Baruch COLLEGE
MARXE SCHOOL OF PUBLIC AND INTERNATIONAL AFFAIRS CUNY

CUNY INSTITUTE FOR DEMOGRAPHIC RESEARCH

Enhancing the Supplemental Poverty Measure to Estimate the Impact of Health Insurance Benefits on Poverty

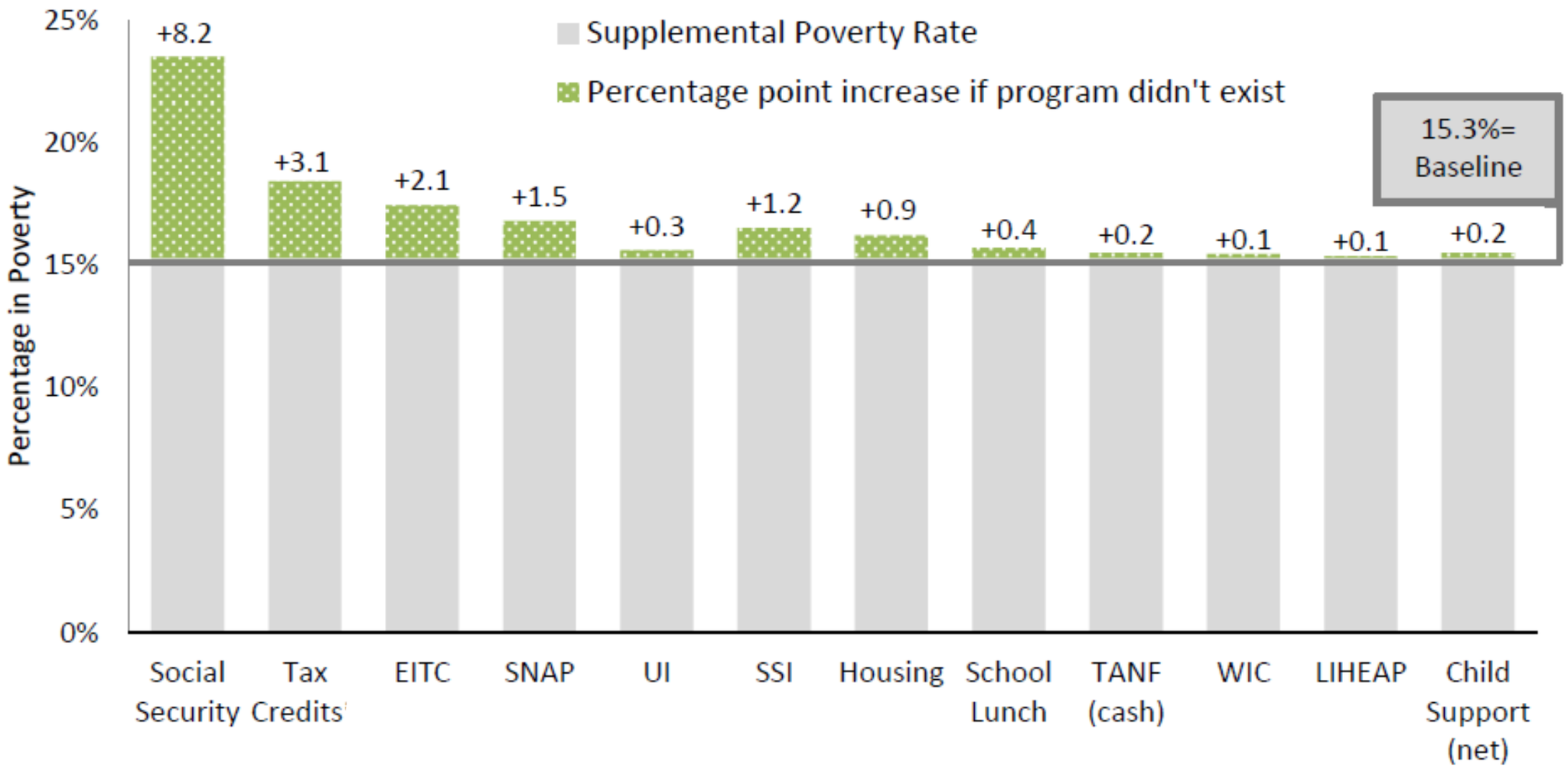
Sanders Korenman,
Dahlia Remler & Rosemary Hyson

