

# Federal Action, Local Impact: Policy Evaluation

Day Manoli

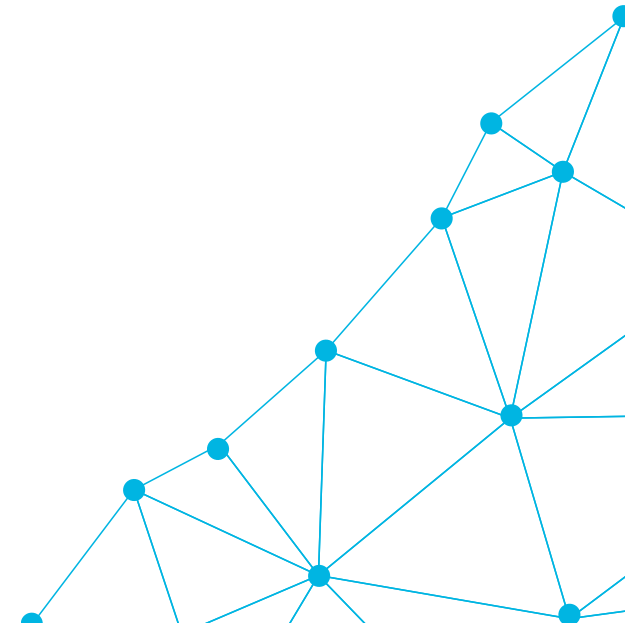
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# Outline

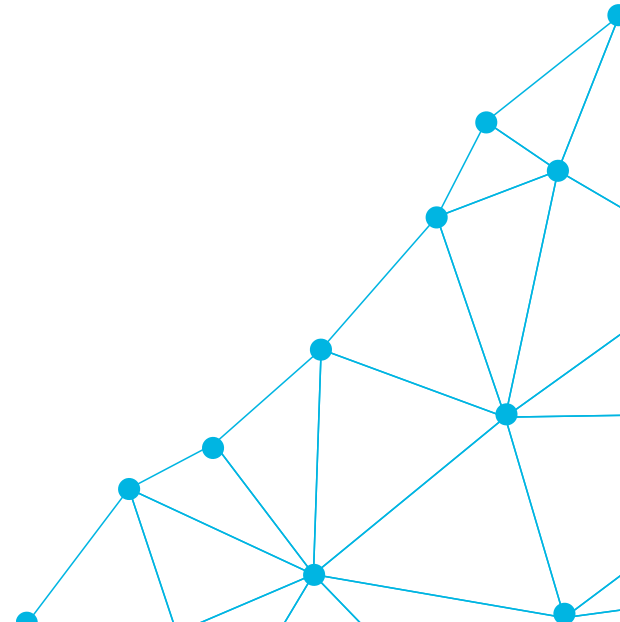
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1. A bit about me
2. What is good policy?
3. What is current policy?
4. What do we know?
5. Thoughts on how to evaluate policy changes



# What is good policy?

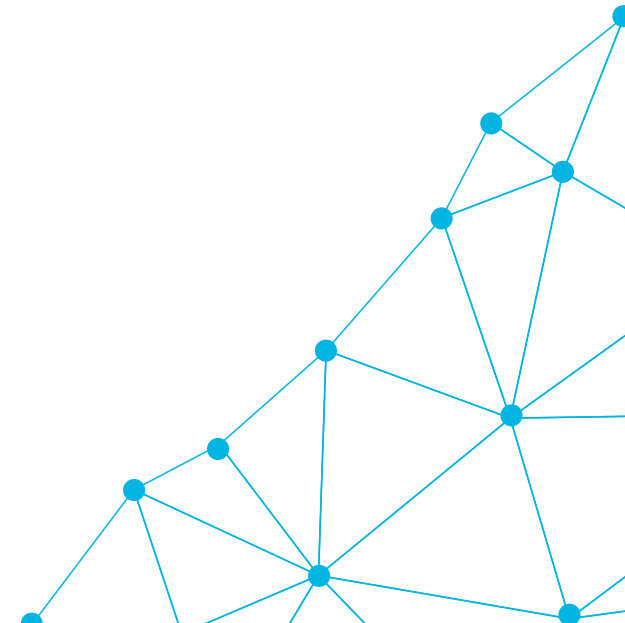
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# What is good policy?

