

How Did Expansions of Children’s Public Health Insurance Affect Participation in the Supplemental Security Income Program?

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This issue brief highlights findings from a study of the interplay between two important public programs for vulnerable children: Medicaid and the Supplemental Security Income (SSI) program. Medicaid eligibility for children expanded in the late 1990s and early 2000s, primarily due to the creation of the Children’s Health Insurance Program (CHIP). Because people who receive Medicaid or CHIP often access other public supports, these expansions may have affected other social safety net programs, including SSI. We found that on average, expanding Medicaid eligibility did not affect youth SSI applications or awards, though there were differences between states. States where expansions in public health insurance coverage led to a significant decrease in both applications and awards had higher transaction costs associated with entering Medicaid via SSI, which could explain the decrease in SSI participation.

Introduction

Understanding the interplay between social programs is important. Changing the eligibility requirements or benefit structure for one safety net program might affect others, for example. The relationship between Medicaid and SSI participation is particularly relevant to policymakers because both are important sources of support for many children with disabilities whose families have limited incomes. Rigorous debate continues on the appropriate scope of these programs.

For example, Congress recently considered substantial cuts to Medicaid as part of efforts to repeal the Patient Protection and Affordable Care Act (ACA). Understanding the interaction between these two key programs is essential for the full accounting of the potential benefits and costs should eligibility changes be implemented for these programs.

This brief presents findings from a study that estimates the causal impact of CHIP-era expansions in Medicaid eligibility on children's participation in SSI (Levere et al. 2019). Our results rule out a “welcome mat” effect—that is, that expanded access to Medicaid *increased* children's participation in SSI. We find some evidence of substitution between the two programs, with the availability of Medicaid to more children *reducing* the number of SSI applications and awards to children. Yet the size of the substitution effect depended on the states' policies on linking the SSI and Medicaid programs; we only found evidence of substitution in states where SSI recipients were not auto-enrolled in Medicaid. Any substitution between programs could result in significant fiscal savings in the form of benefits not paid to children who would otherwise be accepted to SSI but choose not to apply when there is another way for them to obtain Medicaid.

Intersection of child SSI and CHIP

SSI is an important safety net for poor families who have children with disabilities. In 2015, it provided benefits to about 1.3 million children (SSA 2015). SSI provides a cash payment to help parents care for their qualifying children with disabilities. In most states, SSI receipt also confers Medicaid coverage to the child, which can be particularly valuable for children with disabilities because Medicaid covers a broad range of medical and supportive services at zero or minimal cost-sharing to families. In 32 states and the District of Columbia, child SSI recipients automatically receive Medicaid. In the remaining 18 states, SSI recipients must meet additional criteria to receive Medicaid benefits.

Many children from low-income families also qualify for public insurance through state Medicaid and CHIP programs. Enacted in 1997, CHIP was designed to help close coverage gaps for children whose families cannot afford private coverage but still have household incomes too high to qualify for Medicaid. The rollout of CHIP in the late 1990s through the early 2000s led to a dramatic increase in the number of children who were eligible for public insurance (Leininger and Levy 2015).

Along with the expansion of eligibility to a new group of poor and near-poor families, a hallmark of the CHIP-era expansions was the easing of the administrative burden associated with Medicaid and CHIP applications for children. Many states eliminated or reduced complicated income disregards and reporting requirements, shortened their applications, and increased the time between recertification intervals for public coverage, making it easier for those eligible to take up Medicaid coverage (Lewit 2014).

Newly available Medicaid coverage after the CHIP-era expansions offered children with disabilities an alternative path to obtaining Medicaid in addition to SSI. The new eligibility categories—requiring minimal administrative and time burden on the part of families—offered a potentially attractive substitute for gaining public insurance coverage in comparison with pursuing SSI, especially for families who were primarily applying to SSI for the associated Medicaid benefit.