Federal Committee on Statistical Measurement
Research and Policy Conference
Session on Supplemental Poverty Measure: Potential Improvements
March 7, 2018

Acknowledge: Russell Sage Foundation & Robert Wood Johnson Foundation
The Social, Economic and Political Effects of the Affordable Care Act Program

SPM useful for measuring the poverty-reducing impact of many cash and in-kind transfers, but not HI

Figure 9. Impacts of Select Safety Net Programs on Supplemental Poverty Rate, 2014



Sources: Tabulations by the U.S. Census Bureau, Social, Economic and Housing Statistics Division, Poverty Statistics Branch; Current Population Survey, Annual Social and Economic Supplement, 2015; U.S. Census Bureau, "Current Population Reports," P60-254; Kathleen Short, "The Supplemental Poverty Measure: 2014," at www.census.gov/hhes/povmeas.

Source: "Poverty in the United States: 50-year Trends and Safety Net Impacts", Office of Human Services Policy, ASPE, U.S. Department of Health and Human Services, A. Chaudry et al., March 2016.

Approximate Expenditures ($Billion) c. 2016

Medicare	600
Medicaid	550
ESI, Federal tax expenditure	200+
ACA Premium subsidies	30
Social Security (OASDI)	900+
EITC	70
SNAP	65
SSI	55
TANF	35
Housing, low inc. (fed.)	50

Health Inclusive Poverty Measure (HIPM): Concept

- Puts health care and/or health insurance "needs" directly in poverty threshold
- Values health insurance benefits as resources to meet those needs

ELSEVIER

Contents lists available at ScienceDirect

Journal of Health Economics

journal homepage: www.elsevier.com/locate/econbase

Including health insurance in poverty measurement: The impact of Massachusetts health reform on poverty

Sanders D. Korenman, Dahlia K. Remler *

School of Public and International Affairs, Baruch College, City University of New York and CUNY Institute for Demographic Research, USA

Why a valid HIPM Not Possible Before ACA

- NAS panel (1995), Moon (1994) recommended "SPM"
- *Tried hard* to put health care &/or insurance in needs
  - could find no valid way at that time
  - *Health care* needs highly variable & skewed, depend on enormous clinical detail
  - Historically: *Health insurance premiums* depended on (detailed) health status, employment, etc.

➔ Could not determine $ for HI in poverty needs threshold

- HI benefits in resources inconsistent if HI need not in threshold
- Health insurance cannot be used for other needs (not fungible)

➔Not valid to count HI benefits in resources

NAS Report

NAS panel *reluctantly* chose "material only" poverty approach (MOOP subtracted and treated as nondiscretionary) and acknowledged that the treatment of health care was a weakness:

[The revised measure] *"…does not explicitly acknowledge a basic necessity, namely medical care, that is just as important as food or housing. Similarly, the approach devalues the benefits of having health insurance, except indirectly."*

It recommended:

> *"As changes are made to the US system of health care, it will be important to reevaluate the treatment of medical care"*

SPM Implicit Health Needs

SPM improves greatly on OPM.

But, implicitly, for health care & insurance, what you spend is exactly what you need.

If you buy a lot, then you "need" a lot

➔ wealthier people who buy more/better care or insurance may be deemed poorer by MOOP subtraction

If you go without care/insurance & spend less, you "need" less

➔ Uninsured going without useful, necessary care is <u>not</u> an unmet need. Result is **not** SPM poverty.

SPM does not count value of subsidized insurance as a resource, but subtracts any premium payments.

➔ HI subsidy (e.g., ACA) could make you poorer, according to the SPM.

SPM measures 1 of 3 sources of economic value of insurance

1. **Value of HI in reducing MOOP**
   - Sommers & Oellerich, JHE (2013): Medicaid ➔ - 0.7% point SPM

     "Beyond the program's presumed primary benefit of improved access to care & health…"
2. **Access-to-care value of HI**
   - when uninsured get less/no care, not treated as an unmet need
3. ***Ex ante* risk reduction value of HI**
   - HI valuable even if *ex post* did not use health care, did not have MOOP;

Access to care & *ex ante* risk reduction are also necessities.