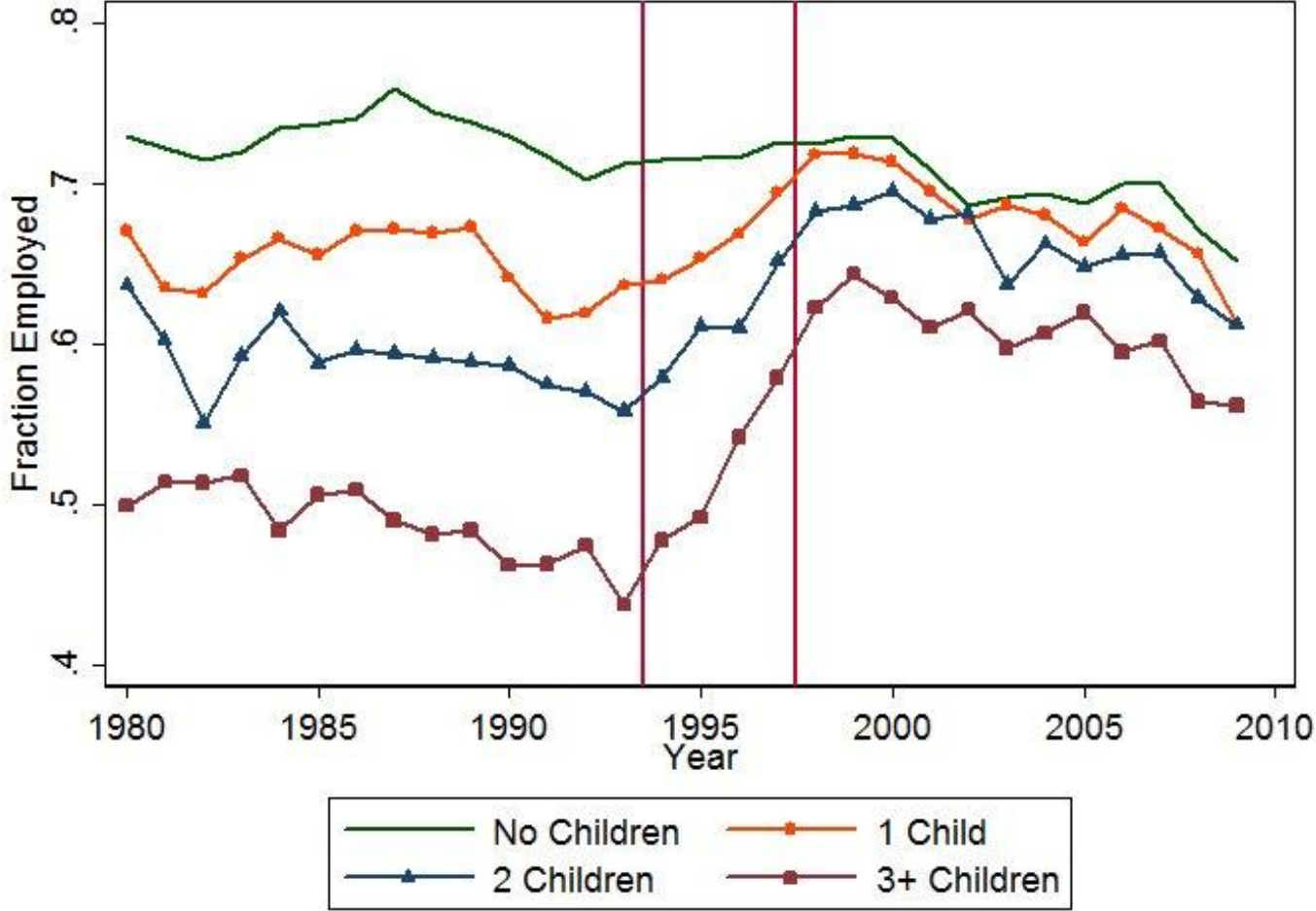
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- Public finance economists generally focus on redistribution and inefficiency
  - Could give cash to individuals (achieves redistribution), but this distorts incentives (inefficiency)
  
- Basic tradeoff creates motivations for in-kind transfers instead of cash transfers
  - Provide healthcare (Medicaid)
  - Provide food (SNAP)
  - Provide employment (jobs subsidies)
  - Provide assistance for children (child transfers)
  
- Achieve redistribution more efficiently?
  - Reducing behavioral inefficiencies, but important administrative costs

