Finding Practical Solutions To ‘Crowding Out’

To extend coverage to the uninsured, we must find ways to stem the substitution of Medicaid for private insurance.

by Richard Curtis, Mark Merlis, and Ann Page

The findings of David Cutler and Jonathan Gruber, and Lisa Dubay and Genevieve Kenney, have important implications for the design of proposals to expand Medicaid or other public coverage to reach uninsured children, most of whom have a working parent. As one ascends the income scale, more and more members of the target population are eligible for employer coverage, and a steadily larger share of any new public investment could go not to cover the uninsured but to replace current employer contributions. Moreover, much of this gain would be realized not by small, low-wage firms, which rarely provide coverage, but by large firms with some low-wage workers.

The substitution of Medicaid for private dollars and private coverage not only represents an inefficient use of scarce public funds but also may have negative effects for beneficiaries. Medicaid beneficiaries have often faced access barriers, largely because of low Medicaid provider payment rates. The shift from employer coverage to Medicaid often forces a change in providers, which may reduce continuity of care. Also, many families prefer private coverage simply because of the welfare stigma associated with Medicaid.

Offsetting these considerations, however, are very strong financial incentives to prefer Medicaid. Most employers require workers to contribute to health insurance premiums, and required contributions are larger for family coverage. Moreover, Medicaid imposes only nominal cost sharing—or none at all—and provides broader benefits, especially for children, than typical private plans do. These cost differences are presumably the major factor in crowding out.

As Cutler and Gruber point out, one way of limiting the crowding-out effect would be to change the financial incentives. For families with access to employer group plans, Medicaid could assist with the employee costs for that coverage, instead of providing benefits directly. This would prevent families from shifting from employer-based coverage to Medicaid. It also might encourage participation in employer plans by families who are now forgoing coverage altogether: Public dollars could leverage private dollars to extend coverage to uninsured families.

In fact, federal law already requires state Medicaid programs to pay the employee share of costs for group coverage for a Medicaid-eligible worker or a worker with Medicaid-eligible dependents when it would be cost-effective to do so—that is, when the cost of buying into the employer coverage is less than the expected cost of providing equivalent Medicaid benefits.

This provision, enacted in 1990, might have
been expected to prevent much of the crowding out of private coverage that has been observed. In practice, however, most states only buy into employer coverage for a very small number of beneficiaries who can be expected to incur very high costs, such as persons with acquired immunodeficiency syndrome (AIDS) or other expensive conditions. Although the data suggest that a large proportion of nonwelfare Medicaid beneficiaries—particularly those above the poverty level—may have access to employer plans, state Medicaid programs have not taken advantage of this potential coverage.

**Barriers To Enrolling Beneficiaries In Private Plans**

A few states, such as Iowa and Texas, have moved more aggressively to enroll Medicaid beneficiaries in private plans. However, they have encountered a number of legal or practical barriers. Even identifying persons with potential coverage and obtaining plan information from employers have been problematic.

Medicaid applicants may not always disclose the availability of coverage from their employer, and if they are not enrolled in the employer plan, they may have no detailed information about it. States can bypass applicants and seek basic availability information directly from employers. For example, Iowa has added health insurance questions to the earnings verification forms used in the eligibility process. However, states have had less success in obtaining the detailed information they need on benefits and charges. Under the Employee Retirement Income Security Act (ERISA), it is not clear that self-insured employers have any obligation to furnish health plan information to workers who are not participating in the plan. ERISA’s preemption of state action might mean that the state itself could not require the release of information. Employers, of course, have little incentive to cooperate with existing state initiatives to increase participation in employer plans.

**Assessing cost-effectiveness.** Under current federal guidelines, states are expected to compare the employee costs for a given employer group plan with the average costs of providing the equivalent Medicaid benefits to demographically comparable recipients. Some states have difficulty compiling the Medicaid spending data needed to use the federal formula. Moreover, the guidelines require that the Medicaid comparison data be adjusted to match every minor variation in employer plans; the comparison must be performed separately for employer plans with and without dental care, with different levels of cost sharing, and so on. The Health Care Financing Administration (HCFA) has approved streamlined methodologies in some states, but case-by-case cost-effectiveness assessment remains administratively burdensome.

**The enrollment process.** Many employers allow workers to enroll in their health plan only at the start of employment, during an annual open enrollment period, or at the time of a “qualifying event,” such as loss of spousal coverage as a result of divorce or death. As a result, many months can elapse between the time a family applies for Medicaid and the next opportunity to enroll in the employer plan. One solution, which would require federal legislation, might be to require employers and insurers to treat the establishment of Medicaid eligibility as a qualifying event and allow midyear enrollment in the employer plan. One concern raised by this approach is that limited open enrollment periods are designed to prevent workers from obtaining coverage only when they become sick. An exception for Medicaid beneficiaries arguably might promote adverse selection. However, the effect on individual employers could be limited by small-group market reform leg-
islation in the states. Also, it might be argued that, to the extent that some women have shifted from private coverage to Medicaid during a pregnancy, adverse selection has actually been in the opposite direction.

Cost sharing and wraparound coverage. Under current law states must pay, in addition to the employee share of premiums, all deductibles, coinsurance, or other cost sharing required under the employer plan. In addition, direct coverage must be provided for Medicaid benefits not included in the private plan. Because of the enormous variation in employer benefit packages, states have found administration of these wraparound requirements especially burdensome. If Medicaid coverage is extended to higher-income populations, it may be appropriate to consider whether certain employer plans might be deemed sufficient, without a need for supplemental Medicaid benefits. (Some participants, such as children with special needs, still would require wraparound benefits.)

Improving The Public/Private Coverage Fit

Resolution of some of these technical issues might encourage states to make greater use of the private coverage that is potentially available to Medicaid beneficiaries. However, broader measures to improve the fit of public and private coverage should be considered in the design of any proposals that affect persons further up the income scale. First, sliding-scale subsidies might be used as an alternative to current Medicaid policies, under which families get full coverage or nothing. This could help more families to meet their employer contributions while reducing the incentive to drop employer coverage for free Medicaid. Second, subsidy programs might be coordinated with the employer purchasing organizations now growing in many states. This could promote greater continuity of coverage while possibly encouraging more small firms to participate in these arrangements.

Some people are concerned that measures to maximize employer coverage will some-how penalize low-income workers—for example, that employers will reduce wages if more employees accept health insurance. As John Holahan notes, however, any gains employers have realized from crowding out have been almost imperceptible; the same is likely to be true of any added expenses they incur as a result of corrective measures. Only a small portion of employees of most firms that make significant health insurance contributions would qualify for low-income subsidies. In addition, despite some recent erosions, employer contributions will be an important potential source of children’s coverage for the foreseeable future. Finding practical solutions to the problem of crowding out is critical to the political credibility of coverage expansion proposals and should be a major focus in the design of any new initiatives.

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