' exposure to financial risk that may drive the main findings. Section 6 develops a model of the interaction between bankruptcy and Medicaid and presents calibration results that utilize our empirical estimates. Section 7 estimates the share of bankruptcies among low-income households that are driven by medical costs. Section 8 concludes.

2. Previous research on the determinants of consumer bankruptcy

Many studies have explored the determinants of consumer bankruptcy. The research generally falls into two categories. One strand of research emphasizes the strategic nature of the household bankruptcy decision. The studies find that households are forward-looking and optimally choose whether or not to file for bankruptcy based on the financial advantage of doing so. Households take the generosity of the bankruptcy system into account in making savings and investment decisions. As a result, the bankruptcy system leads to ex-ante moral hazard.

For example, several studies document that households respond to financial incentives when deciding whether to declare bankruptcy. Fay et al. (2002) study a sample of respondents to the Panel Study of Income Dynamics who have declared bankruptcy. The authors find that households are more likely to declare bankruptcy when the financial benefits of doing so outweigh the costs. Researchers have also documented that stigma and the availability of credit may be

critical factors. Both Zywicki (2005) and Gross and Souleles (2001) conclude that the stigma of declaring bankruptcy has diminished over time. Similarly, Livshits et al. (2007) estimate a structural model of household financial decisions. The authors conclude that the rise in personal bankruptcy has been driven mainly by the increasing availability of consumer credit and a decline in the social cost of filing for bankruptcy, rather than by uncertainty or medical shocks.

A second strand of research quantifies the role of adverse, potentially unforeseen shocks that may lead to consumer bankruptcies. For instance, Keys (2009) studies the relationship between unemployment and bankruptcy. Additionally, a study by Himmelstein et al. (2005) estimates that medical costs are pivotal in more than half of all consumer bankruptcies. In interviews with bankruptcy filers, the authors find that 54% of respondents cite “any medical cause” when asked what led them to declare bankruptcy. The finding confirms other qualitative studies that point to adverse events as the primary driver of personal bankruptcy (Sullivan et al., 1989). One concern with this study, however, is that the authors define medical costs broadly. They include the birth or death of a family member, alcoholism, drug addiction, and uncontrolled gambling as “any medical cause.” Dranove and Millenson (2006) re-analyze the same survey data using a narrower definition of medical causes and attribute far fewer bankruptcies to medical costs. They estimate that 17% of bankruptcies are due to medical causes, most of which involve low-income households. Recent follow-up studies suffer from similar drawbacks. Himmelstein et al. (2009) interview a sample of bankruptcy filers, 29% of whom state that medical costs were a reason for filing. The authors then add to this estimate respondents who did *not* state that medical costs were a factor in their bankruptcy, but who did describe substantial medical costs. In this way, the authors calculate that 62% of bankruptcies can be classified as “medical,” even though more than half of the relevant respondents did not list medical costs as a primary cause of their decision to file for bankruptcy.

More broadly, a concern with both strands of research is that the studies do not employ quasi-experimental variation in the determinants of bankruptcy, which makes it difficult to credibly estimate the causal effect of interest. To our knowledge, this paper is the first to document the relative importance of medical costs in the bankruptcy decision using plausibly exogenous variation in public health insurance eligibility.

3. Empirical strategy and data

This section briefly describes the Medicaid expansions we study, the data we use, and our empirical framework.

3.1. Background on Medicaid expansions

In the mid-1990s, states expanded Medicaid eligibility to cover all young children living in families with incomes below 133% of the federal poverty line, and in certain states, their parents. In 1997, the Medicaid program was augmented further with the introduction of the State Children's Health Insurance Program (SCHIP), which expanded Medicaid eligibility for children and pregnant women. Many states also went beyond the minimum federally required extended eligibility. New Jersey, for example, offered Medicaid to children whose families earned less than 350% of the federal poverty level (see Gruber, 2000; Gruber and Simon, 2008 for more details on the Medicaid program). Many states also expanded eligibility for parents in conjunction with their SCHIP expansions.² Crucially for our

² There exists anecdotal evidence that most Medicaid expansions during this time period involved retrospective eligibility. For instance, hospitals may apply for Medicaid on behalf of eligible but uninsured patients. To our knowledge, little research has documented the extent of this practice. We believe that retrospective eligibility may be an important part of how Medicaid affects household finances; households that are eligible but do not enroll may still be covered after illness or injury.

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