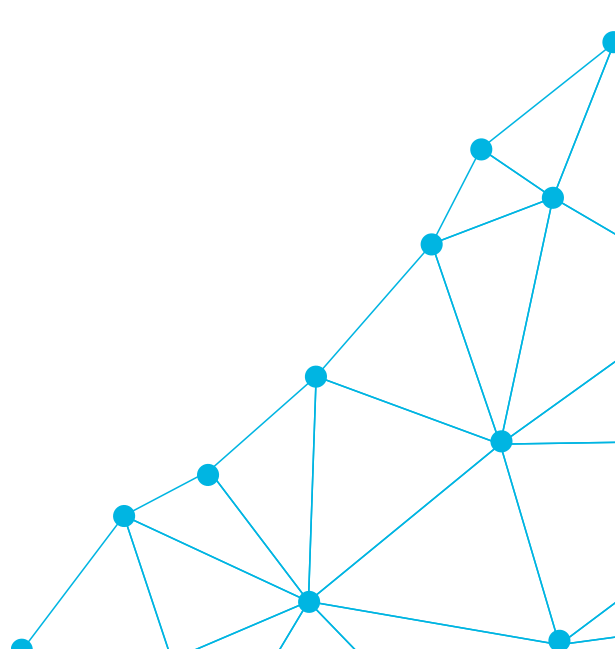


# What do we know from past experiences?

Employment Rates for Single Women by Year and Number of Children



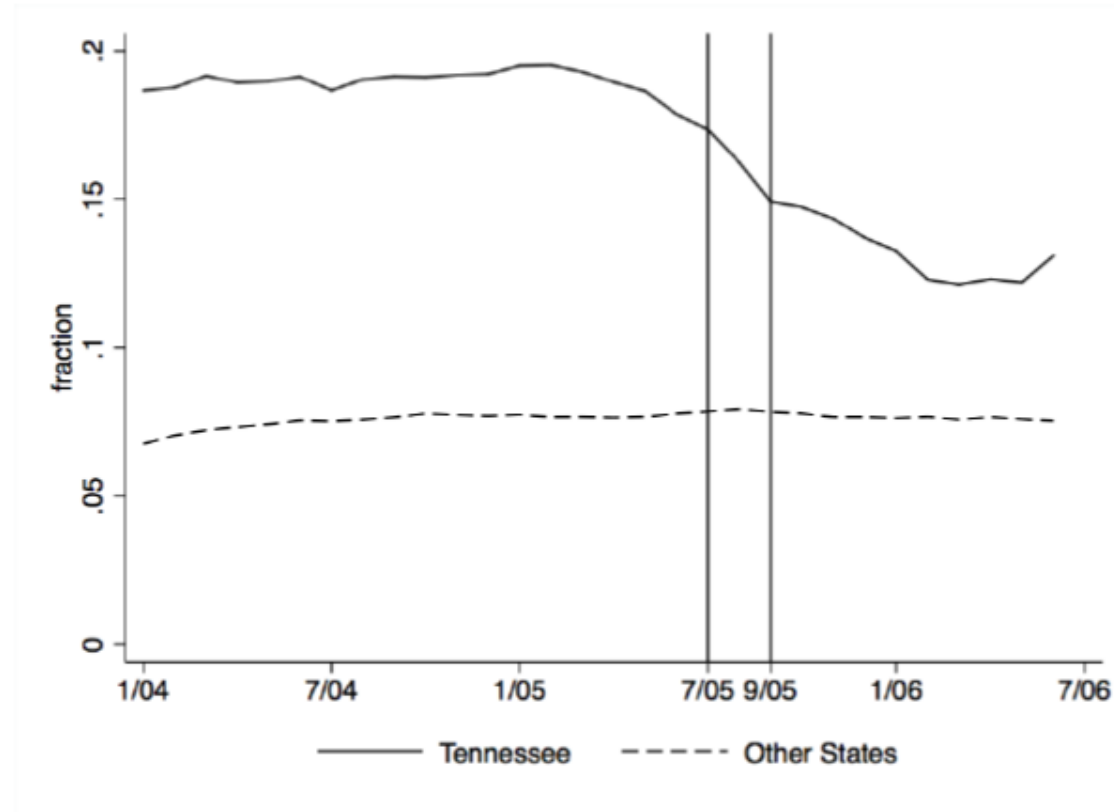
1990s Welfare Reform



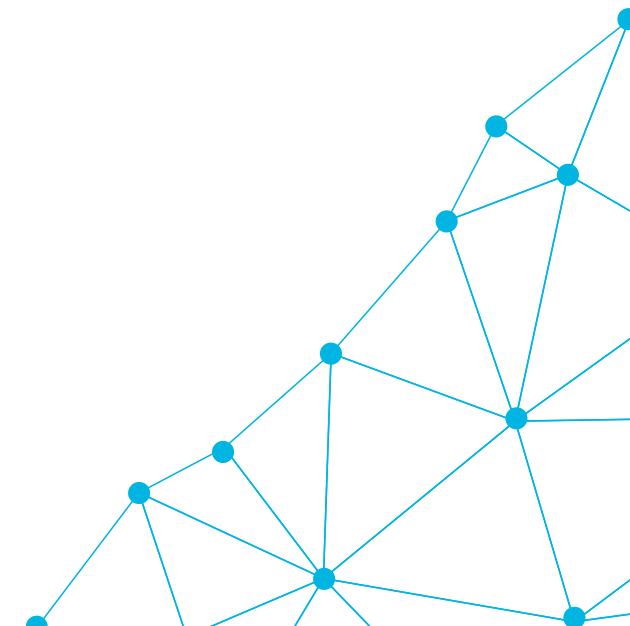
# What do we know from past experiences?

TN Medicaid Disenrollment (DeLeire 2018)

Figure 1. Fraction of Adults with Medicaid Coverage, Tennessee vs. Other Southern States