SPM ***cannot*** show health benefits' direct effects on poverty through meeting the need for health insurance or care.

Do not expect a non-health measure of poverty to capture well the impact of health benefits (ACA, Medicaid) on poverty

Health Inclusive Poverty Measure (HIPM)

- Revision of SPM
- Threshold: add health insurance need to SPM threshold
  - ACA Guaranteed Issue & Community Rating ➔ Can determine $ for health insurance need based on age.
  - HI Need = 2nd cheapest silver plan in ACA rating area

    (or cheapest MA-PD plan for Medicare recipients)
- HIPM Resources:
  - SPM resources before the MOOP deduction
  - Add net health insurance benefits the family receives
  - Those without HI benefits have no HI resources
- Non-fungibility of HI: Never value HI resources > HI need
- Cost-sharing needs: deduct capped non-premium MOOP from resources

USA 2014

GOVERNMENT PROGRAMS & POLICIES

By Dahlia K. Remler, Sanders D. Korenman, and Rosemary T. Hyson

DOI: 10.1377/hlthaff.2017.0331
HEALTH AFFAIRS 36,
NO. 10 (2017): 1828-1837
©2017 Project HOPE—
The People-to-People Health
Foundation, Inc.

Estimating The Effects Of Health Insurance And Other Social Programs On Poverty Under The Affordable Care Act

HealthAffairs

At the Intersection of Health, Health Care and Policy

Data & Analysis Samples

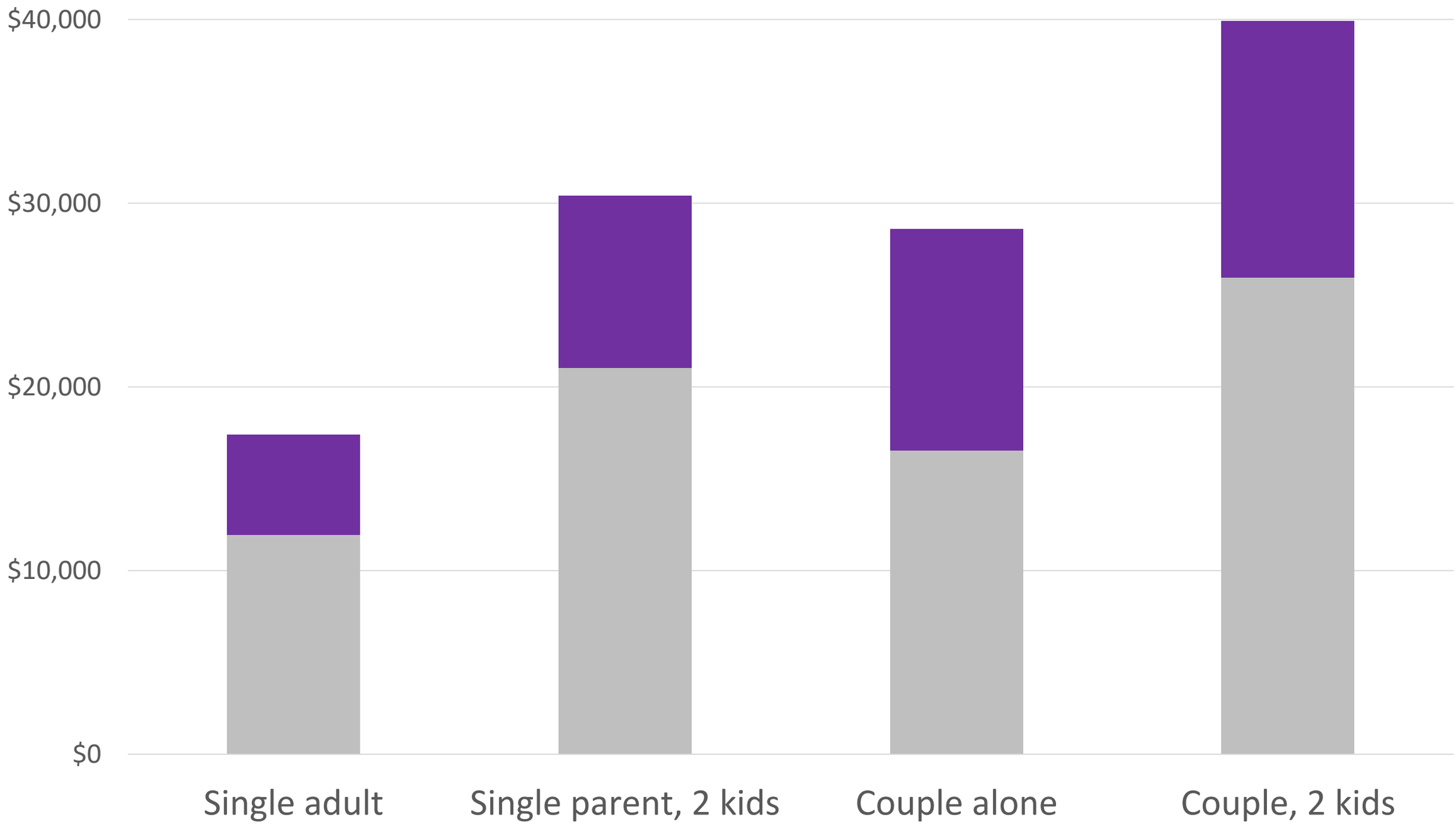
- Main Data: CPS Annual Social and Economic Supplement
- CPS Supplemental Poverty Measure Research file
- CPS OUTTYP Extract File (for health insurance coverage of household members from someone outside the household)
- ACA Marketplace Health Plan Data (from RWJ)
- Medicare Advantage-Prescription Drug plan data (CMS/NBER)
- State Medicaid & CHIP: premiums & cost-sharing (KFF reports +)
- 2014 and 2015
- To focus on ACA impacts, present results mostly for
  - Households without a disability recipient
  - Persons under age 65
  - Individuals not imputed to be undocumented (Borjas 2017)

