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Changes in Health Care Financing & Organization (HCFO)

findings brief

Consequences of SCHIP Expansions for Household Well-Being

key findings

- Substituting private insurance with SCHIP coverage is associated with an increase in non-health spending in families, and most of this increase in spending is allocated to transportation and saving for retirement
- This result suggests that SCHIP eligibility improves the material well-being of low-income families that it is intended to assist

In 2008, approximately 7.4 million children in the United States received health insurance coverage through the State Children's Health Insurance Program (SCHIP). SCHIP coverage expansions and widening eligibility standards can lead to the substitution of private coverage for public insurance coverage, a phenomenon known as crowd-out. Understanding crowd-out is important in assessing the overall impact and value of investments made in SCHIP. If there is extensive substitution of private coverage for public coverage, the program may not meet its goal of reducing the number of uninsured children. Recent research estimates SCHIP crowd-out to be approximately 60 percent.[1] While much of the research to date has focused on the potential negative effects of a high rate of crowd-out, there has been little examination of how coverage substitution improves the economic well-being of families opting for SCHIP coverage.

Study Overview

In a HCFO-funded study,[2] Helen Levy, Ph.D., and colleagues Lindsey Leininger and Diane Whitmore Schanzenbach set out to explore whether the crowd-out effect of SCHIP could, in fact, result in a windfall for families. The primary motivation for substituting public for private coverage for eligible families is clear—SCHIP and other forms of public insurance require less cost-sharing than typical private insurance plans and provide some insulation from financial risk. By reducing the level of out-of-pocket health care costs, families should have a greater share of their total economic resources available for other uses. "We wanted to know: if you sign up for public coverage and that saves you some money, what do you spend that money on?" says Levy.

The researchers framed their analysis in terms of the consumer's budget constraint. The availability of health insurance affects medical and non-medical spending in different ways. For the newly eligible population, the researchers estimated that becoming eligible for SCHIP would have three effects: less out-of-pocket medical spending, less spending on insurance premiums (which, in theory, would also result in higher wages), and a decrease in precautionary household saving. The analyses were designed to shed light on the precise nature of these shifts in spending; the goal was to uncover the complete picture of the benefits of public coverage for low-income families.

Robert Wood Johnson Foundation

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Analysis

The researchers used data from the Consumer Expenditure Survey (CE) Interview Component public use files for 1996-2002. These survey data reflect spending patterns from a nationally representative sample of households. It is considered to be the best widely available data source on household consumption in the United States. The researchers restricted their sample to households with children 18 and under, resulting in 51,188 quarterly observations on 18,386 unique households. The dependent variables were out-of-pocket health spending (spending on both insurance and medical care) and non-health spending, which included several items such as housing, food, transportation, clothing, and retirement.

The CE also includes information on income, household composition, and demographics. Dr. Levy and colleagues used this information, along with the published Medicaid and SCHIP eligibility rules in each state, to determine the number of family members in each household who were eligible for public coverage. The proportion of households with an eligible member grew over the study period. In 1996, 39 percent of sample households included at least one eligible member, and by 2002 that proportion had grown to 48 percent. The final analysis employed several different methods including a difference-in-differences approach, multivariate instrumental variables models, and basic descriptive statistics on study households.

Key Findings

For households with incomes falling between 100 percent and 200 percent of the Federal Poverty Level (FPL), there has been a tremendous increase in those eligible for public insurance; 16 percent in 1996 to 51 percent in 2002. Other income groups saw smaller eligibility changes during the period.

Overall health spending declined slightly for families with incomes at 100 to 200 percent FPL, while it increased for other income groups. Analyses suggest that health spending is lower in families eligible for public insurance, with estimated savings ranging from $361 to $441 per quarter. This estimate is consistent with initial calculations by the researchers to estimate the potential health savings from SCHIP coverage take up. The reduction in health spending increased non-health consumption, with the largest spending increases in transportation and retirement savings.

Study Limitations

The researchers acknowledge two key limitations to their study. First, households with incomes at 100 to 200 percent FPL were not affected solely by SCHIP eligibility changes; there were significant tax changes and other relevant programs that targeted this population during the study time period. These include expansions of the Earned Income Tax Credit and the 1996 welfare reform measures. These changes, as well as a thriving economy, had an influence on consumption. Secondly, the researchers emphasize that while patterns in the data are consistent with the notion that SCHIP expansions resulted in lower health spending and higher total consumption in targeted households, the effects are imprecisely estimated and they cannot rule out very large effects on consumption or no effect at all.

Implications for Policy and Practice

The results suggest that SCHIP expansions can improve the well-being of low-income households. SCHIP eligibility allowed families to shift their financial resources from medical premiums and out-of-pocket health costs to other forms of consumption. This study provides policymakers with valuable information on how families can reallocate limited resources to improve their material well-being, in addition to lowering health spending. "Ultimately the point of transfer programs is to make households in the target population better off," says Levy. "Evaluating whether or not they are better off means looking at overall well-being, not just at one or two outcomes."

While this study provides important additional information on the value of SCHIP, the authors note that other information is needed for a complete analysis of the costs and benefits of the program. In particular, there is a need for a correct estimate of the marginal cost of raising the public funds used to pay for SCHIP to better understand the program's financing. Additionally, a full accounting of SCHIP benefits should include estimates of the program's potential for risk reduction among low-income families.

Conclusion

The Patient Protection and Affordable Care Act (Affordable Care Act or ACA) extends SCHIP reauthorization through 2015 and in that year provides an increase in the federal matching rate. The ACA also mandates that states maintain their current income eligibility levels through 2019 and prohibits states from enacting more restrictive standards than those in place when the law was enacted in 2010.

The costs and benefits of SCHIP will continue to be closely examined as states work to balance their budgets while also covering uninsured children. While crowd-out can create inefficiencies, it also has the potential to raise the well-being of low-income families and provide some protection from financial burdens for this vulnerable population. "When we talk about coverage expansions we tend to focus on 'how will this improve health?' when in fact there are lots of other outcomes that may be affected positively when a household becomes eligible for public coverage," says Levy.

For More Information

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Endnotes

1. Gruber, J. and Simon, K. "Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?," *Journal of Health Economics*, Vol. 27, No. 2, March 2008, pp. 201-217.
2. For additional details on the analysis and complete findings see Leninger, L., Levy H., and Schanzenbach, D. "Consequences of SCHIP Expansions for Household Well-Being," *Forum for Health Economics & Policy*, Vol. 13, No. 1, June 2010, Article 3.