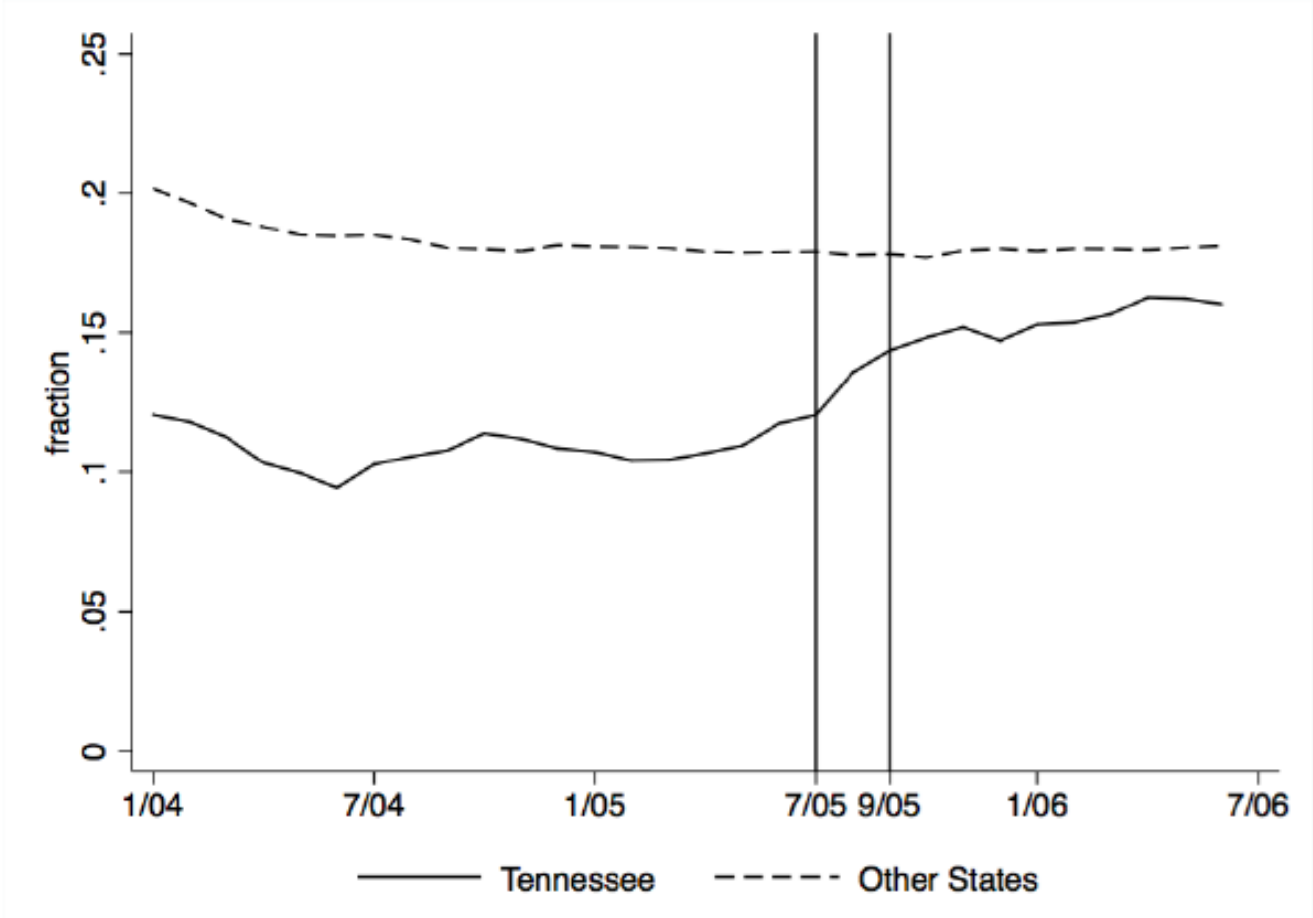


Notes: Monthly rates estimated from an individual-fixed effects model using data on adults ages 18 to 64 from the 2004 Panel of the SIPP (see text). The two vertical lines indicate the months when TennCare disenrollment was initiated (July 2005) and completed (September 2005). Individuals reporting both Medicare and Medicaid coverage, or both Private coverage and Medicaid coverage, are coded as having Medicaid coverage.



# What do we know from past experiences?

Figure 2. Fraction of Adults who were Uninsured, Tennessee vs. Other Southern States



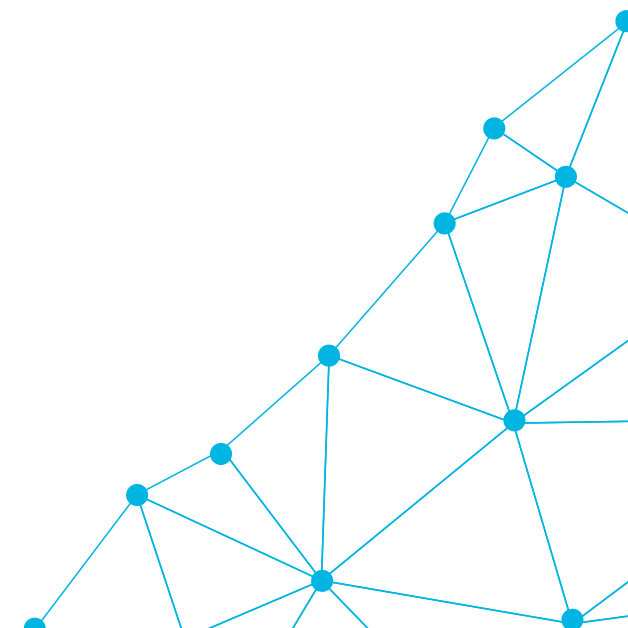
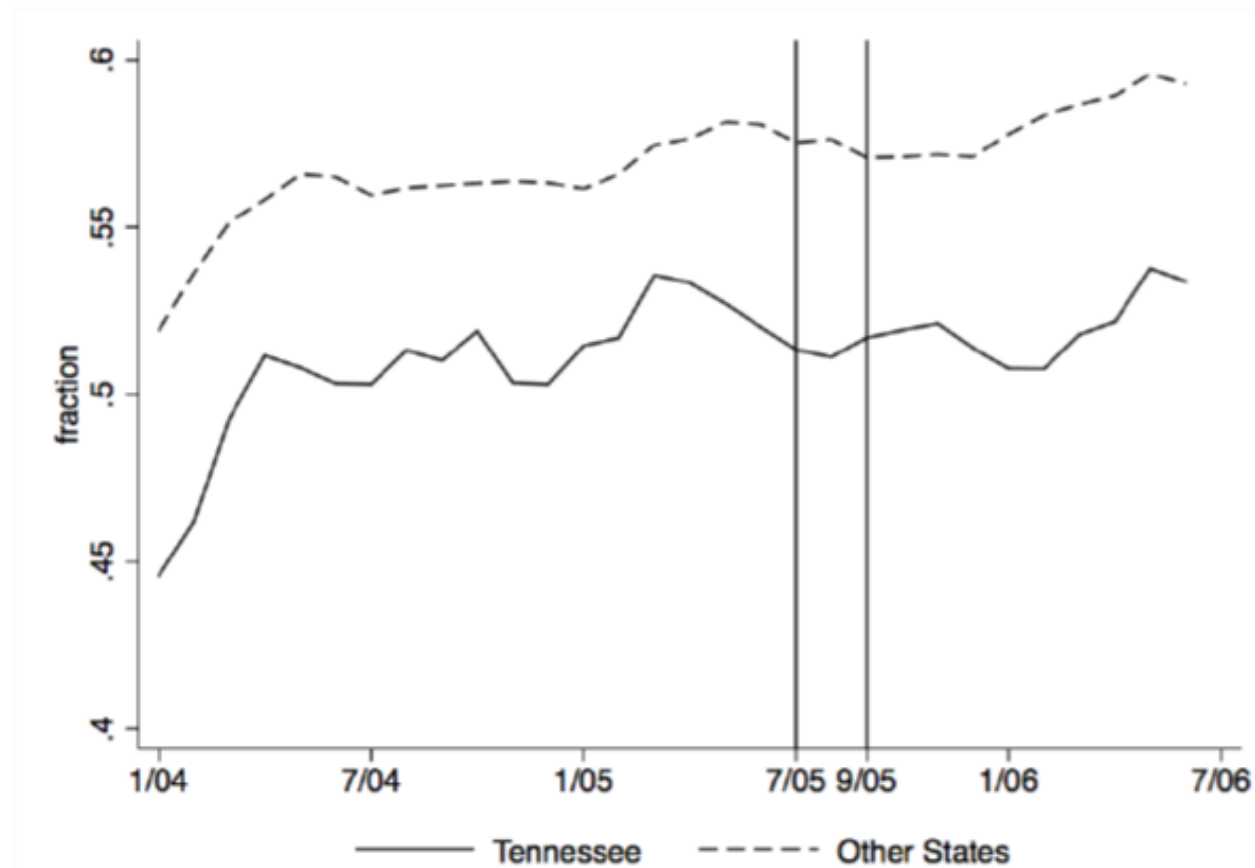
TN Medicaid  
Disenrollment  
(DeLeire 2018)