- Overall sample size = 156,079 in 2014 and 132,903 in 2015

HIPM and SPM Average Thresholds 2015

= SPM Threshold

+ = HIPM Threshold



Poverty Impacts (direct)

- Accounting impacts of benefit programs on HIPM poverty rates

- Accounting impacts….on HIPM poverty gaps

- Comparisons of HIPM poverty and deep poverty rates across states that did and did not expand their Medicaid programs
  - un-adjusted and regression-adjusted rate differences
  - HIPM vs. SPM

Categories of Benefits

Non-Health

Social Ins. (SI) other than Health:

- Social Security OASDI
- unemployment compensation
- workers compensation
- some veteran's payments

Means-Tested Transfers (MTTs)

- SSI
- Public assistance/welfare/TANF
- SNAP
- capped housing subsidies
- school lunch program
- WIC
- energy assistance

Tax Credits

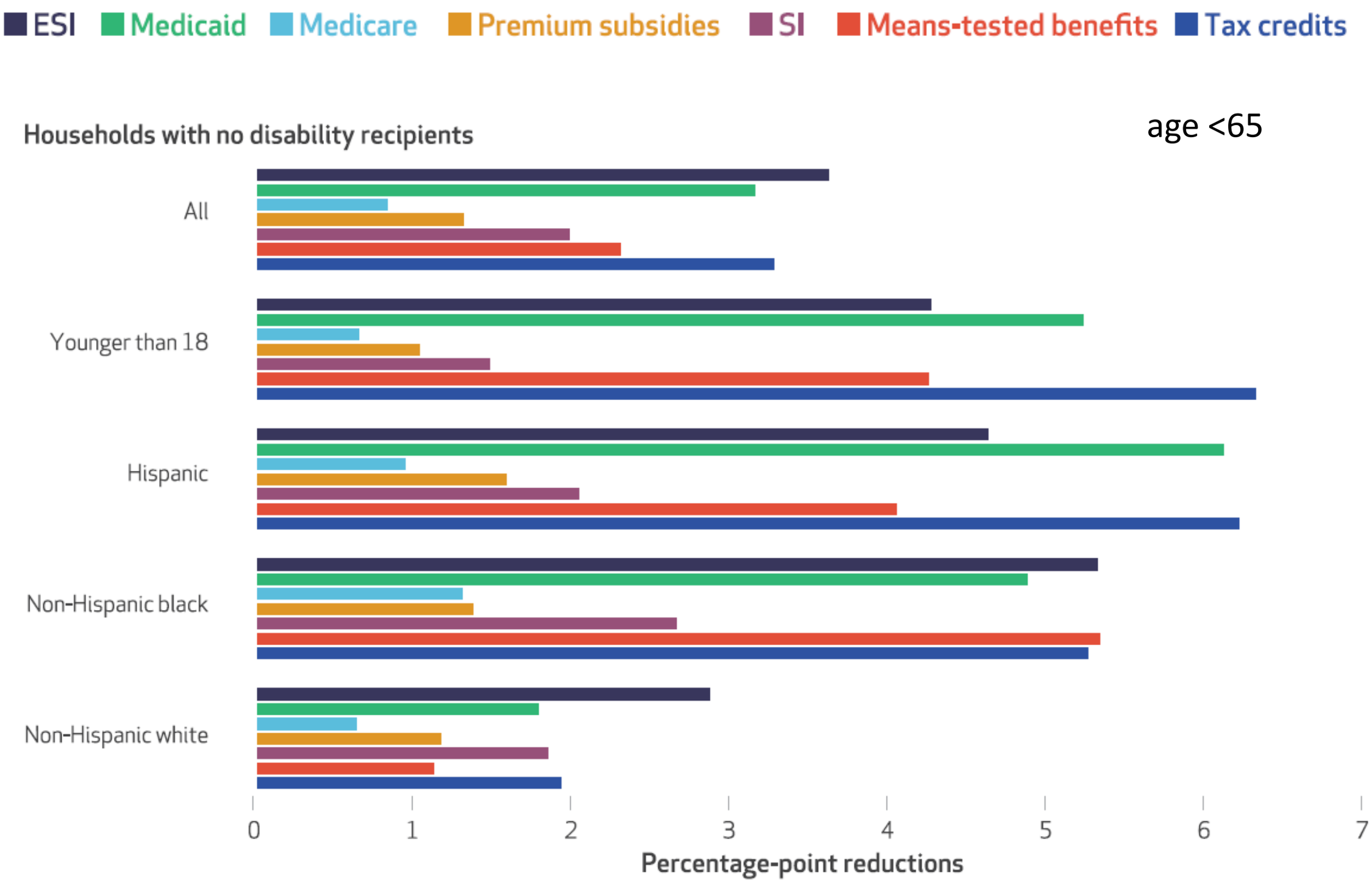
- EITC
- CTC

Health

- Employer Insurance (ESI)
- Medicare
- Medicaid
- ACA Premium Subsidies

EXHIBIT 2

Percentage-point reductions in health-inclusive poverty rates from various programs, by selected characteristics



Source: Remler, Korenman, Hyson

Source: Remler, Korenman, Hyson (2017)

EXHIBIT 3

Percentage-point reductions in health-inclusive poverty rates from various programs among people in households with no disability recipients, by health insurance type

