Did Medicaid Expansions For Pregnant Women Crowd Out Private Coverage?

One estimate finds only a small amount of trade-off (“crowding out”) between public and private insurance.

by Lisa Dubay and Genevieve Kenney

EDITOR’S NOTE: The question of whether expansions in Medicaid coverage lead to declines in private insurance coverage (“crowding out”) has emerged in recent years as an important issue in the health policy community. Although it is generally agreed that crowding out is a problem, there is widespread disagreement regarding its extent. The Peer Review section offers an opportunity for health policy leaders and researchers to present differing interpretations of a controversial issue. Here, Lisa Dubay and Genevieve Kenney, and David Cutler and Jonathan Gruber, set out opposing views on the impact of Medicaid expansions on private coverage. Following that, Richard Curtis and colleagues, then John Holahan, comment on the importance and the policy implications of the authors’ findings.

Concern about high infant mortality and morbidity in the United States and the erosion of private insurance coverage sparked major expansions in the Medicaid program beginning in 1986. These expansions, which were aimed at increasing prenatal and other health services available to pregnant women, were followed by large increases in the number of Medicaid-eligible births and declines in the number of births to uninsured women. Nonetheless, recent research on the national impact of these expansions suggests that they had only a small effect on the timeliness of prenatal care and the incidence of low-birthweight births.

A number of researchers have suggested that the lack of improvement during the early years of the expansions may have been the result of demographic changes in the population giving birth, continuing problems with the Medicaid enrollment process, and access problems that low-income pregnant women faced. Two other factors that may help to explain the lack of strong effects serve as the focus for this paper: the extent to which Medicaid is reaching its target population, and the extent to which Medicaid is substituting for employer-sponsored coverage.

Speculation on the latter issue has been fueled partly by the fact that following the expansions, growth in Medicaid-covered births vastly outpaced the decline in uninsured births, which indicates that there was a reduction in private insurance coverage during the expansion period. Indeed, some observers have argued that 50 to 100 percent of the increase in Medicaid coverage for pregnant women was attributable to the “crowding out” of private insurance. Crowding out is a phenomenon whereby more generous Medicaid eligibility policies that are designed to extend coverage to the uninsured may prompt some privately insured persons to drop their coverage to take advantage of the expanded public subsidy. This can have two major policy implications. First, the substitution of Medicaid for private coverage may lead...
to fewer improvements in access to care and health status than expected. Second, crowding out may lead to greater-than-expected increases in Medicaid spending.

The Medicaid expansions took place at a time of shrinking employer-sponsored coverage across the board. However, this fact alone does not mean that the expansions caused private coverage to decline. In fact, other observers have argued that the previous literature fails to adequately control for the secular declines in employer-sponsored coverage that were occurring over the period of analysis.

Our goal here is to document the changing picture of health insurance coverage for pregnant women in the four-year period following the Medicaid expansions and to assess the extent to which crowding out may have influenced trends. We attempt to build on the previous literature by identifying and analyzing insurance coverage of pregnant women and making an explicit attempt to account for secular changes in employer-sponsored insurance coverage over the period. A key contribution of this paper is that it examines the potential for crowding out at different eligibility thresholds.

Data And Methods

For this analysis we used The Urban Institute’s Transfer Income Model, Version 2 (TRIM2), a microsimulation model of tax and transfer programs affecting individuals and families. The database underlying TRIM2 is the March Current Population Survey (CPS), a nationally representative sample of the U.S. population. For this analysis, we used the 1989 and 1993 versions of the March CPS.

**Extent of crowding out.** Here we summarize the four steps used to estimate the extent of crowding out over the expansion period. First, because we believe that the potential for substitution of Medicaid for employer coverage varies dramatically by income, we examined how the distribution of insurance coverage of pregnant women changed between 1988 and 1992 separately for poor (family incomes up to 100 percent of poverty) and near-poor (family incomes of 100–185 percent of poverty) pregnant women. Second, we netted out the declines in employer coverage for a group likely to be unaffected by the expansions—men ages eighteen to forty-four—by income group, to explicitly control for the erosion of employer-sponsored coverage occurring over the period independent of the expansions. What remains is the amount of the decline in employer-sponsored coverage attributable to crowding out for each income group. Third, we divided the crowding-out effect by the increase in Medicaid enrollment for pregnant women to assess how much of the increase resulted from crowding out, by income group. Finally, we weighted our results by the percentage increase in the number of Medicaid-enrolled pregnant women over the time period in each income group.