# What do we know from past experiences?

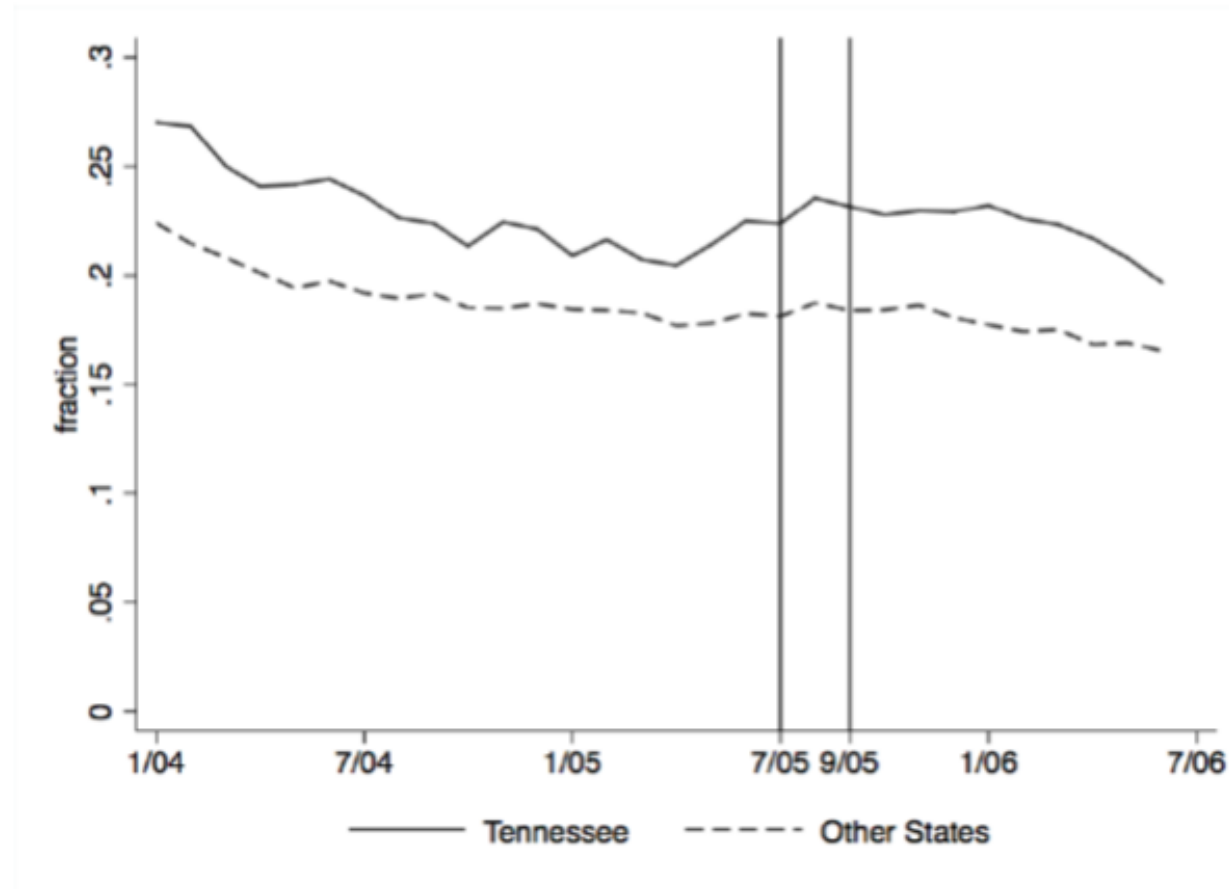
Figure 6. Fraction of Adults who were Employed Full-time, Tennessee vs. Other Southern States

TN Medicaid  
Disenrollment  
(DeLeire 2018)

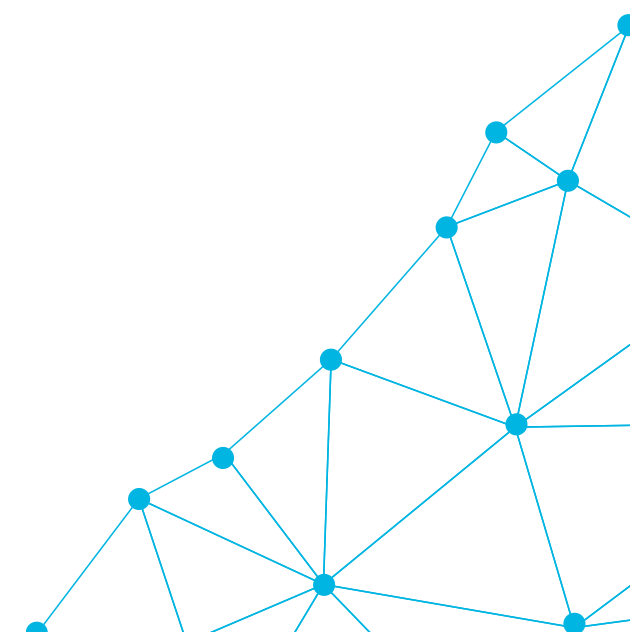


# What do we know from past experiences?

Figure 7. Fraction of Adults who were Employed Part-time, Tennessee vs. Other Southern States