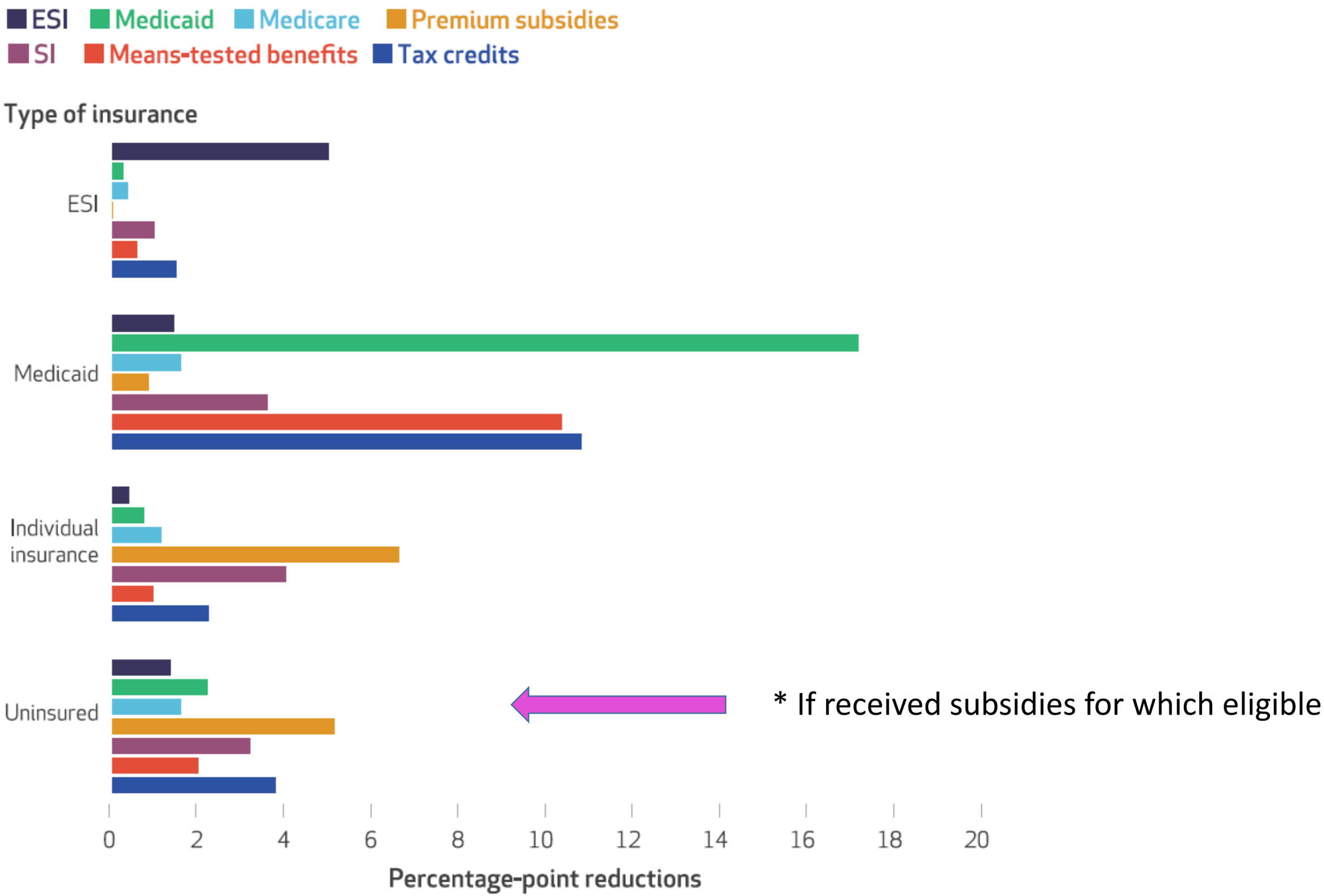