**Caveats.** Several problems with the CPS data and limitations to our analysis should be noted. First, estimates of the uninsured from the CPS reflect the number of persons for whom none of the specified types of coverage is reported for the year (the default category). Ideally, respondents would be asked whether they had been uninsured for either part or all of the past year. Thus, if survey respondents are answering the questions as intended, the only persons reported as uninsured on the CPS are those without insurance for the entire year.

Second, persons responding to the CPS may be reporting their coverage status at the time of the interview, rather than their status during the previous calendar year, as requested. The evidence suggests a mix of responses among CPS respondents. For this analysis we assume that respondents are reporting coverage during the previous year. Third, participation in Medicaid and other income-related programs is almost certainly underreported because the number of persons on the survey who report participation is much lower than the number of program participants. We use the TRIM2 ed- ited version of the CPS to address this concern.
Fourth, a number of respondents reported having had both Medicaid and employer coverage over the past year. Women in this category are likely a mix of those who retained both Medicaid and employer-sponsored coverage for some part of the year and those who had Medicaid at some point during the year and employer coverage at another point. It is not clear how to interpret changes in the status of such respondents. We assume that half of them had only Medicaid coverage at a point in time and that the other half had only employer coverage. Therefore, counts of these respondents are split evenly between those who reported having had the two types of coverage in each of the two years.

Fifth, pregnant women are not explicitly identified on the CPS. We use an algorithm developed for other Urban Institute projects that identifies women who were pregnant in the year prior to the March survey. However, our approach underestimates the number of pregnant women. Also, it does not allow us to capture changes in insurance coverage that may have occurred during the last one to three months of pregnancy for those women whose infants were born between January and March of a given survey year.

Sixth, the CPS data are cross-sectional. A definitive analysis of the issue of crowding out requires the use of a longitudinal database to shed light on the dynamic nature of health insurance coverage. Since the only other work to date on this issue also uses the CPS, our analysis provides additional context for assessing those results.

Finally, we assume that changes in insurance coverage of men ages eighteen to forty-four are an appropriate control for what would have been expected for pregnant women independent of the expansions, since pregnant women are more likely than men to have dependent coverage. In fact, there is evidence to suggest that this is the case: Between 1989 and 1993 employee health insurance contributions rose by twice as much for family coverage as for individual coverage. Therefore, we believe that the likely bias in this analysis is to overestimate the crowding-out effect.

Results

In 1992, 33 percent of the pregnant women in our sample reported having Medicaid coverage at some point during the year they were pregnant, and 54 percent reported having employer-sponsored coverage (Exhibit 1). Almost 8 percent of all pregnant women were uninsured for all of 1992. The importance of Medicaid coverage varied tremendously by income group.

To what extent is Medicaid covering the target population? To determine the extent to which the Medicaid expansions have reached their target population, we calculated Medicaid participation rates for all eligible pregnant women. Two-thirds of all pregnant women who were eligible for Medicaid coverage were actually enrolled. This varied by Medicaid eligibility category. More than 90 percent of those women who were eligible through Aid to Families with Dependent Children (AFDC) eligibility were enrolled in Medicaid. Participation rates for the population made eligible through the poverty-related Medicaid expansions was lower, in part but not entirely because of the greater prevalence of employer-sponsored coverage among these women. Women with employer coverage who were eligible for Medicaid under the poverty-related expansions enrolled in Medicaid at a rate of 30 percent, while eligible women without employer coverage enrolled at a rate of 44 percent. Of those pregnant women who remain uninsured, 41 percent had family incomes below 100 percent of poverty, and 30 percent had incomes of 100–185
percent of poverty. Moreover, 81 percent of uninsured pregnant women were eligible for Medicaid coverage.

