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Medicaid Expansion, Crowd-Out, and Limits of Incremental Reform

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MEDICAID EXPANSION, CROWD-OUT, AND LIMITS OF INCREMENTAL REFORM

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Medicaid is the cornerstone of America's efforts to bring health insurance coverage to the poor and disabled. It anchors the public side of our mixed public-private system, which seeks to provide coverage for the poor, elderly and disabled, leaving all others to obtain coverage through private markets. But this system has an enormous gap: 45 million Americans are covered neither by public nor private insurance. Even in prosperous times, that gap is growing. In the absence of national interest in a dramatic shift in health finance, our mixed public-private system must adjust to reverse, or at least keep up with this trend. No health finance task is more important, as those without insurance coverage suffer increased risk of sickness and earlier death, as well as exposure to impoverishment caused by health expenditures.

Incremental efforts over the past fifteen years have attempted reform within the public-private system by targeting relief to those in the gap between private coverage and existing public programs. Medicaid, along with its new sister program, Children's Health Insurance Program ("CHIP"), has played a central role in the legislative attempts to knit together more closely the American system of health coverage.[1] The reality of growing ranks of uninsured low-income families has sparked further interest in incremental reform through public program expansion. As with past efforts, these reforms seek to provide coverage for low-income uninsured, while maintaining the private employment-based insurance system as the dominant source of health coverage.[2]

This Article examines one potentially significant factor determining the success of incremental reform: the problem of the displacement of private

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1. *See infra* notes 43-44.
2. *See* discussion *infra* Part II.

coverage by public program expansion. Efforts to reduce uninsurance by expanding public programs is demonstrably displacing private coverage to a small, but probably growing degree. Crowd-out, as this displacement is known, occurs at the boundaries between public and private systems.[3] As public programs expand, some of the new beneficiaries are not long-time uninsured, but rather are workers or their dependents who drop or forego private coverage. This displacement of private coverage raises the price of incremental reform, and marginally weakens the private insurance system.

This displacement is a minor problem today. Recent attempts to expand public insurance have been troubled more by a shortage of applicants than by massive flight from private coverage.[4] In the near term, displacement of private coverage is unlikely to rise to levels high enough to justify public policy concern. However, Congress has mandated a study of the issue in connection with one recent expansion, CHIP.[5] While state and federal officials have been diverted to the more important task of identifying, enrolling and retaining eligible children, the issue of displacement has received little attention. However, the studies are likely to bring the issue back to the forefront if officials overreact to reports of some level of crowd-out. It is one thesis of this Article that such overreaction can be avoided if officials anticipate some reasonable level of crowd-out and respond to its emergence proportionately and reasonably.

The second thesis of this Article is that crowd-out serves as a true marker of a fundamental fault in our mixed health finance system, and that the phenomenon of crowd-out challenges the notion that we are well-served by shoring-up the private employment-based system as our dominant source of coverage. It is a tenet of incrementalism that the rate of uninsurance may be reduced through government subsidization of health insurance for those near the border between public programs and private coverage. For this to be done "efficiently" (without eroding private coverage and minimizing the public cost of expanding coverage), those with access to private coverage must be barred from the new opportunities for public subsidy. But, as the cost-sharing obligations of insured low-income workers increase, barriers to enrollment in public plans are ineffective unless draconian, and if draconian, they seem to clash with the fundamental goals of equitable access to government subsidy and reliable and continuous access to insurance coverage for all Americans. Therefore, the now-minor problem of crowd-out signals an opportunity to reconsider the fundamental mix of private and public coverage in our health finance system.

3. *See* discussion *infra* Part II.
4. *See infra* notes 80-103.
5. *See infra* notes 133-36.

Part I of this Article describes the trend of increased uninsurance and discusses why this trend poses a significant public policy problem. It then discusses the current incrementalist strategy of expanding public programs to reduce uninsurance. Part II describes crowd-out as a phenomenon by which insurance expansion efforts exhibit less than surgical precision, displacing private insurance to some extent. Part III evaluates the significance of crowd-out, arguing that crowd-out is best understood in the near term as a minor wrinkle in an otherwise smooth course of incremental reform. It goes on to argue that crowd-out may be seen as more than a technical glitch in public program expansion, but instead reveals substantial faults in our public-private finance system. Ultimately, if workplace economics continues to cause shrinkage in the rate of employment-based coverage, public programs may be forced from their current stop-gap role to one of the dominant sources of insurance for working Americans.

I. THE EROSION OF PRIVATE INSURANCE COVERAGE AND THE EXPANSION OF MEDICAID

A. The Private Side: The Problem of Uninsurance

It is tempting to permit the numbers to speak for themselves when discussing modern health coverage trends. The percentage of non-elderly Americans without health coverage rose from 13.8% in 1977 to 19.2% in 1996,[6] and the trend has continued.[7] Those living below the poverty level fared the worst, with thirty-five percent of the non-elderly uninsured,[8] but the "near-poor" fared little better, at thirty-two percent.[9] Even these numbers tend to underestimate the extent of the problem. Many people not counted among the ranks of the uninsured nevertheless suffer breaks in health coverage. About 71.5 million Americans were without health insurance for some portion of 1998.[10] In addition, a large and growing number of families—perhaps as

6. Jon R. Gabel, *Job-Based Health Insurance, 1977-1998: The Accidental System Under Scrutiny*, HEALTH AFF., Nov.-Dec. 1999, at 71.

7. *See* U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, HEALTH, UNITED STATES, 1999 WITH HEALTH AND AGING CHARTBOOK 14 (1999) (reporting that the total percentage (including the elderly) uninsured rose from 15.6% in 1996 to 16.1% in 1997).

8. *See* ELLEN O'BRIEN & JUDITH FEDER, THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, EMPLOYMENT-BASED HEALTH INSURANCE COVERAGE AND ITS DECLINE: THE GROWING PLIGHT OF LOW-WAGE WORKERS (1999), *available at* http://www.kff.org/contents/1999/2134/2801plightoflowwageworkers.pdf.

9. *Id.* The "near poor" have incomes between 100% and 199% of poverty. *Id.*

10. Robert Kuttner, *The American Health Care System: Health Insurance Coverage*, 340 NEW ENG. J. MED. 163, 164 (1999). *See* Stuart H. Altman et al., *Healthcare for the Poor and Uninsured: An Uncertain Future, in* THE FUTURE U.S. HEALTHCARE SYSTEM: WHO WILL CARE FOR THE POOR AND UNINSURED? 2-3 (Stuart H. Altman et al. eds., 1998) [hereinafter THE

many as those without any coverage— are "underinsured," meaning that their insurance does not protect them from spending ten percent or more of their family income on health care.[11]

The lack of health insurance is more than a financial matter. It is a matter of health, and indeed of life and death. "A substantial body of literature demonstrates that people without health insurance are less likely to seek medical care, less likely to get it, and, as a result, are likely to experience worse health and higher death rates than people who have insurance protection."[12] The problems raised by uninsurance are particularly acute for children, for whom the lack of insurance means deprivation of preventive care such as routine diagnostic and screening examinations and immunizations, as well as care for chronic childhood conditions such as asthma and ear infections, at a time when such deprivation will have maximum impact on physical and cognitive development.[13]

The statistics on uninsurance spell at least short-term problems for American workers and their families. The longer-term issues revolve around the *reasons* for this decrease in private insurance coverage, and the prospects for future improvement, or, alternatively, further erosion in employment-based coverage. The ranks of the uninsured are swollen with low-income workers who are either not offered insurance, or are offered it on terms that require a level of cost sharing that they cannot, or will not, meet. The uninsured

FUTURE U.S. HEALTHCARE SYSTEM] ("[N]early 24% of those interviewed in March 1995 had been uninsured in the week prior to the interview. Among those under age 65, this number jumps from 24% to nearly 27% . . . .") (footnote omitted).

11. Uwe E. Reinhardt, *Employer-Based Health Insurance: R.I.P.*, *in* THE FUTURE U.S. HEALTHCARE SYSTEM, *supra* note 10, at 325 ("To be uninsured means that gaps in coverage leave an insured family exposed to a significant risk of losing a large fraction of its income to illness."). *See* Kuttner, *supra* note 10, at 165-66 (reporting rising rates of uninsurance, defined as gaps in insurance coverage leading to out-of-pocket expenditures of ten percent or more of family income on health care).

12. Diane Rowland et al., *Uninsured in America: The Causes and Consequences*, *in* THE FUTURE U.S. HEALTHCARE SYSTEM, *supra* note 10, at 25. *See* U.S. CONGRESS, OFFICE OF TECHNOLOGY ASSESSMENT, DOES HEALTH INSURANCE MAKE A DIFFERENCE? BACKGROUND PAPER 18-19 (1992) ("[T]here is considerable evidence that the activities of health professionals in caring for patients may vary in relation to the insurance status of the patient . . . . [I]nsurance coverage plays a role in decisions to order procedures or otherwise use health resources . . . . [However,] studies which attempt to demonstrate direct relationships between the activities of health professionals in caring for patients and the outcomes of that care in terms of patient health are scarce.") (citation omitted).

13. Kuttner, *supra* note 10, at 165. *See* Families USA, *One Out Of Three: Kids Without Health Insurance 1995-96* (March 1997), *at* http://www.familiesusa.org/kwohi.html (last visited Aug. 14, 2000); Jeffrey J. Stoddard et al., *Health Insurance Status and Ambulatory Care for Children*, 330 NEW ENG. J. MED. 1421 (1994).

overwhelmingly (seventy-three percent)[14] are in families with at least one full time worker,[15] most of whom work in low-wage jobs.[16] The problem of uninsurance therefore increasingly concerns the working poor, and not only the destitute unemployed.[17]

Several closely-related trends converge to explain the erosion of insurance coverage among the working poor. The cost of employee health coverage has risen in relation to background inflation over the last fifteen years.[18] This inflationary trend flattened in the mid-1990s,[19] due in part to the one-time effects of the general shift to managed care financing.[20] In more recent years,

14. *See* O'BRIEN & FEDER, *supra* note 8, at 2. Eighty-five percent of the uninsured live in families with at least one full or part-time worker. *Id.*

15. *Id.* Seventy-nine percent of uninsured persons with family incomes between 100% and 199% of the poverty level live in a family with at least one full-time worker; 90% of the uninsured near-poor live in families with at least one full-time or part-time worker. *Id.*

16. *Id.* at 2. *See* JOHN HOLAHAN & NIALL BRENNAN, THE URBAN INSTITUTE, WHO ARE THE ADULT UNINSURED? 4 (2000), *available at* http://www.newfederalism.urban.org/htm/series_b/b14/b14.htm (only twenty-one percent of low income (i.e., income below 200% of the federal poverty level) live in families without a worker).

17. One group of the very poor has not benefited from recent Medicaid expansions: childless adults without permanent and total disabilities remain outside the reach of federal public insurance programs. *See* Rowland et al., *supra* note 12, at 30.

18. Katherine Levitt et al., *Health Spending in 1998: Signals of Change*, HEALTH AFF., Jan.-Feb. 2000, at 125.

19. *Id.* at 124-25.

20. *See* Kuttner, *supra* note 10, at 166-67 ("Although managed care dramatically reduced the inflation in health insurance costs for employers in the mid-1990s, this seems to have been a one-time savings. The underlying demographic and technological trends are unchanged, and employers and benefit consultants report sharply rising premiums in 1999."). The cost-savings derived from the general adoption of managed care financing flowed from the superior ability of managed care plans to bargain with health care providers for price savings. The savings are "one-time" in the sense that the benefits of this bargaining with respect at least to hospital and other institutional services seem to have squeezed about as much marginal benefit to the plan as can be reached without seriously challenging the solvency of these institutional providers. *See also, The Balanced Budget Act of 1997: A Look at the Current Impact on Patients and Providers: Testimony Before the House Subcommittee on Health and Environment, Committee on Commerce* (2000) (statement of Gail R. Wilensky, Chair, Medicare Payment Advisory Commission), *available at* http://com-notes.house.gov/cchear/hearings106nsf (last visited Aug. 8, 2000) (although hospital revenues have suffered from federal reimbursement changes, three-quarters of the decline in margin from 1997 to 1998 are attributable to payment policies of private managed care plans; reductions in margin are sufficient to trouble financial markets); Peter Wehrwein, *Follow the Shrinking Managed Care Savings*, MANAGED CARE MAG., Jan. 1999, at 32 (managed care has squeezed out excess cost in health care delivery, is now casting about to achieve savings through other means). That the savings are "one-time" is not to minimize their importance. If, as it appears, health insurance inflation is returning (mostly due to factors beyond the control of managed care, including the aging of the population and the continuing development of efficacious new pharmaceuticals and technologies), costs will at least rise from a lower cost base as a result of the savings realized by managed care.

however, health insurance inflation is back, with premium increases that approach the double-digit levels of the early 1990s.[21] As a result of this inflation, employers are facing sharply increasing costs for employee health coverage.[22]

At the same time, the American workplace is changing in ways that have made health coverage for low-wage workers less available. Jobs in the "new economy," although increasing in number, have shifted slowly from large to small firms, from full-time to part-time jobs and from manufacturing to personal services.[23] As a result, the increase in the number of jobs in this economy does not translate into broad economic advancement for the working poor. One other important change in the workplace in recent years has been the growing gap in income between the rich and poor. Since 1980, while the real (inflation adjusted) income of the wealthiest rose, the income levels of families in the bottom twenty percent of income distribution fell in inflation-adjusted terms.[24] The experience of falling real wages was visited with particular force on less educated workers, who will be unable to advance in an increasingly information-based and technology-hungry economy.[25]

21. *See* JOEL E. MILLER, NATIONAL COALITION ON HEALTH CARE, DEJA VU ALL OVER AGAIN: THE SOARING COST OF PRIVATE HEALTH INSURANCE AND ITS IMPACT ON CONSUMERS AND EMPLOYERS 5-7 (2000), *available at* http://www/nchc.org/survey.html (n.d.); Levitt et al., *supra* note 18, at 131-32.