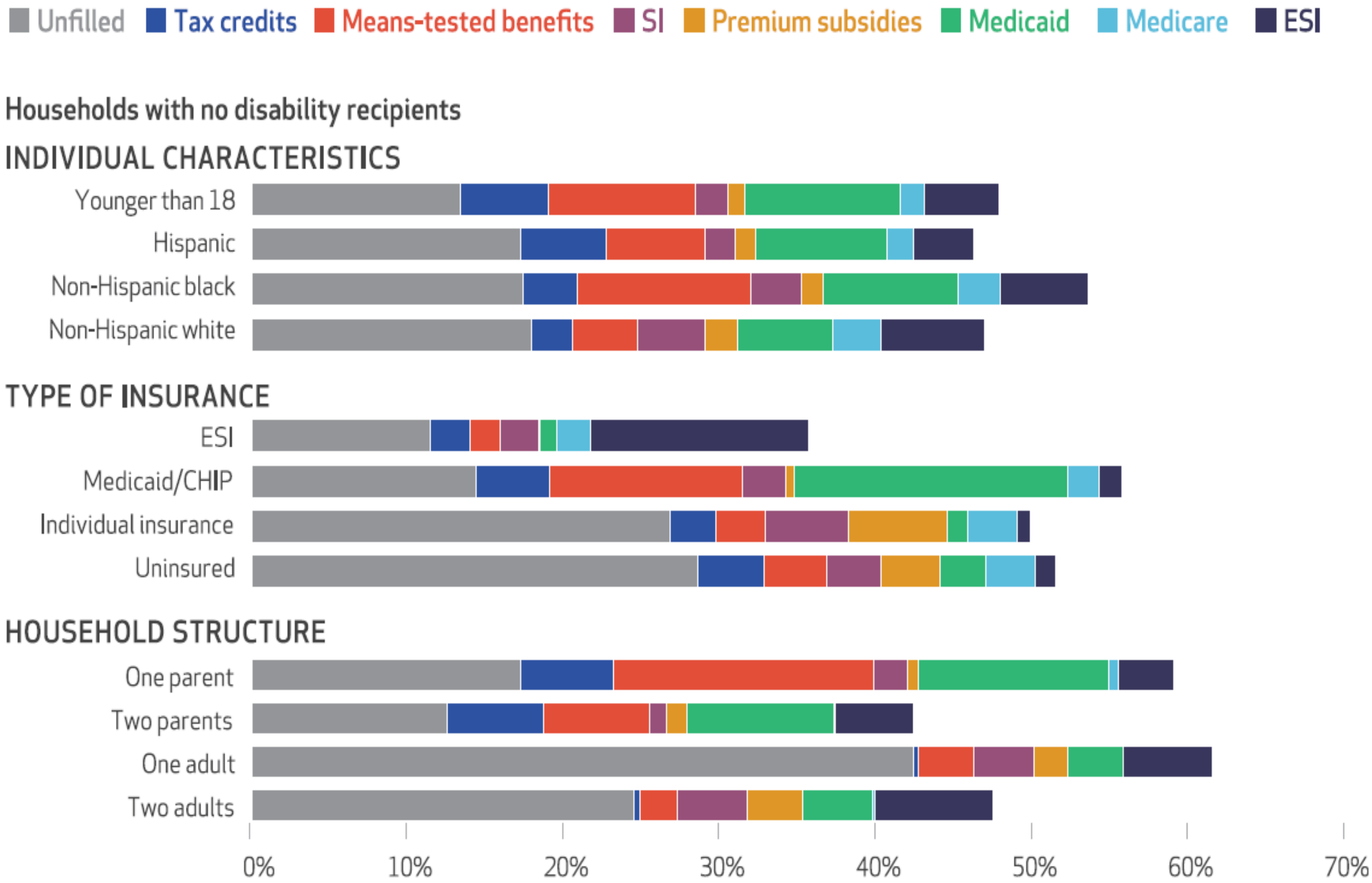