**Did the Medicaid expansions crowd out employer insurance?** To determine the extent of crowding out, we first examined changes in insurance coverage for pregnant women by income group and then compared the trends for pregnant women to those of a comparison group. Based on these differences, we estimated the extent of crowding out that occurred over the expansion period.

*Changes in health insurance coverage for the poor, 1988–1992.* For poor pregnant women (incomes below 100 percent of poverty), the share with Medicaid coverage increased by 4.4 percentage points between 1988 and 1992 (from 74.3 percent to 78.7 percent). In addition, the share of poor pregnant women with employer-sponsored coverage increased by 2.8 percentage points (from 6.5 percent to 9.3 percent). The share of poor pregnant women who were uninsured fell by almost seven percentage points, from 16.6 percent to 9.7 percent—a much larger decline than for all pregnant women, for whom the rate of uninsurance fell by only three percentage points.

These patterns suggest that the expansions resulted in a decline in the number of births to uninsured women living in poverty and virtually no crowding out of employer insurance. Given the dramatic drop in the percentage of poor pregnant women without insurance, the expansions in Medicaid appear to have provided a “safety net” for these women. The lack of crowding out is likely attributable in large part to the low level of employer insurance coverage for households at this income level.

*Changes in insurance coverage for the near-poor, 1988–1992.* Trends for near-poor pregnant women (incomes of 100–185 percent of poverty) were different. For these women, we observed a large decline in employer coverage and a commensurate increase in Medicaid coverage between 1988 and 1992 (from 53.1 percent to 38.8 percent and from 21.8 percent to 38.5 percent, respectively). There was virtually no change in the share of women in this income group who remained uninsured (from 15.9 percent to 16.2 percent), but near-poor pregnant women were the most likely to be uninsured among all income groups, at 15 percent of all births in 1992.

Although these trends are consistent with the possibility of crowding out for the near-poor, this evidence alone does not indicate whether the changes observed were the result of crowding out or were instead the result of secular changes in the insurance market that
Changes in insurance coverage for the comparison group. To explore the reasons for the shift from employer-sponsored to Medicaid coverage, we compared the experience of pregnant women with that of men ages eighteen to forty-four, who would not have been affected by the income-eligibility expansions. Given the lack of evidence of crowding out for poor pregnant women, we limit our comparison of trends to the near-poor. For men in this category, employer coverage dropped from 40.2 percent in 1988 to 33.4 percent in 1992. This loss of private coverage was offset to some extent by an increase of 2.2 percentage points in Medicaid coverage between 1988 and 1992 (from 6.4 percent to 8.6 percent). However, overall, the rate of uninsured men in this category rose by 5.7 percentage points, from 40.1 percent in 1988 to 45.8 percent in 1992.21

Exhibit 2 presents changes in insurance coverage for near-poor men and pregnant women. The decline in employer-sponsored coverage is much higher for pregnant women than for men in this income range. Also, near-poor pregnant women showed much larger increases in Medicaid coverage than did their male counterparts. Finally, near-poor pregnant women showed virtually no increase in uninsurance, while it increased for men.

These results indicate that there was likely some crowding out of employer-sponsored coverage for near-poor pregnant women as a result of the expansions. But the decline in employer-sponsored coverage for men suggests the possibility that some of the switching from employer coverage to Medicaid for pregnant women was unrelated to the expansions. If near-poor pregnant women had the

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**EXHIBIT 2**


<table>
<thead>
<tr>
<th>Percent change</th>
<th>Pregnant women</th>
<th>Men&lt;sup&gt;a&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>16.7</td>
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</tr>
<tr>
<td>10</td>
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<td>2.2</td>
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<tr>
<td>5</td>
<td></td>
<td>0.27</td>
</tr>
<tr>
<td>0</td>
<td>-6.8</td>
<td>5.7</td>
</tr>
<tr>
<td>-5</td>
<td>-14.3</td>
<td></td>
</tr>
<tr>
<td>-10</td>
<td></td>
<td></td>
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<tr>
<td>-15</td>
<td></td>
<td></td>
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<tr>
<td>-20</td>
<td></td>
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</tr>
</tbody>
</table>

**Employee-sponsored**<sup>b</sup> | **Medicaid** | **Uninsured** |
|-----------------------------------|--------------|---------------|

<sup>a</sup> Only persons ages 18–44 are included in these tabulations.