22. Levitt et al., *supra* note 18, at 131-32.

23. Kuttner *supra* note 10, at 167; Jon R. Gabel, *Job-Based Health Insurance, 1977-1998: The Accidental System Under Scrutiny*, HEALTH AFF., Nov.-Dec. 1999, at 72.

24. O'BRIEN & FEDER, *supra* note 8, at 12 ("Between 1979 and 1995, the average real wage stagnated and wage inequality increased as high-wage workers received real gains, while the remainder of the wage structure fell . . . . [R]eal wages declined for lower paid and less-educated men and women, as well as for workers in low-skill occupations, while real wages rose for highly paid and more educated workers and those in high-skill occupations."). *See* PAUL KRUGMAN, PEDDLING PROSPERITY 130-35 (W.W. Norton & Co. ed., 1994) (noting that the income of the families in the top one percent doubled from 1977-1989, while that of families in the bottom forty percent fell).

25. Joel F. Handler, *Low-Wage Work "As We Know It": What's Wrong/What Can Be Done*, *in* HARD LABOR: WOMEN AND WORK IN THE POST-WELFARE ERA 4 (Joel F. Handler & Lucie White eds. 1999) [hereinafter HARD LABOR].

> The principal reason for the growing inequality and poverty is the decline in the real earnings of the less skilled, less educated workers over the past twenty-five years. In 1973, for men, with one to three years of high school, the median income was $24,079 (1989 dollars); in 1989, it was $14,439. For men with a high school diploma, income dropped from $30,252 to $21,650. For women, with one to three years of high school, the median earnings were $7,920 in 1973; by 1989, they dropped to $6,752. For women with a high school degree, the figures were $11,087 (1973) and $10,439 (1989). Furthermore, the decline in income was not due to the shift in jobs from manufacturing to service; the real wages declined in both sectors.

Id. (footnotes omitted).

> Low-wage and less educated men experienced the largest drop in real wages. The lowest-paid men (the bottom 20 percent of male wage earners) saw their real wages fall by 17 percent between 1979 and 1995, while real wages increased by one percent for the top 20 percent of men. Earnings declined precipitously for less educated men. Wages for men with less than a high school education dropped by 27 percent and wages for high school graduates dropped 17 percent. In contrast, wages for male college graduates rose. Similarly, men in professional occupations saw their wages rise, while men in low-skilled jobs experienced real wage declines.[26]

Coupled with the loss of real wages, low-income workers have lost ground in employment-based health coverage. In 1996, 93.4% of high-wage workers[27] were offered health benefits by their employers, while only 42.7% of low-wage workers[28] were offered coverage.[29] This gap had grown substantially in just the ten years from 1987 to 1996. The offer rate for high-wage workers rose from 87.1% to 93.4%, while the offer rate for low-wage workers fell from 43.4% to 42.7%.[30] But even among low-wage workers, the loss of coverage has been uneven. Full-time workers with twelve months or more tenure in their jobs have tended to continue to be offered coverage, while "peripheral"[31] workers—newer full-time workers and part-time workers—are less likely to be offered coverage than were similarly situated workers in the past.[32] This trend seems ominous, as the "new economy" encourages workers frequently to change jobs, and to accept part-time employment.[33]

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26. O'BRIEN & FEDER, *supra* note 8, at 13.

27. "High wage workers" for these purposes are workers earning more than $15.00 per hour in 1996 dollars. *See* Phillip F. Cooper & Barbara Steinberg Schone, *More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 And 1996*, HEALTH AFF., Nov.-Dec. 1997, at 145.

28. "Low wage worker" for these purposes are workers earning less than $15.00 per hour in 1996 dollars. *See id.*, at 145.

29. *Id.*

30. *Id*.

31. *See* Henry S. Farber & Helen Levy, *Recent Trends in Employment Sponsored Health Insurance Coverage: Are Bad Jobs Getting Worse?*, 19 J. HEALTH ECON. 93, 94 (2000) (defining "peripheral" jobs).

32. *See id.* at 102.

33. One recent study suggests that the extremely tight labor market of the late 1990s has produced a increase in the number of persons covered by employment-based insurance. John Holahan & Johnny Kim, *Why Does The Number Of Uninsured Americans Continue to Grow?*, HEALTH AFF., July-Aug. 2000, at 194. This upturn, however, was largely explained by the movement of previously unemployed persons into employment, and does not suggest a change in the likelihood that those with jobs would obtain coverage. *Id.* at 194-95. The phenomenon seems, therefore, to be related to an extremely high rate of employment, and not to any dramatic shift in the likelihood that an employed person will be offered or accept health insurance. As America is near full employment levels, the increase of employment-based coverage by virtue of an increase in the rate of employment cannot continue. A flattening or downturn in the economy would, then, contribute to perhaps a quite steep drop in employment based-coverage. *See id.* at 196.

Another tool used by employers reacting to increases in health premiums has been the increasing imposition of employee cost-sharing for health coverage. The effect of this trend has been to exacerbate the disparity in health coverage by discouraging low-wage workers from accepting private coverage even when it is offered. There has been a striking fall-off in the rate at which workers opt for, or "take up" employment-based insurance. As the price of health coverage has risen, employers have, in addition to reducing access to coverage, increased employees' share of health premiums.[34] In addition to the simple goal of cost savings, employers have increased the employee share of premiums to encourage workers to take advantage of other opportunities for coverage—including the opportunity for coverage as a dependent under a spouse's policy.[35] The increase in cost-shifting from employer to employee has been dramatic in recent years.

> Between 1985 and 1995, the proportion of workers making no direct contribution to premiums for worker-only coverage dropped by 30 percentage points, from 64 percent to 33 percent, and workers' average monthly contributions increased as workers paid a larger share of higher premiums. In fact, workers' contributions increased more rapidly than premiums.[36]

The employee share of premium for dependent coverage was even higher. The sample costs of family coverage in one recent study found that the employee share was three times higher than the employee share for worker-only coverage,[37] with the employee responsible for a higher percentage of the total premium cost for family than single coverage.[38]

The increase in cost-sharing affects low-wage workers most drastically.[39] That this should be so is hardly surprising, as a worker earning $15,000 per year is less able to cover increasing monthly health premiums than one earning $40,000 per year. The effect was demonstrated in a recent study comparing insurance take-up by income level for the years 1987 and 1996:

> For workers earning less than seven dollars per hour (in 1996 dollars), offer rates were virtually the same in both years, but access rates declined significantly. Offer rates and access rates for high-wage workers (those earning more than ten dollars per hour) increased over the same period. The disparity in both individual and family take-up rates by wages was also greater

34. O'BRIEN & FEDER, *supra* note 8, at 17; THOMAS RICE ET AL., THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, TRENDS IN JOB-BASED HEALTH INSURANCE COVERAGE 31-32 (1998), *available at* www.kff.org; Cooper & Schone, *supra* note 27, at 147.

35. *See* David Dranove et al., *"Competition" Among Employers Offering Health Insurance*, 19 J. HEALTH ECON. 121, 137-38 (2000).

36. RICE ET AL., *supra* note 34, at 32.

37. *Id.* at 64 tbl.A-10.

38. *Id.* at 63-64 (comparing Table A-7 with Table A-10).

39. *See* Richard Kronick & Todd Gilmer, *Explaining the Decline in Health Insurance Coverage, 1979-1995*, HEALTH AFF., Mar.-Apr. 1999, at 36-37.

> in 1996, with workers earning ten dollars or less per hour having greater declines in take-up rates over the time period than higher-wage workers had.[40]

Low-income workers simply have too many preexisting calls on their income to add substantial health insurance cost sharing. Studies performed in the 1990s of low-income workers who were offered subsidized health coverage suggests a direct relationship between the level of cost sharing and the rate at which the offer was taken up. As cost sharing exceeded nominal amounts, low-income families quickly found themselves unable or unwilling to divert funds to health insurance.[41]

In sum, the erosion of health coverage among low-income workers is not a matter of isolated happenstance, but rather is explicable in terms of those workers' position in relation to long-term trends in the labor market. First, the cost of health coverage is rising at a rate well beyond both background inflation and wage inflation, after a lull in the mid-1990s. In addition, employers are responding to these increases by reducing the availability of health coverage, particularly to part-time and new full-time workers, and increasing employee responsibility for health premiums for those to whom they continue to offer coverage. Simultaneously, the wages of low-income workers have been stagnant or declining in real terms for decades; therefore, these workers are less able to meet the growing demands for health benefits cost sharing. Under these circumstances, low-income workers are, in unprecedented numbers, either not offered coverage or are declining it due to high cost. As a result, a cascade of circumstances have come together to drive large numbers of low-income workers and their families from private insurance, and there is no indication that these forces will abate in the near future. The employment-based health insurance system is simply failing low-income workers.

40. Cooper & Schone, *supra* note 27, at 146.

41. *See* ANNE MARKUS ET AL., THE GEORGE WASHINGTON UNIVERSITY SCHOOL OF PUBLIC HEALTH AND HEALTH SERVICES CENTER FOR HEALTH SERVICES RESEARCH AND POLICY, CHIP, HEALTH INSURANCE PREMIUMS AND COST SHARING: LESSONS FROM THE LITERATURE 6-7 (1998). Low income families, although eager to protect themselves from the cost of uninsured coverage, were influenced in their rate of take up by two factors: "(1) the amount of disposable income they have to spend on health insurance as opposed to other goods (e.g., food, clothing); and (2) the price of the coverage (the premium)." *Id.* at 6. One study included in the report found that uninsured low income families enrolled in subsidized coverage at a rate of fifty-seven percent if premium was set at one percent of income, at thirty percent if premium was set at three percent of income, and at eighteen percent if premium was set at five percent of income. *Id.*

B. The Public Side: The Expansion of Medicaid

The increase in the number of workers without health insurance has spurred interest in expanding eligibility in Medicaid [42] or in Medicaid's sister program, CHIP.[43] Other avenues have been proposed for exploration, including larger systemic reform[44] and incremental reform through methods other than the expansion of public programs.[45] But the public remains wary of large-scale changes, and the private market, particularly that for individuals and small groups, seems incapable of providing a platform for reduction in the number of uninsured despite recent legislative tinkering.[46] As a result, many proposals for incremental reforms aimed at the working uninsured and their families have focused on Medicaid and CHIP expansion.[47]

42. Medicaid is Title XIX of the Social Security Act (codified at 42 U.S.C. §§ 1396-1396v (1994 & Supp. IV 1998)).

43. The State Children's Health Insurance Program is Title XXI of the Social Security Act (codified at 42 U.S.C. §§ 1397aa - 1397jj (1994 & Supp. IV 1998)).

44. Bill Bradley, for example, described a comprehensive plan for near-universal coverage in the course of his unsuccessful campaign for the Democratic Party's nomination for President of the United States. His proposal would mandate the purchase of coverage for all children, the cost of which would be supported by federal subsidy at lower income level; the subsidization of coverage of persons aged 18 through 64 through private markets or the plans available through the Federal Employees Health Benefits Program; and, for those 65 and older, the enrichment of Medicare through the addition of prescription drug benefits and social care benefits. *See The Bradley Health Care Proposal: America's Health and America's System of Health Care*, *available at* http://billbradley.com/bin/article.pl?;path=270999 (last visited Aug. 9, 2000).

45. *See* Mark Pauly et al., *Individual Versus Job-Based Health Insurance: Weighing the Pros and Cons*, HEALTH AFF., Nov.-Dec. 1999, at 37-39 (suggesting modifications in the market for individual health insurance as a means of reducing uninsurance). George W. Bush, at this writing the nominee of the Republican Party for President of the United States, has proposed (in addition to modifications in public programs) modifications in private markets, federal vouchers ("health credits") in amounts up to $1,000 per person and $2,000 per family for the purchase of health coverage and expansions in Medical Savings Account programs in order to make health coverage more broadly available. *See Helping Individuals and Small Businesses Purchase Health Insurance*, *available at* http://www.georgewbush.com/issues/domestic/healthcare/points.asp (last visited June 20, 2000).