EXHIBIT 4

Source: Remler, Korenman, Hyson (2017)

Percentages of the health-inclusive poverty gap filled, by selected population characteristics



Results: USA 2015

Korenman, Remler & Hyson (under review)

Reducing Poverty Through Medicaid Expansions

Poverty Rates and Medicaid Expansion Impacts, 2015

(Non-Expansion Rates & Non-Expansion – Expansion Differences; *p<.05)

- Embargoed results

Deep Poverty Rates and Medicaid Expansion Impacts

(Non-Expansion Rates & Non-Expansion – Expansion Differences)

(*p < .05)

- Embargoed results

Summary

- SPM based largely on NAS (1995) recommendations
  - NAS wanted to include health in needs threshold
  - Recommended revisit as US health care system changes
- SPM can only show impact on MOOP, not direct impact of HI in meeting health insurance needs: access and ex ante risk reduction
- Health insurance transfers to low-income population: large and growing.
- HIPM possible, provided Guaranteed Issue, Community Rating and we are willing to accept HI as a need
- HIPM captures major poverty reductions from HI that SPM misses.

Summary of HIPM Results

- Govt HI benefits have major anti-poverty impacts
  - similar to or larger than means-tested transfers (cash + in-kind) or tax credits.
- Employer insurance is also important
- ACA subsidies: important for lone adults & indiv. insured
- Medicaid/CHIP poverty impact for kids: 5.3 % points
- Medicaid Expansion reduced deep HIPM poverty {embargoed result}
- SPM misses much of ACA & Medicaid's impact on poverty