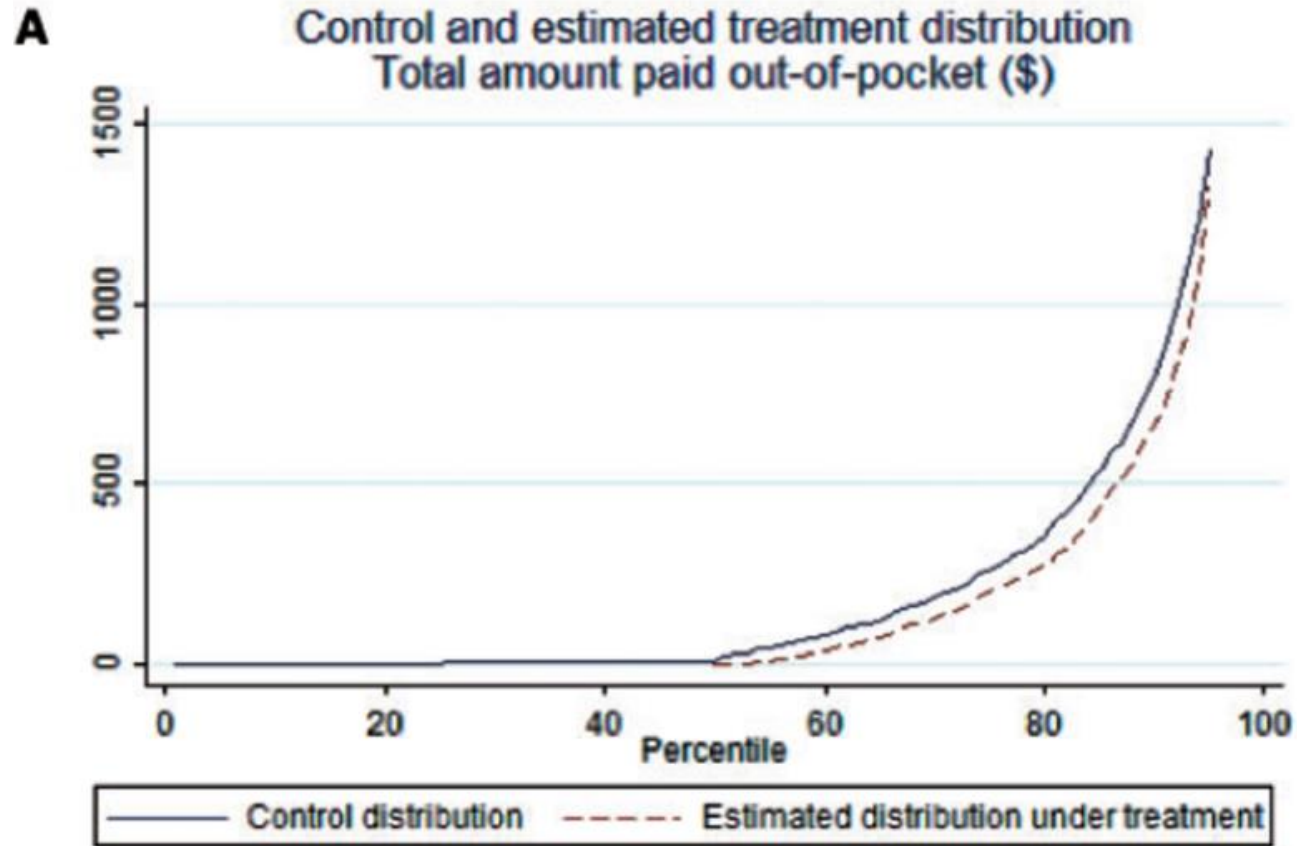


TN Medicaid  
Disenrollment  
(DeLeire 2018)