46. *See* Len M. Nichols, *State Regulation: What Have We Learned So Far?*, 25 J. HEALTH POL. POL'Y & L. 175, 194-95 (2000). Recent attempts at "market reform" in the individual and small group markets have had minimal if any success in increasing net access to coverage; instead, they appear to have made access to coverage better for some (usually the high risk enrollees) and worse for others (usually the low risk enrollees). *Id.*

47. *See Al Gore Unveils Agenda to Improve Health Care for America's Families*, *at* http://www.algore2000.com/agenda/agenda_healthcare.html (last visited Aug. 14, 2000) (Presidential candidate Al Gore describes as the first two points on his health care agenda the expansion of Medicaid and CHIP to cover all children); *On the Issues: Helping Individuals and Small Businesses Purchase Health Insurance*, *available at* http://www.georgewbush.com/issues/domestic/healthcare/points.asp (last visited June 20, 2000) (Presidential candidate George W. Bush proposes to modify CHIP to give states "freedom to innovate and expand coverage of the uninsured . . . so that more eligible people can be reached."); AMERICAN HOSPITAL

Medicaid was created in 1965,[48] in order to "provide a more effective medical assistance program for welfare recipients and to extend medical assistance to additional persons with low income."[49] Initially, Medicaid eligibility was associated with cash-support welfare programs which were targeted at the "deserving" poor[50]—those persons who were both poor and "categorically" eligible: members of families with children and single parents, the elderly, the blind and the disabled.[51] Medicaid's eligibility philosophy began to shift in the 1980s. Between 1984 and 1991, eligibility expanded to include families with two parents present and to pregnant women and children at increasing income levels.[52] By the end of the 1980s, Medicaid had emerged from its role as an adjunct to cash assistance programs and was available to a wide variety of categorically eligible people regardless of their participation in cash assistance programs.[53]

In the 1990s, coverage moved further from prior welfare roots.[54] One manifestation of the growing breadth of the public programs is the wide use of § 1115[55] and § 1915[56] waivers, the use of which permits states to expand

ASSOCIATION, INCREMENTAL SOLUTIONS FOR IMPROVING AND INCREASING HEALTH CARE COVERAGE FOR THE UNINSURED (1999), *available at* http://www.aha.org/about/campaign/1299uninsuredsoln.html (explaining proposal for incremental reform that includes expansion of CHIP to include family members of eligible children and expansion of Medicaid to include low-income childless adults).

48. Title XIX of the Social Security Act of 1965 (codified at 42 U.S.C. §§ 1396-1396v).

49. Laurens H. Silver & Mark Edelstein, *Medicaid: Title XIX of the Social Security Act—A Review and Analysis—Part I*, 4 CLEARINGHOUSE REV. 239 (1970) (footnote omitted) (citing DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, HANDBOOK OF PUBLIC ASSISTANCE ADMINISTRATION §1000 (Supp. D.)).

50. *See* Sandra J. Tanenbaum, *Medicaid Eligibility Policy in the 1980s: Medical Utilitarianism and the "Deserving" Poor*, 20 J. HEALTH POL. POL'Y & L. 933, 935 (1995).

51. *See* ROBERT STEVENS & ROSEMARY STEVENS, WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID 57 (The Free Press 1974)); Tanenbaum, *supra* note 50, at 935.

52. *See* Tanenbaum, *supra* note 50, at 937-39; Thomas M. Selden et al., *Medicaid's Problem Children: Eligible But Not Enrolled*, HEALTH AFF., May-June 1998, at 192-93.

53. Tanenbaum, *supra* note 50, at 937-38; STAFF OF SENATE COMM. ON ENERGY AND COMMERCE, 103D CONG., 1ST SESS., MEDICAID SOURCE BOOK: BACKGROUND DATA AND ANALYSIS (A 1993 UPDATE) 3 (Comm. Print 1993).

54. *See* Louise G. Trubeck, *The Health Care Puzzle: Creating Coverage for Low-Wage Workers and Their Families*, *in* HARD LABOR, *supra* note 25, at 143, 146-47. ("Over the past decade, the expansion of Medicaid to cover non-AFDC families has broken the exclusive eligibility link to AFDC.").

55. *See* 42 U.S.C. § 1315 (1994 & Supp. IV 1998). The waivers are referred to as "§ 1115" waivers (rather than "§ 1315" waivers because Congress created the authorization for the waiver as § 1115 to Title XI of the Social Security Act. Section 1115 waivers are granted "in the case of any experimental, pilot, or demonstration project which . . . is likely to assist in promoting the objectives of" the Medicaid program, 42 U.S.C. § 1315(a), and are employed by states to avoid the rigors of Medicaid's federal requirements in order to expand the population of persons eligible for Medicaid (and thereby permitting states to receive federal matching funds while

Medicaid eligibility to the working poor.[57] The details of these waiver programs vary from state to state. In the waiver programs, states couple cost-saving elements with eligibility expansion. For example, states impose restrictions in the choice of a health care provider or mandate enrollment in a managed care program, and simultaneously expand eligibility criteria, in order to stretch Medicaid dollars to cover more people.[58]

A second indication of a broadening scope of coverage for public programs was the creation of CHIP. Confronted with the reality that over ten million children were without health coverage of any kind, Congress created CHIP as a part of the Balanced Budget Act of 1997, allocating over $20 billion in federal matching funds for the program's first five years.[59] CHIP reaches children with a family income above that reached by Medicaid, targeting children with family income fifty percent above the limit for Medicaid coverage.[60] CHIP's federal financing is through block grants, and it creates no entitlement to coverage.[61] Its funding and eligibility limitations will likely limit the extent to which CHIP will cover those uninsured children; the Congressional Budget Office has estimated that it will cover about 2.8 million in all.[62] In theory, CHIP permits § 1115 waivers to use federal funding to extend coverage to families; however, Health Care Financing Administration ("HCFA") has

exceeding federal limits on financial and categorical eligibility) and to move parts of their Medicaid populations from fee for service to mandatory managed care systems. *See* PHYSICIAN PAYMENT REVIEW COMMISSION, ANNUAL REPORT 422-24 (1997).

56. *See* 42 U.S.C. § 1396n(b),(c) (1994). The waivers are referred to as "§ 1915" waivers (rather than "§ 1396n" waivers because Congress created the authorization for the waiver as § 1915 to Title XIX of the Social Security Act. The waivers permit states to avoid the rigors of Medicaid's federal requirements for pilot or experimental programs in more narrowly constrained areas than those within the ambit of § 1115 waivers.

57. States have also been motivated in pursuing § 1115 and § 1915 waivers of payment and eligibility principles by a desire to regularize and restrain costs. *See* John V. Jacobi, *Mission and Markets in Health Care: Protecting Essential Community Providers for the Poor*, 75 WASH. U. L.Q. 1431, 1443-47 (1997); Colleen M. Grogan, *The Medicaid Managed Care Policy Consensus for Welfare Recipients: A Reflection of Traditional Welfare Concerns*, 22 J. HEALTH POL. POL'Y & L. 815, 818-19 (1997); Suzanne Rotwein et al., *Medicaid and State Health Care Reform: Process, Programs, and Policy Options*, 16 HEALTH CARE FIN. REV. 105, 120 (1995).

58. *See* Ben Wheatley, *State Approaches to Expanding Family Coverage*, 4-5 (State Coverage Initiatives Issue Brief, May 2000); PHYSICIAN PAYMENT REVIEW COMMISSION, *supra* note 55, at 422-24.

59. Sara Rosenbaum et al., *The Children's Hour: The State Children's Health Insurance Program*, HEALTH AFF., Jan.-Feb. 1998, at 76.

60. This understates the expansion of coverage for some children. The actual income limit is the *greater* of fifty percent higher than the "medicaid applicable income level," 42 U.S.C. § 1397jj(b)(1)(B)(ii)(I), or 200% of the poverty level. 42 U.S.C. § 1397jj(c)(4) (1994 & Supp. IV. 1998).

61. 42 U.S.C. § 1397bb(b)(4) (1994 & Supp. IV 1998). *See* Neal Halfon et al., *Challenges in Securing Access to Care for Children*, HEALTH AFF., Mar.-Apr. 1999, at 49.

62. *See* Rosenbaum, *supra* note 59, at 76.

discouraged these waivers until the programs achieve greater experience with the core task of covering children.[63]

A third instance suggesting the broadening use of public programs to cover the working poor is the provision of the Personal Responsibility and Work Opportunity Act of 1996 ("PRWOA"),[64] by which Medicaid eligibility was extended for a period of up to twelve months[65] for families losing eligibility as a result of employment.[66] This provision provided, at least in theory, a bridge for families on cash assistance, allowing them to maintain the security of health coverage through Medicaid as they moved from welfare to work. By permitting state Medicaid offices to "disregard" some portion of family income and assets when determining eligibility, PRWOA creates the potential for substantial future expansion of Medicaid to working families.[67] Thus, Medicaid was again uncoupled from welfare, further emphasizing that Medicaid had become a "health insurance program for low-income families."[68]

In the absence of more comprehensive reforms to provide coverage for the working poor, expansions of public programs are likely to form at least a substantial basis for future efforts to reduce the rate of uninsurance.[69] Several

63. *See* UNITED STATES GENERAL ACCOUNTING OFFICE, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, CHILDREN'S HEALTH INSURANCE PROGRAM: STATE IMPLEMENTATION APPROACHES ARE EVOLVING 10-11 (1999) ("Although title XXI provides the opportunity for section 1115 waivers of title XXI requirements, HCFA will not consider such waivers unless a state's CHIP program has (1) been operational for at least 1 year and (2) completed an evaluation. HCFA's position reflects its belief that it is reasonable for the states to have experience in operating their new title XXI programs before designing and submitting demonstration proposals.").

64. Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 U.S.C. § 1396u-1(c)(1) (Supp. III 1997).

65. In addition, nine states have received federal waivers permitting them to extend Medicaid eligibility beyond the twelve month period. *See* Families USA, *Losing Health Insurance: The Unintended Consequences of Welfare Reform* (1999), *at* http://www.familiesusa.org/uninten.htm [hereinafter *Losing Health Insurance*].

66. 42 U.S.C. §1396r-6(a) (1994).

67. *See* Wheatley, *supra* note 58, at 2-3.

68. Families USA, *Go Directly to Work, Do Not Collect Health Insurance: Low-Income Parents Lose Medicaid* (2000), *at* http://www.familiesusa.org/pubs/gowrk.htm (n.d.) [hereinafter *Go Directly to Work*].

69. To clarify, future incremental reforms are likely to expand *eligibility* for public programs. Recent welfare reform efforts, including the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, have apparently failed in their intended purpose to extend Medicaid eligibility to families as they moved from cash assistance welfare programs. *See Go Directly To Work*, *supra* note 68, at 22; BOWEN GARRETT & JOHN HOLAHAN, THE URBAN INSTITUTE, WELFARE LEAVERS, MEDICAID COVERAGE AND PRIVATE HEALTH INSURANCE 4 (2000); UNITED STATES GENERAL ACCOUNTING OFFICE, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, MEDICAID ENROLLMENT: AMID DECLINES, STATE EFFORTS TO ENSURE COVERAGE AFTER WELFARE REFORM VARY 33-34 (1999); *Losing Health Insurance*, *supra* note 65, at 2. In addition, states have been slow to enroll eligible children in the CHIP program. *See*

Senators have recently proposed the Family Care Act, which would provide funding to extend public insurance coverage to the parents of children participating in either Medicaid or CHIP.[70] Presidential candidate Al Gore proposed that CHIP eligibility be expanded from its current basic limit of 200% of poverty to 250% of poverty, and that children with family incomes above 250% of poverty be permitted to buy into the CHIP program, taking advantage of its presumably lower premium levels.[71] In addition, he would "expand CHIP to parents," permitting working poor families to maintain coverage through the same public program.[72] Candidate George W. Bush, while advocating market-oriented steps to reduce uninsurance, advocated modifications to the CHIP program, giving states "the freedom to innovate and expand coverage of the uninsured."[73] Current public officials, including New York Governor George E. Pataki[74] and New York City Mayor Rudolph W. Giuliani[75] both formerly hostile to expansion of public health programs, have recently advocated expansions of public coverage.[76]

Robert Pear, *Many States Slow to Use Children's Insurance Fund*, N.Y. TIMES, May 9, 1999, at A1. The enrollments of children in CHIP have only balanced the attrition in children's enrollment in Medicaid, leaving no net gain in children's coverage by public insurance. *See* FAMILIES USA, ONE STEP BACK 1 (1999) [hereinafter ONE STEP BACK]. The reasons for states' failure to enroll families in these expanded programs, while an issue of great moment, are beyond the scope of this Article.

70. *See Kennedy Backs Insurance Act For Parents*, HOUS. CHRONICLE, July 23, 2000, at 15, *available* in 2000 WL 24498805.

71. *Al Gore Unveils Agenda to Improve Health Care for America's Families*, *supra* note 47.

72. *Id.*

73. *On the Issues: Helping Individuals and Small Businesses Purchase Health Insurance*, *supra* note 47.

74. *See* Jennifer Steinhauser, *For Giuliani and Pataki, About-Face on Health Issues*, N.Y. TIMES, June 19, 2000, at B1 ("Gov. George E. Pataki, who from the moment he took office has sought to hack away the state's Medicaid budget, recently championed far-reaching legislation to help vast numbers of the state's uninsured population get coverage at the government's expense.").