<sup>b</sup> Change in coverage is statistically significant at the 10 percent level.

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*Authors’ calculations using the TRIM2 edited version of the 1989 and 1993 March Current Population Surveys.*
same experience as men or nonpregnant women in their income group, for example, we would have seen increases of up to six percentage points in the uninsured share.

Extent of crowding out. How much of the increase in Medicaid coverage can be attributed to crowding out? From step three of our crowding-out estimation procedure above, we calculate that 45 percent of the increase in Medicaid coverage for near-poor pregnant women is the result of the crowding out of employer-sponsored insurance.\(^{22}\)

When we make separate estimates of the extent of crowding out for near-poor pregnant women with incomes of 100–133 percent of poverty and for those with incomes of 134–185 percent of poverty, we find that 27 percent and 59 percent, respectively, of the increase in Medicaid coverage over the period is attributable to the crowding out of employer insurance, although the standard errors are large because of the smaller sample sizes. Even though the data do not permit us to assess this definitively, the 27 percent crowding-out estimate for the group with income of 100–133 percent of poverty is consistent with that found for children up to age ten using the same methodology.\(^{23}\) Together these findings suggest that more crowding out will occur as Medicaid eligibility expansions move up the income ladder, and that there is much less crowding out for eligibility levels under 133 percent of poverty.

To estimate the total crowding-out effect, we must account for the fact that two-thirds of women gaining Medicaid coverage over the expansion period (for whom there was no apparent crowding out) had incomes below the federal poverty line. When we do this, using step four above, we estimate that 14 percent of the overall increase in Medicaid coverage for pregnant women that occurred between 1988 and 1991 is attributable to the crowding out of employer-sponsored coverage.\(^{24}\)

To shed light on what accounts for the increases in Medicaid enrollment over the period, we decomposed the increase in Medicaid coverage into its components (Exhibit 3). An estimated 71 percent of the increase in Medicaid enrollment was from pregnant women who would have been uninsured if it were not for Medicaid. And while 14 percent of the increase is attributable to declines in employer-sponsored coverage because of crowding out, almost an equal amount was attributable to declines in employer-sponsored coverage resulting from either the erosion of employer-sponsored coverage or business-cycle effects.

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EXHIBIT 3
Components Of Changes In Medicaid Coverage For Pregnant Women, 1988–1992

<table>
<thead>
<tr>
<th>Component</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Declines in uninsured</td>
<td>71%</td>
</tr>
<tr>
<td>Declines in other insurance</td>
<td>3%</td>
</tr>
<tr>
<td>Crowding out of employer coverage</td>
<td>14%</td>
</tr>
<tr>
<td>Declines in employer coverage</td>
<td>12%</td>
</tr>
</tbody>
</table>

This latter group likely would have been uninsured if not for Medicaid expansions.

Discussion

Do our results explain the lack of strong effects found for the Medicaid eligibility expansions for pregnant women? Certainly, the low Medicaid participation rates for pregnant women covered under the expansions are a partial explanation for the lack of a strong impact. The reason for the low participation rates is unclear. Further research is needed to aid our understanding of whether women who are eligible under the poverty-related expansions are unaware of their eligibility for Medicaid, whether they are unwilling to enroll because of the stigma associated with Medicaid coverage, or whether major problems remain in the eligibility determination process. Given the large percentage of uninsured pregnant women who are eligible for Medicaid, it is important for states to develop strategies to identify such women and to help them receive services early in pregnancy.