We hypothesized that changes in Medicaid eligibility likely affected SSI applications. Filing an application incurs substantial costs, including but not limited to considerable time to navigate the administrative requirements. If a family was on the margin of submitting an application but became newly eligible for Medicaid due to an expansion, the value of an SSI award would decrease because the family could receive Medicaid through the other channel. The decrease in the value of an SSI award could persuade some families *not* to apply for SSI benefits. We hypothesized a smaller impact on awards than applications because SSI cash benefits for the child would likely be an important source of income for potential SSI beneficiaries, who must have sufficiently low-incomes, leading those likely to be awarded to still apply.

Alternatively, increases in public insurance eligibility from the CHIP expansions might have brought more children into SSI. The expansions likely brought some families into the social safety net for the first time, potentially increasing their awareness of other social programs, including SSI. Moreover, as posited in a federal report (Government Accountability Office 2012), greater access to medical care through the newly available Medicaid coverage might have led to more opportunities to receive qualifying—and documented—diagnoses, which could particularly increase SSI participation in the longer term.

Overview of Data and Methods

To answer the research questions, we analyzed counts of SSI applicants and awardees from the Social Security Administration's Supplemental Security Record, which captures the complete application and award history for persons applying to SSI over the period 1997 to 2010. We linked these counts to data from the March supplement of the Current Population Survey and Medicaid income eligibility thresholds. We used these data to calculate our key explanatory variable: the percentage of a national sample of children of each age cohort eligible for Medicaid in a given state and year (Currie and Gruber 1996a; 1996b; Brown et al. 2017). This variable represents the generosity of Medicaid and CHIP eligibility for each age group in a given state in a given year.

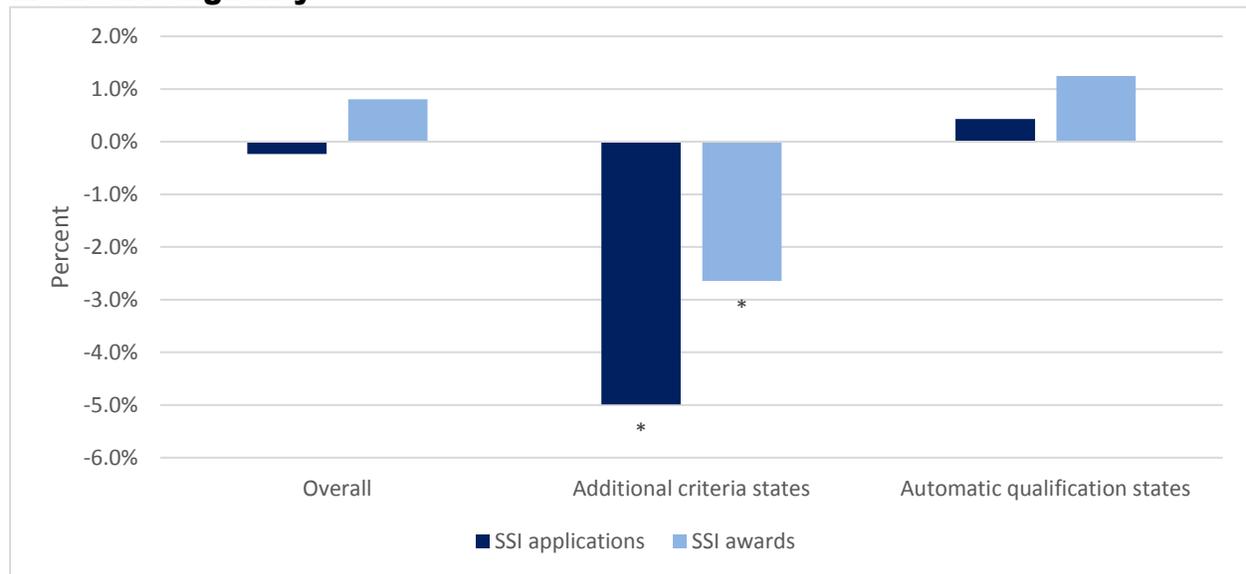
To estimate the impact of expanded Medicaid/CHIP eligibility on SSI applications and awards to children, we used a generalized difference-in-differences approach. This design takes advantage of the variation in timing and extent of the expansions across states and across age groups within states. Details on the methods can be found in Levere et al. (2019).

