

Executive Summary

In the United States over the last twenty years, the provision of subsidized or free medical services to certain members of the low-income population has become a central component of the package of benefits for the poor. In 1988, 53 percent of all means-tested transfers were in the form of in-kind transfers. The Medicaid program, providing health coverage to the poor, accounted for 70 percent of those transfers. The major group eligible for Medicaid services consists of female-headed families on AFDC, for Medicaid eligibility is closely tied to AFDC eligibility even after recent expansions in Medicaid coverage. Because Medicaid is a substantial component of the package of benefits to such families, it has long been suspected that it may provide a strong incentive to enter the AFDC rolls or a disincentive against leaving the rolls. The study described here provides an empirical examination of this issue.

Using data from the Survey of Income and Program Participation, a survey of the U.S. population conducted by the Census Bureau from 1984 to 1986, the relation between AFDC reciprocity and the Medicaid program is examined. The closely related issue of whether Medicaid discourages participation in the work force is also studied. Using data from the survey on health conditions and medical utilization of female heads of family and their children, an index of the importance of Medicaid to each family in the sample is developed. Families with high expected medical expenditures have a higher expected value for the Medicaid program than do families with low expected medical expenditures. Using

data from the survey on private health insurance coverage, indexes of the value of private coverage as well as the probability of private coverage are similarly constructed for each family in the sample.

The first finding from the study is that the suspected disincentives of the Medicaid program are strongly present:

- An increase in the level of expected Medicaid benefits to a family strongly increases its likelihood of being on AFDC and reduces the likelihood that the head will participate in the work force.
- The magnitudes of the effects are not small. A one-third increase in Medicaid benefits would increase the AFDC caseload by 6 percent and would reduce the percentage of female heads who work by more than 5 percentage points.

Nevertheless, closer examination of these effects for families with different levels of expected medical expenditures reveal that the effects do not appear for the majority of families:

- Only a minority of families are affected by the Medicaid program. Only the families with quite high expected medical expenditures respond to the program by staying on the AFDC rolls and failing to participate in the work force. Among a majority of female-headed families, the program does not appear to affect decisions.

The second set of findings from the study relates to the importance of private health insurance. Since most private insurance requires copayment, we find that the value of private coverage for those covered by private health insurance is lower than for Medicaid, even for families with the same health characteristics. We also find, as have many other studies, that private coverage is not universal among working female heads. Our examination of the effects of different levels of coverage and private health insurance benefit levels reveals strong incentive effects in the opposite direction to those of the Medicaid program:

- Higher levels of expected private health insurance benefits exert strong incentives to join the work force and to leave the AFDC rolls.
- The magnitude of the effects are much larger than those exerted by the Medicaid program. Increases in private insurance benefit levels have almost tripled the effects of Medicaid on the AFDC caseload and have more than doubled the effects of Medicaid on the likelihood of participating in the work force. Specifically, an increase in private health insurance equivalent to that for Medicaid would lower the AFDC caseload by 16 percent and raise employment probabilities by almost 12 percentage points.

The results also show that the extension of coverage in the working female-head population would have strong effects:

- Private health coverage for all working female heads would lower the AFDC caseload by 10 percent and would increase employment probabilities among female heads by almost 8 percentage points.
- If all female workers were covered by private insurance, an increase in the benefit level in private insurance plans to bring them up to Medicaid levels would reduce the AFDC caseload by one-fourth and would raise employment probabilities by 18 percentage points.