



Transcript for “Does Child Medicaid Access Improve Long-Term Educational Outcomes?”

Featuring Lincoln Groves

Hosted by Dave Chancellor

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[Chancellor] Hello, you’re listening to a podcast from the Institute for Research on Poverty at the University of Wisconsin–Madison. I’m Dave Chancellor.

For this, our February 2016 podcast, I talked with Lincoln Groves who is a postdoctoral scholar in the National Poverty Fellows program that IRP runs in cooperation with two federal offices within the U.S. Department of Health and Human Services -- the Assistant Secretary for Planning and Evaluation or ASPE, and the Office of Planning, Research and Evaluation or OPRE. Groves was at IRP in December of this past year and gave a seminar talk called “Still ‘Saving Babies’? The Impact of Child Medicaid Expansions on High School Completion Rates,” which was based on the dissertation he did at Syracuse University. ‘Saving Babies’ is a reference to a 1996 paper by Janet Currie and Jonathan Gruber that looks at health outcomes associated with major changes in the Medicaid program between around 1980 and the early 90s that expanded eligibility for low-income children and pregnant moms. So, when we started talking, I asked him about his shout out to the Currie and Gruber paper and how that paper influenced his work.

[Groves] So I just looked at it and wow - this is a really interesting research design, it’s very clear, it’s very creative. This is the type of researcher I want to be, right? So I also love simulations, I love data work, and things like that they were doing were really cool. And so just as a challenging intellectual exercise, I said hey, let me see if I can replicate this. Which, at the time was a very naive exercise because it wasn’t very easy to actually get all of the data required to do that. Fortunately, in Syracuse, New York, there’s long cold winters and you need to do something during those time periods so I just started collecting all of the data to do it. At the time, we’re just trying to find our voices as researchers and I was doing other different projects. I was looking at high school dropouts just in general, so I kind of had the one side of the paper is very much a child investments, child Medicaid, thinking about health improvements. And I had separate work looking at different outcomes in terms of graduation rates. And I was looking at things like impacts of No Child Left Behind, I was looking at exit exams, things like that, and I really wasn’t finding large effects. So I just kind of had these two disparate topics, and I said, well, why don’t I look at them together? There’s this early childhood investments thing and I

said, well this kind of makes sense. One's going up while the other one's going down. In terms of going up, it's access to care for children and the other one's going down, dropout rates -- and graduation rates are... Let me see how these are linked. I put the research design together and started pushing it forward there.

[Chancellor] Groves says that in looking at the connection between Child Medicaid receipt and graduation rates, that he was really asking a straightforward research question:

[Groves] "Do healthier children have better long term outcomes?" That's all this is looking at. So as we look at different kinds of levers and mechanisms by which the government can help facilitate improvements in long run outcomes, health is a pretty obvious one.

[Chancellor] What Currie and Gruber did in their paper and what Groves replicates in his paper is, they look at variation in Medicaid eligibility to see how differences in one of government's big health policy levers over time and place might lead to different outcomes. So, to understand this better, let's take a look at the basic history of how Medicaid eligibility for children worked.

[Groves] In the beginning, Medicaid access was tied to Aid to Families with Dependent Children program in the United States. And that was the cash assistance welfare program -- so most people think of welfare, they think of AFDC back in the day and it changed to TANF, Temporary Assistance for Needy Families in the 90s through welfare reform but they just kind of bundled these projects together once upon a time. So, Medicaid actually is a standalone program, part of President Johnson's Great Society Program and it just, because of the interesting nature of health insurance in the United States, there just wasn't necessarily an outlet for low-income individuals so as part of the Great Society, they realized there was a gap in the market and this was one way to fill that void. So they just tied it to another support program that had existed since the 1930s, which was AFDC, and if the mother, typically it was single mothers qualifying for the program who had children, dependent children -- and they would just do this all together.

[Chancellor] But, there were disadvantages to tying child Medicaid to AFDC. AFDC generosity often fluctuated and Child Medicaid eligibility fluctuated with it. And, since AFDC was mostly directed at single mothers with children, there were relatively large numbers of kids in two-parent married families with low income who weren't eligible for the health benefits. And, because states were able to set their own eligibility criteria, there were remarkable differences in eligibility from state to state.