75. *See id.* ("Mayor Rudolph W. Giuliani, whose administration until very recently made concerted efforts to dissuade people from seeking Medicaid, the government insurance program for the poor, last week announced an aggressive effort to find these very people and *help* them get signed up.") (emphasis in original).

76. Private organizations have also weighed in on public program expansion. As part of its "Campaign for Coverage," the American Hospital Association advocates expansion of CHIP and Medicaid to groups of the poor and working poor now ineligible for the programs. *See* American Hospital Association, *Incremental Solutions for Improving and Increasing Health Care Coverage for the Uninsured* (1999), *at* http://www.aha.org/about/campaign/1299uninsuredsoln.html; Robert Pear, *Insurers Ask Government to Extend Health Plans*, N.Y. TIMES, May 23, 1999, at A16 (reporting that the Health Insurance Association of America, a trade association of many of America's health insurance firms, advocates expansion of the CHIP program to cover persons of all ages up to the poverty level, and the creation of a voucher program to expand coverage for those with family incomes between 100% and 200% of the poverty level).

If this emerging political mood in favor of public program expansions takes root, the architects of expansion will face many challenges, both political and technical. One of the looming technical problems is crowd-out, the phenomenon associated with expansions in public coverage and the concurrent reduction in private coverage in the target eligibility group. The nature and extent of crowd-out is the topic of the next section.

II. THE INCIDENCE OF CROWD-OUT

A. Crowd-Out in Medicaid

Medicaid's original target population—the destitute—had very little access to health coverage.[77] As Medicaid expansions reached the working poor, with incomes slightly above the poverty level, it extended coverage to populations with greater, although still modest, access to employment-based coverage. In 1997, only 21.6% of adults with family incomes below the poverty level were covered by employer-provided coverage, while 46.9% with family incomes between 100% and 200% of the poverty level had employment-based coverage.[78] As the income line between public and private coverage was blurred, researchers became interested in the intermeshing dynamics of the two systems. In particular, they wondered about the extent to which Medicaid expansions covered the previously uninsured, as opposed to simply displacing private coverage.[79]

The interest in crowd-out springs from the coincidence of two trends in the late 1980s and early 1990s. As Medicaid eligibility expanded and enrollment increased,[80] the rate of private coverage fell, particularly among the working poor, and in similar numbers.[81] The "essential policy question" posed by this coincidence was: "Did the Medicaid expansions cause the private coverage

77. Most of the truly destitute, of course, have no family connection to employment (and therefore no access to employment-based coverage), and no means to purchase coverage on their own. In addition, workers in near-minimum-wage jobs are unlikely to be offered insurance coverage. *See* O'BRIEN & FEDER, *supra* note 8, at 4.

78. *See* HOLAHAN & BRENNAN, *supra* note 16. In contrast to both the poor and the near-poor, fully 86.3% of adults with family income above 300% of the poverty level enjoyed employer-sponsored coverage. *Id.*

79. Described more completely, "[c]rowd-out is a term that covers two potential unintended consequences of the Medicaid eligibility expansion: (1) persons with private coverage drop it in order to take advantage of the public subsidy being offered; and (2) some who are uninsured enroll in Medicaid rather than obtain private coverage (as they would have under the more stringent Medicaid eligibility conditions)." Linda J. Blumberg et al., *Did the Medicaid Expansions for Children Displace Private Insurance?* 19 J. HEALTH ECON. 33, 34 (2000).

80. *See supra* text accompanying notes 52-58.

81. *See* Lara Shore-Sheppard et al., *Medicaid and Crowding Out of Private Insurance: A Re-Examination Using Firm Level Data*, 19 J. HEALTH ECON. 61, 63 (2000). *See also supra* text accompanying notes 26-33.

declines, or were the two contemporaneous trends independent?"[82] Researchers thought this question significant because crowd-out diverts public expenditures from their "intended" beneficiaries, thus reducing the efficiency of the expansions.[83] More subtly, crowd-out "may lead to fewer improvements in access to care," as funds that are expended to shift coverage rather than provide new coverage presumably have a less significant affect on the health status of those enrolled.[84]

Researchers have employed many methods in attempting to determine the extent to which Medicaid expansions in the late 1980s and early 1990s resulted in the displacement of private coverage.[85] Some of the researchers examined cross-sections of aggregate population data (usually from the Current Population Survey) to address the issue.[86] These researchers observed the change in insurance status in the eligible population, and adjusted for the effects of other factors (for example, a recession in the economy during the study period) to isolate only the substitution effect attributable to Medicaid expansion.[87] The reported results of these studies were not terribly consistent, with estimates of crowd-out ranging from about fifteen percent to about forty-one percent.[88] It appears that difficulties in correcting changes in insurance status unrelated to Medicaid prevent more precise results from research using cross-sections of population samples.[89]

82. Blumberg et al., *supra* note 79, at 35.

83. *See* Esel Y. Yazici & Robert Kaestner, *Medicaid Expansions and the Crowding Out of Private Health Insurance Among Children*, 37 INQUIRY 23, 23 (2000) ("The extent of crowd out is an important public policy issue because it reduces the effectiveness of government expenditures. Every dollar that unintentionally goes toward subsidizing previously insured children becomes unavailable for use in reducing the number of uninsured, the intended target group of the Medicaid expansions."); Blumberg et al., *supra* note 79, at 34 ("Crowd-out may . . . lead to greater increases in Medicaid expenditures than expected as individuals who previously had private insurance drop it to enroll in the subsidized public program.").

84. *See* Blumberg et al., *supra* note 79, at 34. *See supra* text accompanying notes 12-13 (discussing health-status effect of insurance coverage).

85. Detailed analysis of these studies is beyond the scope of this Article. For a recent comparative analysis, see Yazici & Kaestner, *supra* note 83 at 24-26; LISA DUBAY, THE KAISER FAMILY FOUNDATION PROJECT ON INCREMENTAL HEALTH REFORM, EXPANSIONS IN PUBLIC HEALTH INSURANCE AND CROWD-OUT: WHAT THE EVIDENCE SAYS (1999), *available at* http://www.kff.org/content/1999/19991112m (n.d.).

86. *See* DUBAY, *supra* note 85, at 5.

87. *See* Yazici & Kaestner, *supra* note 83, at 24-25 (discussing D.M. Cutler & J. Gruber, *Does Public Insurance Crowd Out Private Insurance?*, 111 Q. J. ECON. 391 (1996)); L. D. Shore-Sheppard, *Stemming the Tide? The Effect of Expanding Medicaid Eligibility on Health Insurance Coverage* (Unpublished paper, 1996); L. Dubay and G. Kenney, *The Effects of Medicaid Expansions on Insurance Coverage of Children*, 6 THE FUTURE OF CHILDREN 152 (1996). *See also* DUBAY, *supra* note 85, at 5-9 (discussing studies of Cutler & Gruber and Dubay & Kenney).

88. *See* Yazici & Kaestner, *supra* note 83, at 24-25; DUBAY, *supra* note 85, at 5-9.

89. *See* Yazici & Kaestner, *supra* note 83, at 25 ("Our review of the crowd-out literature that uses CPS data has highlighted two points. First, these studies have not reached a consensus on

Another more recent set of studies has produced more homogeneous results. Unlike the cross-sectional studies which examine large swaths of data for two time periods and attempt to discern trends from shifts within a large population, these studies follow a population over a period of time, and discern trends by observing actual shifts in status of the members of the studied population.[90] The advantages of the more direct observations available through longitudinal studies have been described by one of the researchers:

> While cross-sectional data can be used to analyze the impacts of the Medicaid expansions, longitudinal data can identify more complex effects of policy changes. By following individuals over time, movements from one type of coverage to another can be observed. To illustrate why this is important, consider the following example: When cross-sectional data are used, the movement of one group out of employer-sponsored coverage and into uninsurance combined with another group moving from uninsurance to Medicaid might be wrongly construed to be movement from employer coverage into Medicaid. Such a characterization of these more complicated dynamics would be misleading. To avoid this result, some researchers have used longitudinal data.[91]

Cross-sectional studies could then read a simultaneous drop in the rate of employer-sponsored coverage and increase in Medicaid enrollment as due to crowd–out.[92] Longitudinal analysis might demonstrate that the gross data mask two different trends—the movement of one group of people from employer-sponsored coverage to uninsurance, and a separate and unrelated group from uninsurance to Medicaid. The second set of circumstances does not describe the displacement of private coverage by a public program.

The longitudinal studies are not without their methodological problems. Researchers do not have the opportunity to interview the test subjects, and therefore must infer the effect of Medicaid expansion on the subjects' change

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the extent of crowd-out. Second, measurement error associated with Medicaid eligibility and a lack of appropriate controls for state and time variation in insurance status may have confounded estimates of crowd out."); DUBAY, *supra* note 85, at 9 ("The inconsistency of the results from [two of the CPS cross-sectional studies] is either due to differences in their overall methods or in the comparison group used to account for the secular trends. Notably, each set of authors has criticized the other for their choice of comparison groups.") (footnote omittted).

90. *See* Blumberg et al., *supra* note 79, at 38; Yazici & Kaestner, *supra* note 83, at 25, 30-31 (discussing their own results from a longitudinal study, as well as K. E. Thorpe and C. S. Florence, *Health Insurance Among Children: The Role of Expanded Medicaid Coverage*, 35 INQUIRY 369 (1998) and an unpublished study of L. J. Blumberg, L. Dubay and S. Norton (1999)); DUBAY, *supra* note 85, at 9-12 (discussing several studies by the same authors).

91. DUBAY, *supra* note 85, at 9.

92. Researchers using cross-sectional methods are, of course, aware of this problem, and use a number of methods, including regression analysis, to attempt to correct for it. *See id.* at 6-8; Yazici & Kaestner, *supra* note 83, at 24-25. Longitudinal analysis has the virtue of at least attempting to get at this information directly.

in coverage status by comparison to a control group.[93] Researchers' choice of control groups against whom to compare the test group's behavior has not been without controversy.[94] In addition, "sample sizes for the populations affected by Medicaid programs are small in longitudinal surveys compared to cross-sectional surveys such as the CPS potentially resulting in imprecise estimates."[95]

The longitudinal studies have produced results similar enough to each other to give rise to some suggestion of validity. The range of results for crowd-out from Medicaid expansions during the late 1980s and early 1990s from these studies is generally from about fourteen percent to twenty percent.[96] In a recently-published study, Yazici and Kaesnter reported results from an examination of a large set of data on children surveyed in the National Longitudinal Survey of Youth.[97] The authors reported crowd-out of 18.9% for a weighted average of subpopulations studied.[98] Another recent study of Medicaid expansion in the early 1990s shows an even smaller number. Blumberg, Dubay and Norton reported this year that about twenty-three percent of the movement from private insurance to expanded Medicaid during that time period constituted crowd-out.[99] That is, twenty-three percent of those moving to expanded Medicaid from private coverage would otherwise have continued private coverage, while the other seventy-seven percent would have been uninsured due to job loss or other reasons unrelated to Medicaid.[100] The authors found that no significant percentage of those who moved from uninsurance to expanded Medicaid would have had coverage absent Medicaid expansion.[101] The weighted averaging of those two groups results in a total crowd-out rate of four percent.[102]

The convergence of the findings in the longitudinal studies permits tentative conclusions as to the rate of crowd-out from Medicaid expansion during the late 1980s and early 1990s. This rate seems quite low, permitting a finding that at least four out of five of those covered by those Medicaid expansions would otherwise have been uninsured. One study concluded:

> The consistency of recent findings that use a variety of methods and data sources strongly suggests that the Medicaid expansions of the late 1980s and early 1990s did not cause, in a substantial way, employers to cease to offer

93. *See* DUBAY, *supra* note 85, at 9.
94. *See id.*; Yazici & Kaestner, *supra* note 83, at 26.
95. DUBAY, *supra* note 85, at 9.
96. *See id.* at 14-15 (gathering results of longitudinal studies in chart form).
97. Yazici & Kaestner, *supra* note 83, at 27.
98. *Id.* at 30.
99. Blumberg et al., *supra* note 79, at 57.
100. *Id.*
101. *Id.*
102. *Id.*

> private health insurance, nor did it cause families to drop private health insurance. Instead, the results suggest that the expansion of Medicaid effectively stemmed the tide . . . of an ongoing deterioration of private health coverage among low-income children. In the absence of expanded Medicaid coverage, the number of uninsured children would have been significantly greater.[103]

The next section moves to CHIP, Medicaid's sister program.

B. Crowd-Out in CHIP

The CHIP program extends public insurance for children beyond the eligibility limits for Medicaid. It targets near-poor children—those over-income for Medicaid,[104] but whose family income does not exceed the greater of fifty percent above the state's Medicaid income level, or 200% of the poverty level.[105] Studies (some undertaken after the passage of the CHIP legislation) have suggested that crowd-out may be more likely to appear as public programs reach relatively higher-income individuals.[106] Apparently reflecting this concern, Congress structured CHIP so as to reduce the likelihood of crowd-out, and to mandate the study of steps taken by states to minimize crowd-out.