Effects of CHIP-era expansions on children's participation in SSI

On average, we did not find evidence of a meaningful impact of the CHIP-era public insurance expansions on SSI applications and awards among children (Figure 1). Point estimates are small and fairly precisely estimated.

Although the aggregate results suggest no effect of Medicaid eligibility on SSI applications and awards, there are substantial differences between states in this relationship. We classified states by whether they automatically conferred Medicaid after an SSI award. In the states that required people to meet additional criteria to receive Medicaid after a new SSI award (referred to hereafter as additional criteria states), increases in Medicaid eligibility led to a large, statistically significant reduction in children's participation in SSI; a 10 percent increase in eligibility (relative to the baseline rate of 47 percentage points) was associated with an 5 percent decrease in SSI applications and a 3 percent decrease in SSI awards. In the states where an SSI recipient automatically receives Medicaid, there was a small, though not statistically significant relationship between Medicaid eligibility expansions and SSI applications.

Figure 1. Estimated change in SSI outcomes per 10 percent increase in Medicaid eligibility



Source: Authors' calculations using SSA administrative data and CPS data.

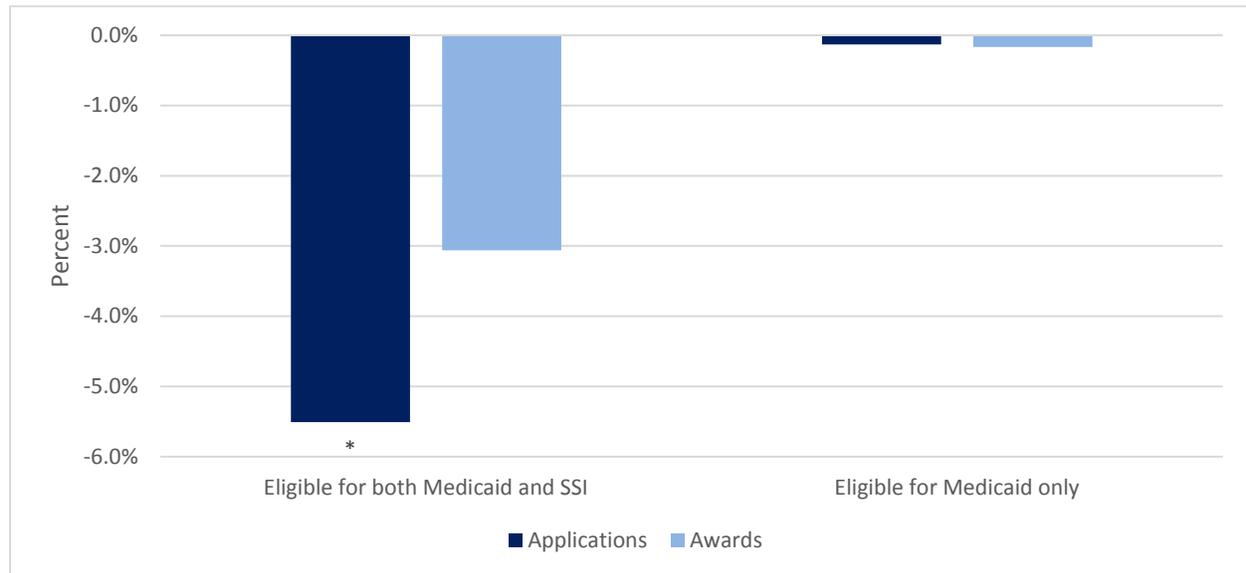
Note: Shows the estimated percent change in SSI applications and awards from a 10 percent increase in Medicaid eligibility, relative to the baseline average rate of eligibility in the relevant state group. Estimates come from a regression of the outcome variable (applications or awards per capita in a given age-state-year cohort) on Medicaid eligibility, controlling for age, state, and year fixed effects and several demographic variables.

* Indicates estimate is different from zero at the 5 percent significance level.

We implemented several checks to help corroborate the results. First, we expected that changes in application behavior that were caused by expansions in Medicaid should occur primarily where the expansions in Medicaid affected those who might also be eligible for SSI. We verified that changes in Medicaid eligibility at income levels below the SSI income threshold led to substitution away from SSI in additional criteria states, whereas changes in Medicaid eligibility at income levels above the SSI income threshold had no detectable effect on SSI applications or awards (Figure 2). This finding reinforces the interpretation of the impact of the Medicaid expansion as the causal effect on SSI outcomes.