[Groves] The example I remember is Alabama being in 1987 at 16% of the federal poverty line, so if you actually had an income (this is like a family of three), if you an income that was 17% of the federal poverty line, boom, you're wealthy is basically what the legislators were saying. You don't necessarily qualify for the program. And then there would be other states like California is the example I remember, 109%, so they were well above it. So, again, they had it tied for a while and then legislators started thinking more about how do we improve access -- and I think they genuinely wanted to do it, improve access to the program, knowing that there are benefits. It kind of also stemmed out of the United States had a very high infant mortality rate, which was very surprising for a western nation. So there was this drive in the 1980s to say, let's find ways to get healthier children and part of that is extending care to the mother while she's pregnant and then

logically there this kind of extension through early childhood and eventually through the entire childhood. So this decoupling, they had federal mandates saying 'ok, you've got to delink the programs' so Child Medicaid can be its own standalone program and the child can qualify on their own and you'll have these dates by which you have to adopt a federal poverty line threshold standard within your state and states are choosing to do it at different times and also sometimes exceeding the minimum level set.

[Chancellor] So Groves uses this variation in state level eligibility for Child Medicaid and links it up with the long term outcome of high school graduation, as we mentioned before.

[Groves] So basically as we think about just identifying a graduation cohort, we can make an assumption they graduate at an average age of 18. Then we can back out what their birth year would have been 18 years and so let's say 1981, what were the state standards during that year and kind of take the simulated sample, this nationally representative sample, and say if all these children would have lived in the state, what percentage of the children would have qualified based upon that state's regulation at that point in time? And we do that for each individual year, so if it's going to be from conception through 5, that's 7 years, we're going to do that seven years through that calculation of just kind of averaging these zeros and ones or we do throughout the entire time, from prenatal care all the way through age 17. So it really is just kind of this broad measure of, how accessible was access to care for low income children to get Medicaid insurance during the time that they were growing up.

[Chancellor] For his results, Groves looks at two main measures -- dropout rate and four year high school graduation rate.

[Groves] So there will be large decreases in the dropout rate and correspondingly, increases in traditional four year graduation rates. Unfortunately the GED is an imperfect substitute. It's not highly valued on the marketplace and there's a large body or at least a decent body of literature which shows that GED holders don't really make much more than high school dropouts. Really, if we want to nudge increased human capital development in the United States, it needs to be traditional diplomas.

In the paper I try to put some meat on these statements in terms of the effects, in terms of the size. I think some nice take home points to think about are, I use this base of 3.8 million potential graduates in 2010. The paper outlines exactly how I get that number, but that's from data of the Common Core of Data. In looking at the impacts on dropouts, there's over 200,000 less dropouts per year in that 2010 measure, and there's going to be correspondingly like 100,000 more graduates that can be directly tied to public health insurance access during childhood. And those are pretty substantial effects, I think.

[Chancellor] I asked Groves what might be behind these effects that he's found and he says there are two obvious areas that may be driving improved high school graduation among children who had Medicaid access.

[Groves] It's just improved health, which just kind of makes sense, that children with access to health insurance will just be healthier, right? And the question is, when does that occur? Is it

early childhood, is it while they're actually in high school for example? Is it someplace in between? We think that as the child is in the seat more often, they're going to have benefits from that. Sick children miss a lot of days from school, there's just issues, before they even enter school if they're just sick a lot, there's going to be decreases in cognitive development, non-cognitive development as well, so we just think that they might not be as prepared. And also, quite frankly, there's an income effect. We know that money matters, especially for low-income families, especially when it could be a couple of thousand dollars. If you're not making that much as a family, not having to pay for things like, especially the birth of a child can be very large for a family that doesn't have a lot of means, especially without insurance. Or just having copays paid for. Or other doctor visits and things like that. That money can be reallocated to other things that could better benefit the family in terms of the long term trajectory of the child. The problem is we can't really disentangle those two effects at this point in time, at least not with the research design that I have and in other ones that I've seen in the literature.

[Chancellor] Groves says that his results – which echo those of the work of Currie and Gruber -- and those of other papers in the field that look at similar questions point toward the importance of children's health as a basic policy issue.

[Groves] To give low income children the potential for opportunities in the United States, we should kind of take care of a few basic measures, and public health is seemingly a lower bar one in terms of, it needs to be addressed before they can start concentrating on higher level issues within their lives. So, giving this access to low income children I think is -- these papers are showing that there are tremendous long term benefits and I think that's very important, especially as we look at today with the ACA debates. So, part of this contention is that there are short run costs that states have to absorb and that makes certain policymakers or certain individuals uncomfortable because it's increasing the size of government, but as we think about the long term benefits, right? So we have a social welfare system here in the United States which is pretty large, let's just be honest about it, right? And yes we don't want to waste money but if we're finding ways that can increase human capital in the long run, it makes these people in theory less dependent on public support programs as adults, more likely to be taxpayers, and then they're paying back, essentially, the government. I think about this as a human capital investment story.

[Chancellor] Thanks to Lincoln Groves for sharing his work with us. You've been listening to a podcast from the Institute for Research on Poverty.