The legislation creating CHIP, and a draft of implementing regulations, evidence legislative and administrative concern that the new public program not displace private coverage. The draft regulations highlight this concern:

> One of the fundamental principles of title XXI is that CHIP coverages should not supplant existing private coverage. Title XXI contains provisions specifically designed to ensure that States use CHIP funds to provide coverage only to uninsured children. These provisions maximize the use of Federal

103. Yazici & Kaestner, *supra* note 83, at 30-31.

104. *See* 42 U.S.C. § 1397jj(b)(1)(B), (C) (1994 & Supp. IV 1998) (defining "targeted low-income child" for purposes of CHIP eligibility as being ineligible for Medicaid).

105. *See* 42 U.S.C. § 1397jj(c)(4) (1994 & Supp. IV 1998) (defining "low-income child" as one whose family income does not exceed 200% of the poverty level); 42 U.S.C. § 1397jj(b)(1)(B) (describing CHIP eligibility standard as met by either meeting the "low-income definition" or living in a family with income that does not exceed the state Medicaid eligibility limit by more than fifty percent).

106. *See* Blumberg et al., *supra* note 79, at 58 ("[T]he fiscal implications of crowd-out under the CHIP program are likely to be greater than under the Medicaid expansions. This is because children eligible for CHIP will, by definition, have higher family incomes than children eligible for Medicaid expansion in their state."); Lisa Dubay & Genevieve Kenney, *Did Medicaid Expansion for Pregnant Women Crowd Out Private Coverage?*, HEALTH AFF., Jan.-Feb. 1997, at 191 ("[E]xtending 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.").

> dollars. Specifically, title XXI requires that States ensure that coverage provided under CHIP does not substitute for coverage under either private group health plans or Medicaid.[107]

State plans implementing CHIP programs must contain "a description of procedures to be used to ensure . . . that insurance provided under the State child health plan does not substitute for coverage under group plans."[108]

Many states had developed some experience in creating programmatic barriers to crowd-out through their implementation of pre-CHIP state insurance expansion programs.[109] These programs have been funded by states, and states' concerns with crowd-out are therefore internally driven.[110] Some of the mechanisms were aimed at lessening the incentives for individuals to drop (or fail to take up) private coverage in favor of public coverage. The most straight-forward mechanisms erect "firewalls"[111] between public and private coverage by denying access to the public programs to either those with access to employment-based coverage with minimal employee contribution requirements or those who have been insured within a three or six month period.[112] States have used these eligibility requirements as a direct means to limit public program access to the uninsured.[113]

Other mechanisms seem less applicable to CHIP. For example, some states have created plans that omit coverage of inpatient care.[114] While this

107. *State Child Health; Implementing Regulations for the State Children's Health Insurance* Program, 64 Fed. Reg. 60882, 60921 (Nov. 8, 1999). This Article is concerned with the relationship between public and private coverage and issues relating to the substitution of CHIP coverage for Medicaid coverage are, therefore, beyond its scope.

108. 42 U.S.C. § 1397bb(b)(3)(C) (1994 & Supp. IV 1998). *See* 64 Fed. Reg. 60882, 60958 (Nov. 8, 1999) (to be codified at 42 C.F.R. § 457.805) ("The State plan must include a description of reasonable procedures to ensure that coverage provided under the plan does not substitute for coverage under group health plans . . . . "). One means by which states may expend their allotted CHIP funds is to purchase private health coverage of an eligible child and her family, so long as such purchase is "cost effective relative" to direct coverage by a public program. 42 U.S.C. § 1397ee(c)(3)(A) (1994 & Supp. IV 1998). A state may not use CHIP funds for such purposes of the purchase of coverage by the state "if it would otherwise substitute for health coverage that would be provided to such children but for the purchase of family coverage." 42 U.S.C. § 1397ee(c)(3)(B). *See* 64 Fed. Reg. 60882, 60958 (proposed Nov. 8, 1999) (to be codified at 42 C.F.R. § 457.810) (crowd-out provisions for state plans purchasing private coverage).

109. *See* Anna Fallieras et al., *Examining Substitution: State Strategies to Limit "Crowd Out" in the Era of Children's Health Insurance Expansions* (Dec. 9, 1997), *at* http://aspe.hhs.gov/health/reports/hinsubst/front.htm. *See also* Trish Riley, *Can We Count on the States to Cover the Poor and Uninsured?*, *in* THE FUTURE OF THE U.S. HEALTHCARE SYSTEM, *supra* note 10, at 276-77 (discussing state-funded insurance expansion programs).

110. *See* Riley, *supra* note 109, at 276-77.

111. *See* Fallieras, *supra* note 109, at Part IV.

112. *Id.*

113. *Id.*

114. *Id.*

step would certainly give a low-wage worker pause before dropping workplace coverage in favor of the public plan, such a program design seems to interfere with the goal of providing meaningful health coverage—it simply leaves out too much that is essential. In any event, states' CHIP plans must provide full access to care, including inpatient care.[115]

Another tool used to discourage employees from dropping private coverage is the use of high levels of cost-sharing.[116] States have set premiums and copayment amounts to approximate or exceed those imposed in employment-based coverage, reasoning that employees would therefore perceive no benefit in shifting from private to public coverage.[117] CHIP programs are limited in their use of such tools, however.[118] In addition, were CHIP to permit states to impose large cost sharing on working poor families, such cost-shifting may limit program participation by families with no access to private coverage. As is described above, high levels of cost sharing in private insurance is one of the main causes of low take-up in employment-based coverage.[119]

Other mechanisms are used in the state-only expansions to limit employer behavior, and specifically to address employers' incentives to drop employee coverage in favor of their employees' enrollment in the new public program. These mechanisms directly co-opt employers by offering them direct and indirect subsidies for providing workplace coverage.[120] States have engaged in more talk than action in this regard, in part for budgetary reasons and in part because this mechanism, depending on its details, actually encourages substitution.[121] In any event, such subsidy to employers is not a meaningful part of the CHIP program.[122]

The Health Care Financing Administration ("HCFA") circulated a letter to the states on crowd-out shortly after CHIP's enactment.[123] The letter reminded

115. *See* 42 U.S.C. § 1397cc(c)(1)(A) (1994 & Supp. IV 1998). State CHIP plans must include inpatient and outpatient hospital care.

116. See Fallieras et al., *supra* note 109, at Part IV.

117. *Id.*

118. States may not impose cost-sharing for children with family income below 150% of poverty, beyond those minimal amounts permitted by Medicaid. 42 U.S.C. § 1397cc(e)(3)(A) (1994 & Supp. IV 1998). For higher-income children, states may impose greater cost-sharing, but the total out-of-pocket expense for all of a family's eligible children is limited to five percent of the family's yearly income. 42 U.S.C. § 1397cc(e)(3)(B) (1994 & Supp. IV 1998).

119. *See supra* text accompanying notes 34-41 (describing high employee cost-sharing as one of the main causes of the erosion of employment-based coverage for low-income workers).

120. *See* Fallieras et al., *supra* note 109, at Part IV.

121. *Id.*

122. *But see* 42 U.S.C. § 1397ee(c)(3) (1994 & Supp. IV 1998) (permitting purchase with CHIP funds of private group coverage under limited circumstances).

123. Letter from Sally K. Richardson, Director, Center for Medicaid and State Operations & Claude Earl Fox, Acting Administrator, Health Resources and Services Administration, to State

states that "[t]he new law contains provisions explicitly designed to ensure that funds are targeted only to uninsured, and not already insured, children."[124] It advised that HCFA would review state plans "to determine if the State has included procedures designed to address any potential substitution concerns."[125] HCFA review was vaguely described for CHIP plans providing coverage directly to children, and the letter indicated that HCFA reserves the right to require modification of state plans should history demonstrate that initial anti-substitution procedures were ineffective.[126] More detailed advice was given for anti-substitution measures in plans proposing the use of CHIP funds to subsidize private insurance.[127]

The principal mechanism selected by states to meet this challenge has been a requirement that applicants be uninsured for a period of three or six months before applying for CHIP coverage.[128] Data gathered by the National Governors Association shows that of the twenty-nine CHIP plans which provide coverage at least in part through non-Medicaid CHIP plans,[129] twenty-five seek to prevent crowd-out by imposing waiting periods—intervals during which the child was not covered by insurance.[130] Of those twenty-five states,

Health Officials, (Feb. 13, 1998), *available at* http://www.hcfa.gov/init/chsub213.htm [hereinafter Letter to State Health Officials].

124. *Id.* at 1.

125. *Id.*

126. *Id.* at 2.

127. *Id.*

128. The HCFA website provides information on all approved state plans. *See* The Health Care Financing Administration, *State Children's Health Insurance Program Approved Plan Files*, *at* http://www.hcfa.gov/init/chpa-map.htm (last visited July 5, 2000). In addition, the National Governors Association ("NGA") has produced a report providing detailed information on state plans and amendments. *See* NATIONAL GOVERNORS ASSOCIATION, STATE CHILDREN'S HEALTH INSURANCE: ANNUAL REPORT (1999), *available at* http://www.nga.org/MCH/Annual/Index.asp [hereinafter NGA ANNUAL REPORT]. The crowd-out provisions discussed in the text apply to programs extending coverage through separate CHIP programs that reach beyond Medicaid eligibility. *See* The Health Care Financing Administration, *New Jersey Title XXI State Plan and Amendment Summary*, *available at* http://www.hcfa.gov/int/chnjfact.htm (last visited July 17, 2000); The Health Care Financing Administration, *Delaware Title XXI State Plan Summary*, *available at* http://www.hcfa.gov/int/chpfsde.htm (last visited July 17, 2000).

129. That is, plans that extend eligibility through CHIP-specific plans that are distinct from Medicaid expansion plans.

130. *See* NGA ANNUAL REPORT, *supra* note 128, at tbl.15. Alternatively or in addition, some states attempt to prevent substitution by checking independent sources for applicant's insurance and/or employment history. *See id.* All NGA Fact Sheets are available at www.nga.org. NGA Fact Sheet on Mississippi plan ("The eligibility process incorporates the investigation of creditable health coverage using data matches and client interviews. . . ."); NGA Fact Sheet on Georgia plan ("Employer information also is validated by checks of wage record data with the Georgia Department of Labor when available."); NGA Fact Sheet on Alabama plan (state is developing "AL Health Care Information Network, which will operate a master patient index of current coverage of Alabama citizens" in order to identify children eligible for private coverage).

twenty-two permit the waiting period to be waived under some circumstances,[131] invariably for circumstances judged to be beyond the control of the applicant or family.[132]

The CHIP statute requires that states gather certain data, file compliance reports and cooperate with federal studies of the CHIP program.[133] Each state was required to submit a comprehensive evaluation of its program by March 31, 2000.[134] The states were specifically required to address the issue of crowd-out.[135] The Secretary of the Department of Health and Human Services, in turn, is required to file with Congress, by December 31, 2001, "a report based on the evaluations submitted by the States . . ., containing any conclusions and recommendations the Secretary considers appropriate."[136] As

131. *Id.*

132. *See id.*, NGA Fact Sheet on New Jersey plan (six month waiting period waived if "insurance is lost through no fault to the family, such as a layoff"); NGA Fact Sheet on Nevada plan (six month waiting period waived if family lost insurance "due to circumstances beyond their control"); NGA Fact Sheet on Alabama plan (three month waiting period applies only to those who "voluntarily drop private insurance coverage"); NGA Fact Sheet for Montana plan (three month waiting period is waived if parent providing coverage is "fired, laid off, becomes disabled, has a lapse in insurance coverage after starting a new job, or the employer discontinues coverage"); NGA Fact Sheet for Vermont plan (one month waiting period is waived if loss of insurance coverage is without "good cause"); NGA Fact Sheet on Wyoming plan (one month waiting period is waived if parent providing coverage is "laid off, fired, can no longer work due to a disability, or has a lapse in insurance coverage because he/she obtains new employment").

133. 42 U.S.C. § 1397gg(b) (1994 & Supp. IV 1998).

134. 42 U.S.C. § 1397hh(b)(1) (1994 & Supp. IV 1998).

135. *See* 42 U.S.C. §§ 1397hh(b)(1)(B)(i), (b)(1)(D) (requiring the report to describe the insurance coverage and access status of participating children prior to their CHIP enrollment, and requiring the report to describe state activities to coordinate activities of the state plan with other private and public sources of coverage). State plans often included studies and evaluations among the mechanisms for addressing the problem of substitution, perhaps in recognition of the uncertainty surrounding the issue. *See* NGA ANNUAL REPORT, *supra* note 128, at tbl.15. *See also*, The Health Care Financing Administration, *Florida Title XXI Program Fact Sheet*, *available at* http://www.hcfa.gov/ init/chpfsfl.htm (last visited Sept. 23, 2000) ("The State will study the Health Kid's program's impact on crowd out."); The Health Care Financing Administration, *Washington Title XXI Program Fact Sheet*, *available at* http://www.hcfa.gov/ init/chpfswa.htm (last visited Sept. 23, 2000) (the state "will conduct periodic surveys of all CHIP households to determine if they had dependent coverage prior to enrollment."); The Health Care Financing Administration, *Wyoming Title XXI Program Fact Sheet*, *available at* http://www.hcfa.gov/init/chpfswy.htm (last visited Sept. 23, 2000) ("Wyoming will also monitor to determine if crowd-out is a problem. If the results of monitoring indicate crowd-out is occurring, the state will develop and implement strategies to prevent crowd-out.").