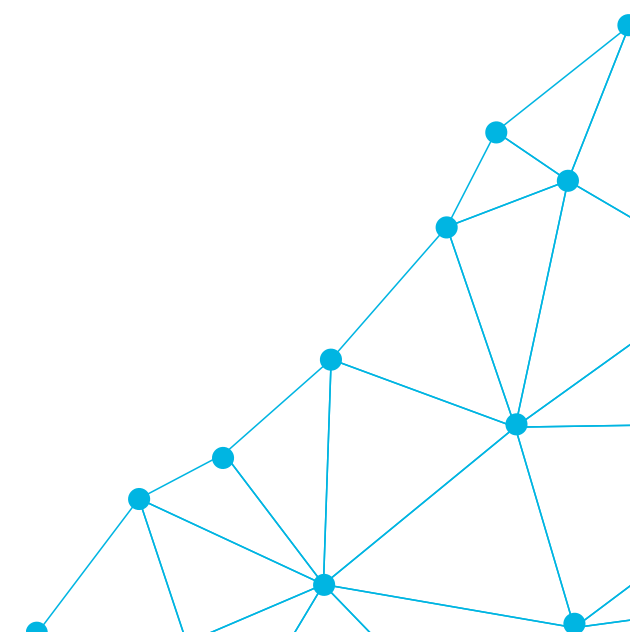
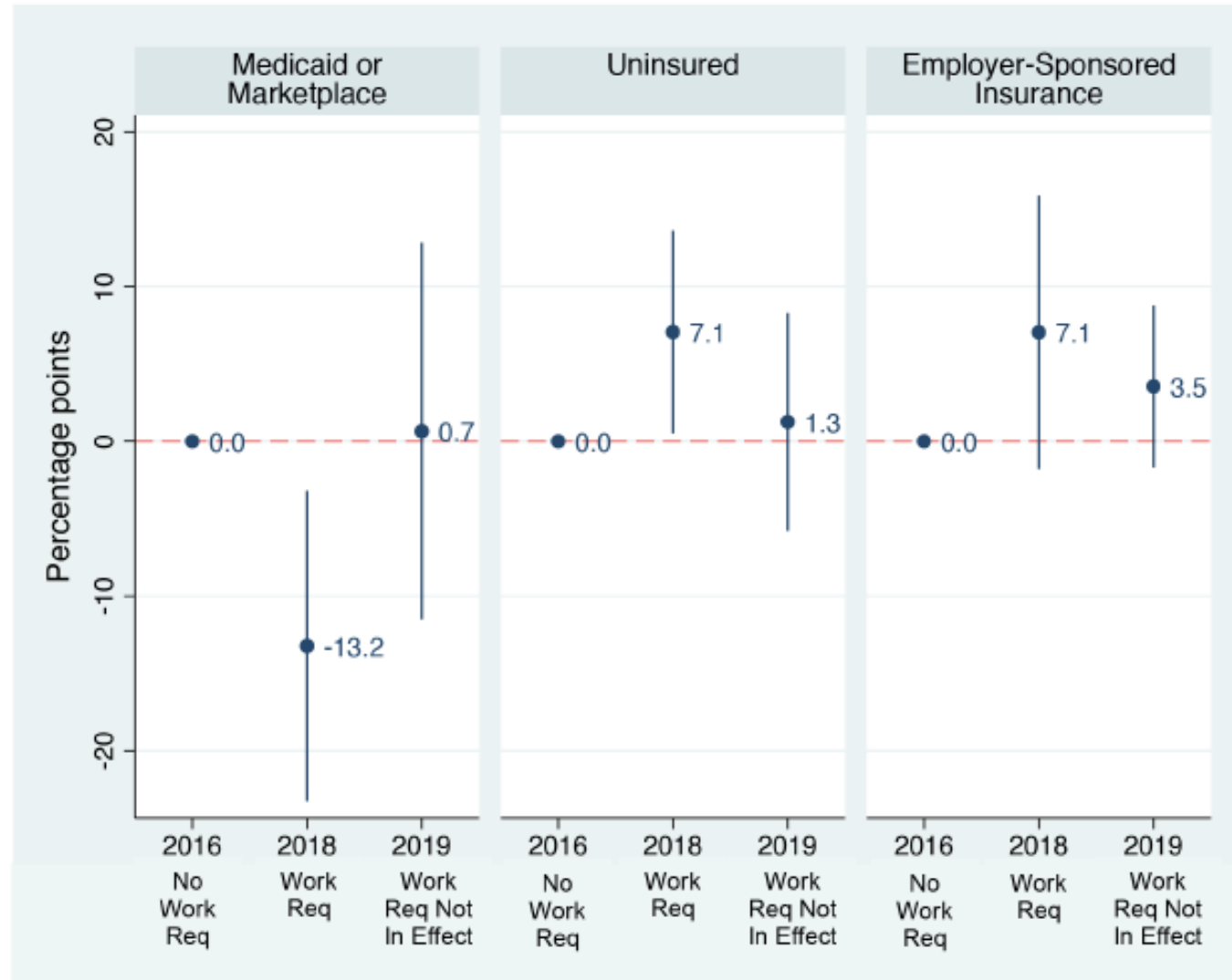
# What do we know from past experiences?

Oregon Health Insurance Experiment (Finkelstein et al 2012)



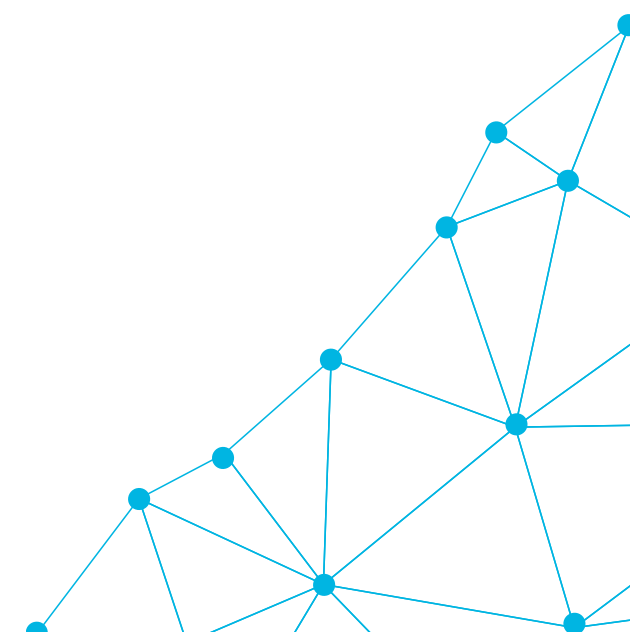
# What do we know from past experiences?