Also, the apparent shift from employer-sponsored to Medicaid coverage for the near-poor, resulting from both the erosion of and the crowding out of employer coverage, means that Medicaid is substituting for some of what would have been private insurance coverage in prior years. This may account, in part, for the lack of strong improvement in access to prenatal care and birth outcomes for the nation as a whole. It is possible, however, that states that raised the income threshold for pregnant women only up to the mandated level (133 percent of poverty) and had low AFDC eligibility thresholds or low levels of employer coverage prior to the expansions may have had less crowding out and may therefore see more positive effects from expanded eligibility than other states.

Policy implications. First, given that the Medicaid expansions took place when employer coverage was deteriorating, the number of pregnant women lacking insurance coverage almost certainly would have risen in the absence of more generous coverage policies for pregnant women—a trend that would have been most acute for the near-poor.

Second, extending Medicaid coverage up to the federal poverty level is likely to involve very little crowding out and to greatly reduce the number without insurance. However, extending Medicaid coverage above the poverty level may well lead to crowding out, given the greater extent of employer-sponsored coverage of the near-poor and the untenable financial burden these families may face to retain such coverage. The effect is likely to vary according to how far above the poverty line eligibility is increased. At the same time, limiting Medicaid coverage to those in poverty will leave a large number of near-poor persons without insurance coverage. States that raise eligibility standards above the federal poverty line may want to implement policies that encourage employers and individuals to maintain their level of effort.

Several states with Medicaid Section 1115 waivers have proposed or implemented such policies. For example, Hawaii mandates that employers provide insurance to all full-time employees, and Rhode Island requires that children and pregnant women with incomes over 185 percent of poverty be under- or uninsured to obtain Medicaid coverage. In addition, some states have begun to take advantage of federal legislation that allows Medicaid to pay copayments, deductibles, and premium contributions under the employer plans of Medicaid-eligible persons in an effort to maintain employer contributions.

Our research raises three important public policy questions. To what extent does Medicaid crowd out private insurance with expansions of the program? For what reasons do women who choose to substitute Medicaid for employer-sponsored coverage do so? And what is the trade-off with such expansions between crowding out and no insurance at all? Definitive information on each is essential for policymakers who are considering further changes to the Medicaid program.

H E A L T H A F F A I R S - J a n u a r y / F e b r u a r y 1 9 9 7
NOTES


4. D. Cutler and J. Gruber, “Does Public Insurance Crowd Out Private Insurance?” *Quarterly Journal of Economics* (May 1996): 391–429. Their crowding-out estimate of 50 percent includes the “conditional coverage” of women of childbearing age, while the 100 percent estimate does not. The theory about conditional coverage is that nonpregnant women of childbearing age will drop their employer-sponsored coverage because they know that if they were to become pregnant they would be covered by Medicaid.

5. This does not mean to imply that employer coverage is preferable to Medicaid. Medicaid covers all preventive care visits and some enhanced services and does not require deductibles and copayments; private insurance coverage often entails cost sharing, which may inhibit some low-income women from obtaining timely or comprehensive obstetric care. Yet the well-documented access and quality problems within Medicaid may present major barriers to timely and appropriate care for some pregnant women. Therefore, substituting Medicaid for employer coverage could lead to better or worse access and outcomes, depending on the characteristics of both coverages.


8. The previous literature analyzed all women of childbearing age, not just pregnant women, which is a problem since only pregnant women are eligible under the expansions.


10. Other things equal, we would have preferred to use the 1987 or the 1988 March CPS, which captures insurance coverage in 1986 and 1987, as preexpansion years. We chose not to do so because changes in CPS questions and improvements to the TRIM2 model that occurred during this period distort comparisons with later years. The 1989 version of the CPS is the first year that contains both the revised CPS questions and the improved TRIM2 methodology. Therefore, we use the TRIM2 edited version of the March 1989 CPS—income and health insurance coverage for March 1988—as our base year. Use of the March 1988 CPS as a base-year file underestimated any changes that occurred as a result of the expansions, given that twenty-five states had increased Medicaid eligibility for pregnant women to 100 percent of poverty by March 1988. However, it still allows us to examine the direction and sources of changes in coverage. We believe that the underestimation will affect only poor women and will be minimal because information from the hospital discharge survey shows that the increase in Medicaid-covered deliveries was small (1.26 percentage points) between 1987 and 1988, compared with almost four percentage points between 1988 and 1989, 1989 and 1990, and 1990 and 1991. These data suggest that there was a lag between when expansions were implemented on paper and when women knew about their eligibility and enrolled, and that the use of 1988 data as a base year is reasonable.
mated our analysis using only states that raised eligibility to 100 percent of poverty after 1988 and still found no crowding out of employer coverage for the poor. Thus, we believe that our estimates using the later data are reliable.