136. 42 U.S.C. § 1397hh(b)(2). The Secretary has contracted with Mathematica Policy Research "to prepare background information for the Report to Congress, including a synthesis of State annual reports, State evaluations, and statistical data; a review of external studies of SCHIP; and an assessment of SCHIP in important areas such as outreach and enrollment, as well as access to, and quality of, health coverage." *See* THE HEALTH CARE FINANCING ADMINISTRATION, SCHIP ANNUAL ENROLLMENT REPORT (FISCAL YEAR 1999) 6-7 (2000),

is described in the following section, the extent of crowd-out in CHIP is not clear, although the short-term and long-term implications for the eventual production of this information are quite significant.

III. THE FUTURE AND CONSEQUENCES OF CROWD-OUT

A. Interest in Crowd-Out: An Interlude

The interest in the problems of crowd-out perhaps understandably waxed at the time of the creation of the CHIP program. The early studies of prior expansions of Medicaid had produced mixed results, which could give rise to concerns that a powerful extension of public insurance above the ranks of the truly destitute would produce as much displacement of private insurance as coverage of the uninsured.[137] Interest had waned two years later. In the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999,[138] Congress ordered additional studies related to CHIP, but the emphasis had shifted from concern over the displacement of private insurance to the dual concern that states were failing to enroll children in their plans,[139] and that those enrolled may have been eligible for Medicaid, a pre-existing program[140]

available at http://www.hcfa.gov/init/children.htm [hereinafter 1999 CHIP ANNUAL REPORT]. In 1999, Congress instructed the Secretary to file an additional report on the same day. *See* 42 U.S.C. § 1397hh(c) (Supp. III 1997), added by the Balanced Budget Refinement Act, Pub. L. No. 106-113, § 703(b), 113 Stat. 1537-314, 394. That report, the product of "an independent evaluation of 10 States with approved child health plans," is to focus on the flip side of the crowd-out problem—the problem of the CHIP program reaching too few eligible children. *See* 42 U.S.C. § 1397hh(c)(3) (describing the matters to be included in the ten-state survey report as supplementing the information provided in the report required by 42 U.S.C. § 1397hh(b)(2)).

137. *See supra* text accompanying notes 86-89.

138. Pub. L. No. 106-113, 113 Stat. 1537-314 (1999).

139. *See* Pub. L. No. 106-113, § 703(c) (codified at 42 U.S.C. § 1397hh(c) (Supp. III 1997)) (requiring federal assessment of state efforts in enrollment, including "[e]valuation of effective and ineffective outreach and enrollment practices with respect to children . . ., identification of enrollment barriers," "[a]n assessment of the effect of cost-sharing on utilization, enrollment, and coverage retention," and "[e]valuation of disenrollment or other retention issues."); *Id.* § 703(d) (codified at 42 U.S.C. § 1397hh(d) (Supp. III. 1997)) (requiring Inspector General of the Department of Health and Human Services to audit, and requiring the GAO to review and report on the Inspector General's audit, states' "progress made in reducing the number of uncovered children, including the progress made to achieve the strategic objectives an performance goals included in the" state's CHIP plan).

140. *See id.* § 703(c) (requiring federal evaluation of "the extent to which coordination (or lack of coordination) between [a state's Medicaid] program and [its CHIP program] affects the enrollment of children under both programs."); *Id.* § 703(d) (requiring Inspector General of the Department of Health and Human Services to audit, and requiring the GAO to review and report on the Inspector General's audit for the number of Medicaid-eligible children enrolled in a state's CHIP program).

for which the federal government pays a smaller share of cost than it does for CHIP.[141]

The fact that CHIP would have enrollment problems should not have come as a surprise, considering Medicaid, a well-established and familiar program, had long struggled to reach millions of eligible but uninsured children.[142] Within two years of its enactment, however, the dominant issue related to the CHIP program was its disappointing growth rate. In 1999, a front-page article in the New York Times opened with the following assessment:

> States are using less than 20 percent of the Federal money that Congress made available, with much fanfare, for a big new program to subsidize health insurance for children in low-income families.
>
> Some states say they cannot find enough eligible uninsured children to use all of the money that they are entitled to receive. Critics say many states have been slow to reach out to eligible children and sign them up.
>
> The program's slow start and the accumulation of unspent money are tempting Republicans in Congress to take back some of the money and use it for other purposes—an idea vehemently opposed by Democrats, by advocates for children, and by governors of both parties.[143]

Demonstrating concern for the slow start-up of the CHIP program, both the White House and HCFA announced initiatives to identify and enroll CHIP-eligible children and to allocate funds to support those efforts.[144] In testimony

141. *See* ONE STEP BACK, *supra* note 69, at 20-21 (attributing a simultaneous drop in Medicaid coverage of children and increase in CHIP coverage of children in part to the fact that "the federal government pays a larger share of the costs of CHIP"); Pear, *supra* note 69, at B22 ("But states have a strong financial incentive to put children into the new program, rather than in Medicaid, because the Federal Government pays a larger share of the costs—65 percent, rather than 50 percent, in high-income states like New York, New Jersey and Connecticut.").

142. *See* Selden et al., *supra* note 52, at 196 ("4.7 million children aged eighteen and under were uninsured [in 1996] despite being eligible for Medicaid, representing approximately two in every five uninsured children in the United States.") (footnote omitted).

143. Pear, *supra* note 69, at A1. Others also noted the slow pace of CHIP enrollment. An Issue Paper published by the Kaiser Commission on Medicaid and the Uninsured stated:

> The recent expansions of children's health insurance programs at federal and state levels offer an unprecedented opportunity to reach out and enroll millions of uninsured children who now qualify for publicly subsidized health coverage. However, even with the infusion of new money and resources to get this job done, states and localities have had limited success reaching the millions of children who are currently eligible but not enrolled for health care coverage.

DAWN HORNER ET AL., THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, EXPRESS LANE ELIGIBILITY: HOW TO ENROLL LARGE GROUPS OF ELIGIBLE CHILDREN IN MEDICAID AND CHIP (1999), *available at* http://www.kff.org/docs/sections/kcmu/current.html.

144. *See Press Release: The Clinton-Gore Administration Takes New Steps to Increase Enrollment of Uninsured Children* (Oct. 12, 1999), *available at* http://www.hcfa.gov/init/whchip12.htm (describing several initiatives to reach out to eligible children, and the funding of a

before Congress in 1999, the HCFA Administrator spoke extensively about outreach and did not mention any concern for the possible displacement of private insurance.[145] HCFA's 1999 Annual CHIP Report to Congress follows through on this emphasis, concentrating on identification, enrollment and retention of eligible children.[146]

Perhaps reflecting the federal focus, states appear to have done little to review their programs for crowd-out. No published source suggests that any of the state reports filed earlier this year contained any systematic study on the topic, no doubt reasonably concentrating instead on the federal government's more pressing concern of identification, enrollment, and retention of eligible children. Informal surveys of state CHIP programs reflect a disinclination to study crowd-out and, often, a disinclination to credit the possibility of its existence in their programs. Most of the CHIP offices contacted had performed no studies of crowd-out or believed that there was no displacement of private coverage associated with their programs.[147] The few states that had conducted either formal or informal investigations of crowd-out found levels in line with studies of crowd-out associated with previous Medicaid

$9 million project by the federal government and a private foundation to identify outreach techniques); *Press Release: Children's Health Insurance Program National Back-To-School Kick Off* (Sept. 22, 1999), *available at* http://www.hcfa.gov/init/990922wh.htm (announcing interagency effort to enroll children in CHIP, and announcing a "$1 million radio campaign, funded by HHS, to promote . . . upcoming enrollment activities . . .").

145. *The Children's Health Insurance Program: Testimony Before the Senate Finance Committee* (Apr. 29, 1999) (statement of Nancy-Ann DeParle, Administrator, Health Care Financing Administration), *available at* http://www.hcfa.gov/init/testm429.htm.

146. *See* 1999 CHIP ANNUAL REPORT, *supra* note 136, at 6. The Report makes only oblique reference to crowd-out, mentioning that a component of states' reports to HCFA is the enrolled "children's access to other health insurance coverage prior to and subsequent to their coverage under the State SCHIP plan." *Id.*

147. Telephone interview by Alexander Shekhdar with Gayle Sandlin, Director, CHIP, Alabama Department of Public Health (May 22, 2000); Telephone interview by Alexander Shekhdar with Joie Wallis, Program Administrator, Division of Medical Services, Arkansas Department of Human Services (May 22, 2000); Telephone interview with Linda Mead, HUSKY Plan Project Director, Department of Social Services, State of Connecticut (May 24, 2000); Telephone interview by Alexander Shekhdar with Fran Ellington, Program Director, Medicaid Eligibility and Quality Control, Department of Medical Assistance, State of Georgia (May 22, 2000); Telephone interview by Alexander Shekhdar with Diane Moore, Division Medicaid Administration, Department of Health and Welfare, State of Idaho (May 26, 2000); Telephone interview by Alexander Shekhdar with Susie Baird, Director of Programs, Bureau of TennCare, Department of Health, State of Tennessee (May 24, 2000); E- mail from Jane Longo, Chief, Bureau of KidCare, Illinois Department of Public Aid (May 24, 2000) (on file with the author); E-mail from Ann Rugg, Managed Care Senior Administrator, Office of Vermont Health Access, Department of Social Welfare, State of Vermont (May 23, 2000) (on file with the author); E-mail from Dedrea McCoy, Department of Medicaid Services, Division of Children's Health Programs, State of Kentucky (May 24, 2000) (on file with the author).

expansions.[148] With respect to crowd-out and other areas of interest in the CHIP program's development, states appear to be too absorbed in the difficult task of bringing a new program on-line to develop a great deal of data.[149] No national studies accompanied the passage of CHIP legislation, and it will be difficult to examine the effects of CHIP after the fact.[150] The study recently commissioned by HCFA will therefore be of great significance.[151]

B. The Implications of Renewed Interest in Crowd-Out

The expansion of public program eligibility into the ranks of the working poor, occasioned by the shrinking private coverage of this group,[152] will be accompanied by some degree of displacement of private coverage. Prior expansions resulted in some displacement of private coverage, although four out of five of those enrolled would otherwise have been uninsured.[153] At the lower ends of the wage spectrum, many workers are uninsured, while many others are not. For workers with family incomes below 200% of the poverty level, the percentage of insured and uninsured workers is about even.[154] As expansions target near-poor working families, then, eligible persons will increasingly have at least nominal access to private coverage.[155] These expansions, including CHIP programs, will therefore increasingly give rise to a clash between the goals of providing coverage for the uninsured and limiting public programs to those without access to private coverage.

The lack of recent attention by state and federal officials to crowd-out, described above, suggests a danger of surprise and overreaction when some

148. Telephone interview by Alexander Shekhdar with Office of Children's Health Programs, Department of Health and Human Services, State of South Carolina (May 23, 2000) (South Carolina estimates its crowd-out rate at approximately ten percent of enrollment); Telephone interview by Alexander Shekhdar with Susan Moore, Bureau of Health Economics, Department of Health, State of New York (May 26, 2000) (New York estimates that its "actual" crowd-out rate is between four percent and six percent of enrollment); Facsimile from Chad Westover, Administrator, Children's Health Insurance Program, Department of Health, State of Utah (May 23, 2000) (on file with the author) (Of a survey of 201 applicants for Utah's SCHIP program, sixty-three applicants, or thirty-one percent, most recently had employer-sponsored health insurance.); INSTITUTE FOR CHILD HEALTH POLICY, FLORIDA KIDCARE PROGRAM EVALUATION REPORT xiii (2000), *available at* http://www.ichp.edu/FloridaKidCare/flaKC.htm (overall only eleven percent of children had employer-based coverage prior to entering the KidCare Program).

149. *See* Halfon et al., *supra* note 61, at 58.

150. *Id.* at 56-58.

151. *See* 1999 CHIP ANNUAL REPORT, *supra* note 136.

152. *See supra* text accompanying notes 77-79.

153. *See supra* text accompanying note 103.

154. *See supra* text accompanying note 78.

155. That is, more people income-eligible for public programs will at least be offered private coverage, although an increasing number of these income-eligible people will decline the offer due to the high cost-sharing associated with the private coverage. *See supra* text accompanying notes 39-41.

degree of crowd-out is recognized. The antidotes to this overreaction are awareness and perspective. The surprise that may accompany the recognition of a moderate level of crowd-out in public program expansion is illustrated by the recent experience of Rhode Island with its broad public expansion program, RIte Care.