Second, we also expected to find no relationship between states' CHIP expansions, which were focused on children, and SSI outcomes for people age 65 and older. We indeed found no impact of the eligibility expansions for children on SSI applications and awards among the elderly in additional criteria states (results not shown). The overall results were also unchanged when we varied the regression specification in different ways.

Figure 2. Estimated change in SSI outcomes in additional criteria states per 10 percent increase in Medicaid eligibility, by income level



Source: Authors' calculations using SSA administrative data and CPS data.

Note: Shows the estimated percent change in SSI applications and awards in additional criteria states from a 10 percent increase in Medicaid eligibility, relative to the baseline average rate of eligibility in the group with incomes low enough to be eligible for both Medicaid and SSI versus those with incomes that qualify them only for Medicaid. Estimates come from a single regression of the outcome variable (applications or awards per capita in a given age-state-year cohort) on both groups of Medicaid eligibility, controlling for age, state, and year fixed effects and several demographic variables.

* Indicates estimate is different from zero at the 5 percent significance level.

Policy implications

Although we did not find that increases in Medicaid eligibility led to changes in applications and awards to SSI overall, we did find that increases in Medicaid eligibility significantly reduced applications and awards in states where there was a hurdle to Medicaid entry after SSI entry; that is, where Medicaid entry after SSI entry was not automatic. We attribute this to the fact that in the additional criteria states, the expansion led to a larger reduction in the transaction costs of entering Medicaid than it did in states that auto-enrolled SSI recipients into Medicaid. Before the expansion, the primary transaction cost in states with additional criteria was needing to file a separate application for Medicaid. Further, in some of these states, the Medicaid income criteria were more stringent than the SSI income criteria, so some SSI recipients in those states might not qualify for Medicaid. Transaction costs therefore fell more in states with additional criteria, indicating that the availability of an alternative route to Medicaid coverage might be particularly appealing to potential SSI applicants in these states. Substituting Medicaid for SSI is consistent with health insurance playing an important role in the decision to apply for SSI.

Our findings rule out that the CHIP-era expansions of Medicaid led to a “welcome-mat” effect for SSI. Past policy debates considered that a welcome mat effect could lead to complementarity between government benefits programs. Such an effect might occur if participating in one government benefits program, and thereby gaining a deeper understanding of the entire social safety net landscape, led to increased participation in other similar programs. We

find instead that the two programs are more likely to act as substitutes, with increased Medicaid eligibility reducing SSI applications.

There could be significant fiscal savings to SSI when there is another way for low-income children to obtain Medicaid. First, fewer applications to SSI could reduce SSA's administrative costs of screening and processing applications. Second, fewer awards to children who would otherwise apply and qualify would reduce SSI cash benefit outlays. Taken together, this implies that expanding Medicaid could induce cost savings in the SSI program.

These results are therefore pertinent to the ongoing debate about reforming the health insurance system in this country. If proposals to change Medicaid eligibility or reduce funding for these programs go into effect, some of the cost savings could be offset by more children participating in child SSI. Similarly, an expansion in Medicaid might be accompanied by reductions in SSI participation, offsetting some of the increased costs of new coverage. Understanding the potential spillover effects on childhood SSI receipt is an important input for the full accounting of potential benefits and costs of Medicaid and CHIP eligibility.

This study has several limitations. First, we focused on expansions in eligibility that came largely as a result of the CHIP legislation, and also on children's participation in SSI. Hence, these results may not generalize to expansions of public eligibility to other age groups. Second, although there is some evidence of reduced participation in children's SSI as a result of these expansions, this may only indicate a delay in SSI participation. In the full paper we also present results for the long-term effects of Medicaid expansions in youth on adult SSI participation, finding evidence of fewer applications from young adults, but insignificant impacts on SSI awards. Studies that consider other expansions and age groups would deepen our understanding of the complex relationship between these two important safety net programs.

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