11. Additional details are available from the authors at The Urban Institute, 2100 M Street, NW, Washington, DC 20037.

12. In 1988, 51 percent of persons with family incomes of 100–200 percent of poverty had employer-sponsored coverage, whereas only 13 percent of those with incomes below 100 percent had such insurance. Holahan et al., “A Shifting Picture of Health Insurance Coverage.”


14. The TRIM2 model uses the health insurance questions and other data from the CPS to create health insurance status indicators for each individual. In addition, TRIM2 corrects for under-reporting of Medicaid enrollment and identifies each Medicaid-eligible person’s eligibility category. To do this, TRIM2 passes each person on the CPS through the various state rules for Medicaid eligibility to identify which persons are eligible for coverage. Statistical procedures are used to choose enough additional persons from the pool of eligible persons who did not report coverage on the CPS to match the known enrollment figures. For example, after correction, TRIM2 identified 24.3 million Medicaid enrollees on the March 1991 CPS, a figure much closer to the 24.7 million known to have been enrolled than to the 19.6 million reporting coverage on the uncorrected CPS. The TRIM2 model aligns program enrollees with known enrollment figures in each state by age and disability group. When we use the unedited CPS, our crowding out estimates remain unchanged.

15. We first identify all infants under age one. We then match infants to their mothers using information on family structure and assume that the mothers were pregnant during the previous year.

16. This occurs because (1) women who were pregnant during the year but did not deliver in the relevant March-to-March period are not identified; and (2) not all infants can be matched with a mother. The former issue should not bias analyses of the percentage of pregnant women with certain characteristics, because we are simply taking a sample of pregnant women in a given year: those who delivered their children in the twelve months prior to the survey. The latter issue may affect our results somewhat if the dimensions we are examining (income or insurance coverage) are correlated with our inability to identify the mother.

17. Although we are not certain of either the direction or the magnitude of this effect, we believe that it is likely to result in a slight underestimation of Medicaid coverage and a corresponding overestimation of employer-sponsored coverage and the uninsured. Based on 1991 data in California, Georgia, Michigan, and Tennessee, we estimate that between 8 and 18 percent of all Medicaid-financed deliveries are to women who enrolled in Medicaid in the third trimester of pregnancy. From this we estimate that the lack of information on changes in insurance status of these women in their last months of pregnancy could translate into an underestimate of Medicaid coverage by 3.75 percent when the whole sample is considered but should not affect estimates of changes in health insurance coverage. In addition, it may slightly underestimate actual Medicaid participation rates.


19. Of changes in the rates of poor pregnant women with Medicaid coverage, employer-sponsored coverage, and no insurance coverage, only the change in the rate of the uninsured was statistically significant at the 5 percent level.

20. At the 5 percent level, changes in the rates of employer and Medicaid coverage for near-poor pregnant women were statistically significant; changes in the rate of uninsured near-poor pregnant women were not statistically significant.

21. Significant at the 5 percent level.

22. That is, take the difference between the percentage point changes in employer-sponsored insurance for near-poor men ages eighteen to forty-four and near-poor women and divide it by the percentage point change in Medicaid coverage for near-poor pregnant women.


24. The assumption that all those reporting both Medicaid and employer-sponsored coverage had employer coverage in 1988 and had Medicaid in 1992 gives an upper-bound estimate on the crowding-out effect of 19 percent.