RIte Care began with the filing of an application for a § 1115 waiver in July 1993.[156] The program began accepting members on August 1, 1994, and initially accepted families with children under age six and with incomes under 250% of the poverty level; the plan was expanded in 1996 and 1997 to cover families with children up to age eighteen.[157] Pursuant to a CHIP application filed on January 5, 1998, RIte Care incorporated CHIP's enhanced federal matching payments for children who would not, absent the § 1115 waiver, have been covered by Medicaid.[158] The program included anti-displacement provisions. Children eligible under the CHIP coverage must be uninsured, and may not have refused or dropped, within the year prior to application, employment-based coverage with an employee premium cost of less than $150 per month for individual coverage or $300 per month for family coverage.[159]

Through RIte Care, Rhode Island embarked on a plan to create "seamless coverage" for low-income children and their families, combining a state program, a § 1115 waiver increasing Medicaid eligibility and a CHIP program.[160] Through a Medicaid expansion program,[161] adults were eligible for public coverage with family incomes up to 185% of the poverty level.[162] Pregnant women and children were eligible for coverage with family incomes up to 250% of the poverty level.[163] This RIte Care expansion succeeded in identifying, enrolling and retaining families, and by May 2000 it covered

156. The Health Care Financing Administration, *Rhode Island Statewide Health Reform Demonstration Fact Sheet*, *available at* http://www.hcfa.gov/medicaid/rifact.htm (last visited Oct. 15, 2000).

157. *Id. See* R.I. GEN. LAWS § 42-12.3-9 (1993).

158. *See* The Health Care Financing Administration, *Rhode Island Title XXI State Plan Fact Sheet*, *available at* http://www.hcfa.gov/int/chpfsri.htm (last visited Oct. 15, 2000).

159. *Id*.

160. *State Legislative Agendas Focus on Managed Care and Chip: Potential and Value of Further State Reform Debated*, 30 STATE INITIATIVES IN HEALTH CARE REFORM 7 (March 1999).

161. This expansion provided, beginning in 1999, coverage for adults with income up to 185% of the poverty level pursuant to a "§ 1931 income disregard." *See* Wheatley, *supra* note 58, at 3. "Section 1931" refers to § 1931 of the Social Security Act, 42 U.S.C. § 1396u-1 (1994 & Supp. IV 1998).

162. R.I. GEN. LAWS § 40-16-1 (1999).

163. R.I. GEN. LAWS §§ 42-12.3-3, 3-4 (1993). The expanded program for children is referred to in the legislation as "RIte Track." For ease of reference, and consistent with popular discourse, the program will be referred to generally as "RIte Care."

"101,600 low- and middle-income adults and children, about 10 percent of the state's population . . . ."[164]

As costs increased beyond budgeted levels,[165] criticism of the program centered on crowd-out. A recent editorial in a Rhode Island newspaper captured this focus on private coverage displacement:

> [RIte Care] has been wildly successful in bringing health coverage to Rhode Island's low- and moderate-income populations. But because of a sharp jump in enrollments, RIte Care now accounts for more than half of the expected $50 million increase in state Department of Human Services spending . . . . It has done wonderfully well in reducing the numbers of uninsured Rhode Islanders. Only 10 percent of Rhode Islanders have no health insurance, compared with 18 percent nationally . . . . Where have the new beneficiaries come from? Well, some 20,000 Rhode Islanders dumped their private coverage to sign up for the free state plan.[166]

The level of crowd-out experienced by the program was reported in the press as approximately twenty percent,[167] a rate not jarringly out of line with the rates estimated for Medicaid expansions with less generous eligibility levels.[168] The press reports suggested a high level of concern that this level of crowd-out was unexpected, and unexpectedly high.[169] The press also cited the enrollment of state employees (prohibited under state law) as a systemic problem,[170] although this form of substitution accounted for only eight of over one-hundred-thousand enrollees, and all had apparently been removed from the program.[171]

Under these circumstances, Rhode Island officials could have reacted favorably, concluding that the aggressive outreach undertaken to promote

164. Christopher Rowland, *Officials Rethinking RIte Care's Mission*, PROVIDENCE J.-BULL., May 21, 2000, at A1.

165. *Id.* ("The Department of Human Services budget has a projected $50 million deficit in its health-related programs; more than half of it is due to RIte Care overruns.").

166. *The RIte Care Crisis*, PROVIDENCE J.-BULL., June 1, 2000, at B6.

167. Rowland, *supra* note 164, at A1 (reporting that "up to 20,000" of a total of 101,600 people covered by the program in 2000 "dumped private health insurance to take advantage of the free state plan").

168. *See* text accompanying notes 86-102.

169. *See* Rowland, *supra* note 164, at A1 ("Political leaders scrambling to control the state's budget-busting RIte Care health-insurance program have discovered a troubling trend: up to 20,000 Rhode Islanders have dumped private health insurance to take advantage of the free state plan."); *The RIte Care Crisis*, *supra* note 166, at B6 ("RIte Care now accounts for more than half of the expected $50 million increase in the state Department of Human Services spending . . . . Where have the new beneficiaries come from? Well, some 20,000 Rhode Islanders dumped their private coverage to sign up for the free state plan.").

170. *See* Rowland, *supra* note 164, at A1 ("There have even been a few isolated instances of state employees signing up for RIte Care . . . ."); *The RIte Care crisis*, *supra* note 166, at B6 ("State employees are not allowed to join RIte Care, but several have sneaked in.").

171. *See* Rowland, *supra* note 164, at A1.

public knowledge of the RIte Care program[172] had succeeded in a way that would make CHIP programs around the country envious.[173] The fiscal realities, of course, put the brakes on that reaction. The high enrollment in the program, whether attributable to the success of the outreach program, increases in the employee costs of coverage for low-income workers, or other factors external to the RIte Care program,[174] resulted in the public program's coverage of ten percent of the state's population, with the program on the hook for twice as much, should all those eligible apply.[175]

To its credit, Rhode Island did not react to the higher-than-expected cost of the program by slashing it and reducing eligibility or services. The response, however, highlights the importance of taking seriously the developments in crowd-out in public program expansion. Rhode Island reacted to what was cast in the public discourse as a crowd-out problem, quite predictably, with a crowd-out solution. Initially, the state was determined to move quite aggressively to limit displacement of private coverage. An early draft of the amendatory statute, for example, would have barred access to RIte Care for employees who refused or dropped coverage if the employer paid more than fifty percent of the premium, even if the employee's share of the premium would have imposed a crushing burden on a low-income family.[176] The Rhode

172. *See id.* ("The state undertook promotion efforts. The state Department of Human Services won a grant, part of which was used to support the work of thirty-four outreach workers around the state.").

173. *See supra* text accompanying notes 142-43 (discussing national concern over the slow growth rate of CHIP programs).

174. *See* Rowland, *supra* note 164, at A1 (describing several factors that might have contributed to high RIte Care enrollment, including outreach, the fact that "[e]mployers and employees have faced double digit increases in health-care costs for three straight years . . .," and difficulties experienced by Rhode Island's health insurance companies).

175. *Id.* ("Legislators are nervous about the potential for continued increases. By current estimates, 196,000 could qualify to join RIte Care, nearly double the current number of clients.").

176. *See* Felice J. Freyer & Christopher Rowland, *State Leaders Unveil Plan They Say Will Save RIte Care*, PROVIDENCE J.-BULL., June 16, 2000, at A1. The article discussed other restrictions for employees with some connection with workplace coverage:

> The new legislation sets a waiting period for certain adults applying for RIte Care, and places new restrictions on eligibility for RIte Care (and RIte Share [a proposed new segment of the public program applicable to income eligible people with some access to private coverage]). It would bar people whose premium costs are low or whose employer pays 80 percent of the premium; people (with a few exceptions) who have refused or dropped, within the previous six months, employer-sponsored health insurance in which the employer pays more than 50 percent of the premium; and people whose employer drops coverage for a class of employees who would qualify for RIte Care.
>
> Additionally, RIte Care enrollees whose income is more than 150 percent of the federal poverty level (about 10 percent of the current RIte Care population) would have to pay some co-payments and premiums, on a scale based on income. But those costs could not exceed 5 percent of an enrollee's income.

Island Director of Human Services suggested that this and other anti-crowd-out provisions would result in the disqualification of about four-thousand then-current RIte Care participants, and would bar four-thousand people expected to apply in the next year.[177] Advocates expressed concern that the changes would limit access to needed health coverage.[178]

The process leading to the passage of the amendatory statute softened this hard edge. In adopting a "RIte Care Stabilization" Act,[179] the General Assembly reaffirmed its goal of "providing or creating access to affordable health insurance for all Rhode Islanders who are uninsured."[180] It noted that this commitment to full insurance was not to be interpreted as a turning away from the traditional support of "coverage available through private employer-based health plans."[181] The legislation stands in contrast to press discussions of the RIte Care budget problems, and the discussions of an early draft of the amending language, which focused on people "dumping" private coverage and "sneaking" into RIte Care eligibility. The introductory language of the legislation sets forth a series of findings, which in no way blames the working poor of Rhode Island for the program's unexpectedly high costs. Instead, the findings attribute the costs to "an erosion in access to affordable employer-based health-insurance coverage,"[182] attributable to "escalating costs of private health coverage . . . for small businesses,"[183] and to "instability" in the state's market for health finance, evidenced by the loss of two major health insurers.[184] The legislature, in addition, found that the solution to RIte Care's budgetary woes will be addressed by attempting to shore up the private employer-based insurance market.[185]

The legislation takes only two new steps to address crowd-out in RIte Care. First, it conditions families' participation in RIte Care on their enrollment in any offered employer-based insurance plans,[186] but creates a

Id.

177. *Id.* (citing Christine C. Ferguson).

178. *Id.* (citing Marti Rosenberg, of Rhode Island Health Care Organizing Project).

179. An Act Relating to Health Reform, R.I. 2000—RIte Care Stabilization, Small Employer Insurance Reform, and Health Insurers' Accountability, 2000 R.I. Pub. Laws ch. 00-229 [hereinafter RIte Care Stabilization Act].

180. *Id.* § 1.

181. *Id*.

182. *Id.* § 1(1).

183. *Id.* § 1(3).

184. RIte Care Stabilization Act, *supra* note 179, § 1(2).

185. *Id.* § 1(4) - (6). The RIte Care Stabilization Act is predominantly concerned with small group and individual market reform, devoting seventeen of the substantive sections to that task, and only three sections to modifications to RIte Care itself.

186. *Id.* § 2 (adding new § 40-8.4-12(a) which directs the Department of Human Services to achieve a plan amendment requiring "eligible individuals with access to employer-based health insurance to enroll themselves and/or their family" in the insurance plan as a "condition of

premium support program which will pay some or all of the employee share of such employment-based coverage.[187] The second change was to permit the Department of Human Services to adopt regulations subjecting to cost-sharing, for the first time, a group of public program participants: those with family income between 150% and 185% of poverty.[188] The latter provision, however, limits the contribution of the low-income family to three percent of income, less than the five percent discussed in a draft version of the statute.[189]

In the process from the initial public splash about crowd-out in Rhode Island to the passage of the legislation "stabilizing" RIte Care, the discourse and language moved from knee-jerk to measured response. There are two short-term lessons that can be drawn from Rhode Island's experience. First, pay attention to the issue of crowd-out. The issue is not an entirely simple one. If the "discovery" that some modest percentage of public program participants were eligible for some level of private coverage catches governmental officials flat-footed, the press and those hostile to public insurance programs can be expected to make out of the discovery some combination of skullduggery on the part of low-income participants and incompetence on the part of the program's administrators. Rhode Island officials, it is safe to say, would have preferred to *act* to create a private premium support component in RIte Care, rather than *react* to assertions in the press that the state was standing by while program participants cheated taxpayers.

The second lesson derives from Rhode Island's eventual thoughtful and measured response. The response reflects an understanding that public program demand is affected by the deterioration of the level of private, employment-based coverage, particularly for low-income workers. It reflects an understanding that not all instances of employment-based coverage are created equal. Increasingly, again particularly in the case of low-income workers, offers of coverage can be accepted only at a high cost-sharing price—one that many low-income workers cannot pay.[190] The response also reflects an understanding that the government's interest in slowing the erosion of private coverage does not overcome the need to be fair about access to government subsidies.

participation" in the public program and adding new § 40-8.4-12(f) which directs the Department of Human Services to adopt regulations disqualifying for a period of time a person who refuses to enroll in available employer-based coverage).

187. *Id.* § 2 (adding new § 40-8.4-12(a) which provides for premium support for employment-based coverage pursuant to the terms of new § 40-8.4-12(b)).

188. *Id.* § 2 (adding new § 40-8.4-12(b)).

189. *Compare* RIte Care Stabilization Act, *supra* note 179, § 2 (creating new § 40-8.4-12(b)) *with* Freyer & Rowland, *supra* note 176, at A1 (discussing the draft bill's inclusion of a five percent cost-sharing provision).

190. *See supra* text accompanying notes 34-41 (discussing the increasing incidence of high cost-sharing requirements accompanying offers of health insurance to low-income workers).

Initially, it was reported that Rhode Island would act to prevent crowd-out by taking quite a hard line on the effect of access to private coverage on enrollment in RIte Care.[191] Instead, the state sought to protect private coverage while treating low-income workers equitably. Under these circumstances, equitable treatment entailed permitting low-income workers a similar opportunity to obtain and retain insurance coverage, notwithstanding whether the worker happened to be employed in a setting in which private coverage was offered.

The principle of equitable treatment does not require government to ignore the fact that a low income worker has access to private coverage. But it does require that a worker not be made worse off—less able to secure and retain health insurance coverage for her family—depending on the accident of a particular workplace's benefits package.[192] Rhode Island eventually broadened the scope of analysis beyond what Blumberg, Dubay and Norton call "target efficiency," and considered the fairness—the "horizontal equity"—implications of RIte Care's subsidy design. Rhode Island attempted to hew to this principle by encouraging or requiring workers to take advantage of private coverage opportunities, while assuring that the state will permit them to do so with approximately the same cost-sharing responsibility as a low-income worker with the same family income covered by the public program.

The Rhode Island experience may be recapitulated in Washington and in state capitals when formal crowd-out analysis is undertaken of CHIP and other recent public program expansions. The lessons from the Rhode Island experience seem to be two-fold. First, governmental officials and advocates supporting public program expansion should be aware of the apparent inevitability of the emergence of some level of crowd-out in any public program expansion. As the low-income workplace becomes less likely to offer full health benefits to workers and their dependents, public programs will be expanded to reach the working poor. The second lesson is that the response to crowd-out—ideally formulated before front page articles appear—should contemplate the complex nature of the task of efficiently expanding public

191. *See* Freyer & Rowland, *supra* note 176, at A1 (discussing draft language that would bar RIte Care membership unless employer's share of premium was quite low).

192. Blumberg et al., *supra* note 79, at 53-59.

> The crowd-out issue has the opportunity to focus the debate over how society will evaluate the success of public insurance programs. On one hand is the goal of minimizing the public cost per newly insured individual (target efficiency). On the other hand is the goal of providing public income support in such a way that people in similar economic circumstances receive similar levels of assistance (horizontal equity). The concern with crowd-out, per se, touches only upon the efficiency with which a program targets public dollars to the previously uninsured. While target efficiency is a relevant and important component of judging the cost-effectiveness of particular programs, it is not the only criterion against which new programs need to be evaluated.

Id.

program access to the working poor. In reaching the working poor, public programs will inevitably be reaching into a demographic group in which a large percentage of people have some access to private coverage. As the Rhode Island experience demonstrated, people have understandable and legitimate reasons for favoring public coverage over the private coverage associated with high levels of cost-sharing. A response to crowd-out should not fight that reality, but should permit the public program to mesh smoothly and efficiently with the changing economics of private-sector workplace benefits, building in incentives for employers and low-income employees to play by the rules.

The long-term implications of crowd-out in public program expansions merit a few words. Here, we admittedly move onto more speculative ground, but, if a few not unreasonable assumptions are granted, the long-term implications could be significant. In particular, dynamics surrounding crowd-out suggest a diminution of the importance of America's system of private, employment-based insurance and a concomitant increase in the significance of public insurance, potentially reversing the traditional balance in America's mixed public-private health finance system.

The assumptions that underpin this scenario are several—but not unreasonable. First, it seems reasonable to assume that the "new economy" will continue to drive a fall-off in access to health benefits for low-income workers. In particular, low-income workers are less likely to be offered coverage,[193] and, in particular, "peripheral" workers—part-time workers and newer full-time workers are less likely to be offered coverage.[194] If the "new economy" continues to encourage job-shifting and part-time employment, then it is reasonable to expect an increase in "peripheral" workers.

Second, it seems reasonable to assume that the cost of health coverage will continue to rise relative to background inflation. There is a recent revival of dramatic premium increases.[195] The drivers of this resurgence of price inflation include the adoption of increasingly expensive technology, the escalating use of increasingly expensive drugs and the aging of the population.[196] These causes of health coverage inflation seem unlikely to diminish in the foreseeable future. Third, as the cost of coverage continues to rise, it seems reasonable to assume that employers will continue to exhibit the

193. *See* Cooper & Schone, *supra* note 27, at 145.

194. *See* Farber & Levy, *supra* note 31, at 102.

195. *See* MILLER, *supra* note 21, at 5-7; Levitt et al., *supra* note 18, at 131-32. *See also* Stephen Barr, *Costs Rise 9% in Federal Health Plans; Third Year in a Row of Big Premium Jumps*, WASH. POST, Sept. 19, 1999, at A1.

196. *See* MILLER, *supra* note 21, at 9-18. *See also* Robert W. Dubois et al., *Explaining Drug Spending Trends: Does Perception Match Reality?*, HEALTH AFF., Mar.-Apr. 2000, at 234-35. For seven conditions associated with treatment with pharmaceuticals, the drug treatment costs over a three-year study period increased at a level ranging from 43% to 219%. *Id.*

tendency to pass a portion of that increased cost on to employees,[197] specifically in the form of increased cost-sharing for dependent coverage.[198] In particular, this effect will be felt by employees of smaller businesses and part-time workers.[199]

Fourth, it seems reasonable to assume that the trend of relatively flat compensation levels for low-income workers[200] will continue, as an information-based economy rewards the well-educated and penalizes those without education or technical skills. And fifth, it seems likely that the burden of increased cost shifting on low-income workers and workers in small businesses, particularly those with a large number of part-time workers, will continue to result in a low rate of take-up of offers of employment-based health coverage by these workers.[201]

Should these predictions prove more or less accurate, there will naturally be pressure to continue to expand public programs to provide coverage for the uninsured families of the working poor. Indeed, as Rhode Island worked through its budgetary concerns with its comprehensive public insurance expansion program, it concluded that the increasing demand for public coverage was attributable in large part to the inability of workers to afford private coverage.[202] The Rhode Island General Assembly concluded that these economic factors, rather than cheating by RIte Care enrollees, was the cause of the program's unexpected growth.[203]

In recent years, the rate of uninsurance has risen only gradually because increases in public programs have masked the deterioration of employment-based coverage.[204] As pressure grows to provide coverage to the working poor left uncovered as a result of workplace shifts, public officials are likely to follow the thought process evidenced by the Rhode Island General Assembly.

197. *See* O'BRIEN & FEDER, *supra* note 8, at 17; RICE ET AL., *supra* note 34, at 31-32; Cooper & Schone, *supra* note 27, at 147.

198. *See* RICE ET AL., *supra* note 34, at 63-64.

199. *See* David Dranove et al., *"Competition" Among Employers Offering Health Insurance*, 19 J. HEALTH ECON. 121, 135-38 (2000) (small firms and firms with a high percentage of part-time workers impose higher cost-sharing burdens on their employees).

200. *See* O'BRIEN & FEDER, *supra* note 8, at 12; Handler, *supra* note 25, at 4.

201. *See* Cooper & Schone, *supra* note 27, at 147 (low-income workers).

202. *See* RIte Care Stabilization Act, *supra* note 179, § 1(4), (5).

203. *See* text accompanying notes 179-85.

204. *See* Rowland et al., *supra* note 12 ("The 1988 through 1995 decline in employer-sponsored coverage would have produced a larger number of uninsured Americans had it not been accompanied by an increase in Medicaid coverage."). As has previously been noted, the apparently temporary flattening of health care cost inflation and historically low rates of inflation were associated in the late 1990s with a small increase in employment-based coverage. *See* Holahan & Kim, *supra* note 33, at 194. The possibility that these two factors (historically low unemployment and flat health care inflation) will continue into the future for any substantial period of time seems quite remote.

That path has two components. First, they will recognize that the pressure on public programs is based on the dynamics of the workplace—and principally on the growth in the cost of coverage to low-wage employees.[205] Second, they will come to realize that crowd-out is a complex factor in the consideration of public program growth. As Rhode Island seems to have discovered, crowd-out is not a significant cause of the growth pressure on public programs. Rather, crowd-out must be taken into account in program design, in order to assure a proper mesh between public and private coverage that both maximizes private sector coverage and treats low-income workers equitably.[206] If the five assumptions discussed above hold, and if officials follow the path set out by Rhode Island, then we will experience a steady growth of public programs without substantial concern about crowd-out.[207]

In addition to this negative point—that crowd-out is not a barrier to public program expansion—there are three positive points related to the crowd-out dynamic that suggest an accelerated shift in the health finance balance to public programs. All are related to the fact that the public program expansion of the last fifteen years has moved Medicaid and its related programs beyond the destitute to the working poor, a progression that is likely to continue as public program expansion reaches more and more deeply into the ranks of employed Americans.

The first positive point is that the expansion of public programs may lessen the stigma now attached to Medicaid participation. Insurance coverage is not sufficient to provide health care to patients—health care providers must be willing to participate in the insurance program and to treat appropriately the patients covered by the insurance.[208] As public programs expand, they cease to be poverty programs, and thereby may shed their image which has caused some health care providers to either shun Medicaid recipients or treat them with less respect than privately insured patients. And it works both ways—as health care providers cease treating participants in public programs differently,

205. This pressure will be exacerbated with a downturn in the economy and a drop in the rate of employment. *See supra* notes 193-95.

206. *See supra* text accompanying notes 179-85.

207. As is noted above, the enrollment dips in public programs related to the uncoupling of Medicaid from welfare have eroded public program enrollment. *See* UNITED STATES GENERAL ACCOUNTING OFFICE, *supra* note 63. The correction of this problem, serious though it is, is beyond the scope of this Article, which assumes that the steps suggested in the works described above in note 63 can correct this erosion.

208. *See* Sidney Watson, *In Search of The Story: Physicians and Charity Care*, 15 ST. LOUIS U. PUB. L. REV. 353, 359-60 (1996); Sara Rosenbaum, *Rationing Without Justice: Children and the American Health System*, 140 U. PENN. L. REV. 1859, 1874-75 (1992).

the program participants will be less inclined to feel that membership in the public program sets them out as less than a full member of society.[209]

The second positive point is that the intermeshing of public and private coverage may aid in establishing greater continuity of coverage for low and moderate income Americans. Workers change jobs, and low-income workers shift from private to public coverage as their employment circumstances change.[210] As the intermeshing of public and private coverage proceeds, low-income workers are more likely to maintain coverage as their employment status changes; the public program subsidy will rise or fall depending on the degree of private coverage available in the workplace, but their membership in a health plan could remain continuous. Low-income families would therefore "have more reliable access to health coverage and a greater likelihood of receiving both preventive and primary health care, leading to improved health status."[211]

The third positive point might seem not all that positive to some. Although the Rhode Island experience and the studies of crowd-out associated with prior Medicaid expansions suggest that crowd-out ought not be a barrier to public program participation, expansions of public programs do appear to displace private coverage to some degree.[212] This effect is likely to become greater as the income levels for public programs increase.[213] The Rhode Island response to crowd-out did not attempt to eliminate the displacement of private coverage—such a result would have been inequitable for those low-income workers with inadequate private coverage, or private coverage associated with crushing levels of cost-sharing. Rhode Island's remedial steps therefore balanced an interest in protecting private coverage with a desire to treat low-income workers equitably. Crowd-out, then, may be minimized, but it cannot be eliminated. Crowd-out will, therefore, accelerate the expansion of public programs.

IV. CONCLUSION

The expansion of Medicaid and related public programs responds to a pressing need. Shifts in the labor economy have diminished the extent to which workers—particularly low-income workers in new or part-time employment—are covered by traditional employment-related health coverage. States and the federal government have responded in the last fifteen years by

209. *See* Jennifer P. Stuber et al., *Beyond Stigma: What Barriers Actually Affect the Decisions of Low-Income Families to Enroll in Medicaid?* 7 (July 2000), *available at* http://www.hfni.gsehd.gwu.edu/~chsrp/pdf/stig.pdf.

210. *See* UNITED STATES GENERAL ACCOUNTING OFFICE, *supra* note 63, at 16.

211. *Id.*

212. *See supra* text accompanying notes 96-102.

213. *See* Blumberg et al., *supra* note 79, at 58.

expanding public programs to attempt to stem the tide of uninsurance. Legislators have raised concerns that such expansions of public programs from the ranks of the destitute to the working poor will crowd-out private coverage.

Crowd-out has manifested in Medicaid expansions in the late 1980s and early 1990s, and it will occur in the context of present and future expansions. It arises in part, however, because the employment-based insurance system has changed; the cost-sharing imposed on low-income workers, and particularly those with new and part-time jobs, can exceed their ability to pay. Their inclination to "drop" private coverage is therefore understandable, and anti-displacement measures that subsidize low-income workers' cost-sharing burdens must become a standard part of public program expansions.

Public and private coverage, then, has become enmeshed in two ways. First, these two parts of our health insurance system, once geared to entirely different populations, now substantially overlap at the level of low- and moderate-income workers. Second, these low- and moderate-income workers will increasingly, in response to concerns for crowd-out, be served by a hybrid system, in which their coverage is financed in part by their employer, and in part by a public program. The trajectory of workplace economics and the rising cost of health coverage suggest that the dominance of the private insurance system in America will continue to diminish, as public programs move into the business of covering low- and moderate-income workers. Under reasonable assumptions about the future cost of health care and the American labor market, this trend can be anticipated to lead to a transformation of America's mixed public-private health insurance system from one dominated by private coverage to one in which public coverage is the norm.