Arkansas Medicaid Work Requirements (Sommers et al 2020)



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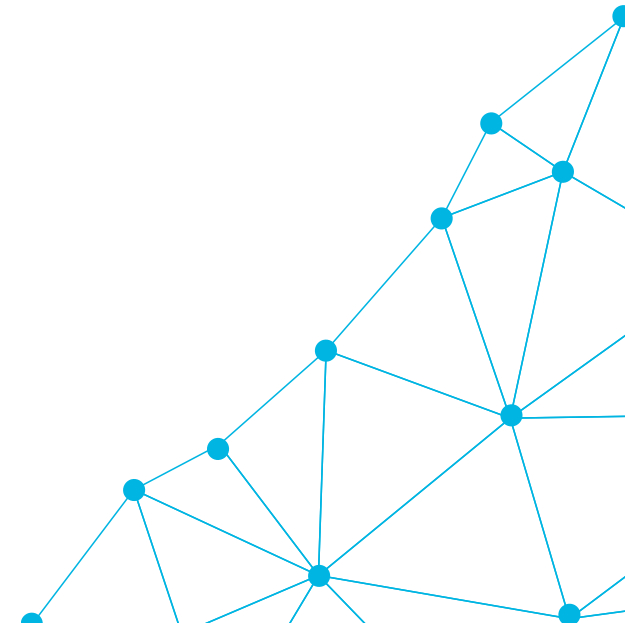


# What do we know from past experiences?

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## Implementation matters

- How will states implement work requirements and recertifications?
- How will states and counties reduce SNAP payment error rates?
- How will IRS/Treasury implement child savings accounts?

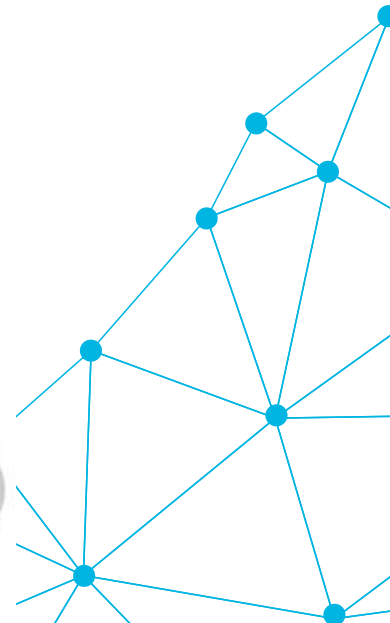


# What do we know from past experiences?

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Implementation matters

- Healthcare.gov
- FAFSA
- IRS Correspondence Audits

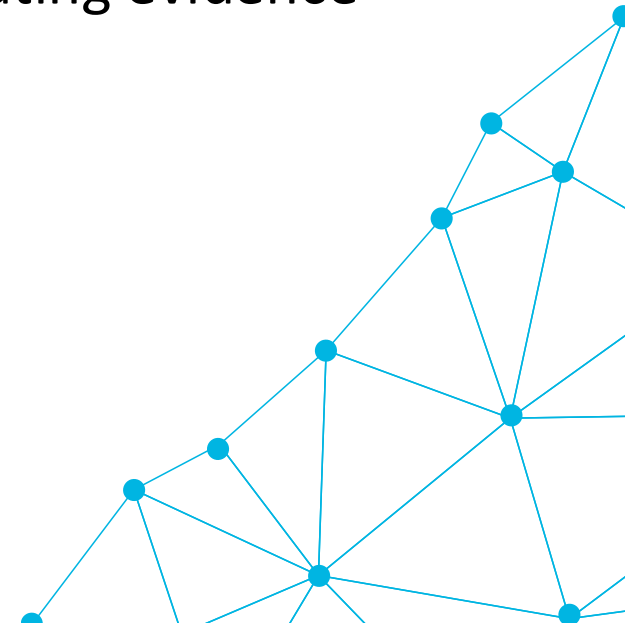


# How to understand and evaluate policy changes?

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## Storytelling

1. Who are the characters? Beneficiaries, case workers, employers
2. What are the motivations? Incentives, local context/environment is significant
3. What are the assumptions? Supporting evidence, establishing credibility, professors and other researchers can be helpful resources for providing and evaluating evidence
4. Any pictures? Graphs, clear causal mechanisms, data fills in details
5. What would have happened in the absence of the policy change?



# Thank you!

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# THE OREGON HEALTH INSURANCE EXPERIMENT: EVIDENCE FROM THE FIRST YEAR\*

**Amy Finkelstein, Sarah Taubman, Bill Wright, Mira Bernstein, Jonathan Gruber, Joseph P. Newhouse, Heidi Allen, Katherine Baicker, and Oregon Health Study Group**

## **Abstract**

In 2008, a group of uninsured low-income adults in Oregon was selected by lottery to be given the chance to apply for Medicaid. This lottery provides an opportunity to gauge the effects of expanding access to public health insurance on the health care use, financial strain, and health of low-income adults using a randomized controlled design. In the year after random assignment, the treatment group selected by the lottery was about 25 percentage points more likely to have insurance than the control group that was not selected. We find that in this first year, the treatment group had substantively and statistically significantly higher health care utilization (including primary and preventive care as well as hospitalizations), lower out-of-pocket medical expenditures and medical debt (including fewer bills sent to collection), and better self-reported physical and mental health than the control group.

# Consequences of Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care

**Benjamin D. Sommers, MD, PhD, Lucy Chen, BA, BS, Robert J. Blendon, ScD, E. John Orav, PhD, Arnold M. Epstein, MD, MA**

Department of Health Policy and Management, Harvard T.H. Chan School of Public Health, Boston, MA (B.D.S., L.C., R.J.B., A.M.E.), the Department of Medicine, Brigham & Women's Hospital, Boston, MA (B.D.S., E.J.O., A.M.E.), and the Harvard Ph.D. Program in Health Policy (L.C.)

## Abstract

In June 2018, Arkansas became the first state to implement work requirements in Medicaid, requiring adults ages 30–49 to work 20 hours a week, participate in “community engagement” activities, or qualify for an exemption to maintain coverage. By April 2019, when a federal judge put the policy on hold, 18,000 adults had already lost coverage. We analyze the policy’s effects before and after these events, using a telephone survey in late 2019 of 2,706 low-income adults in Arkansas and three control states, compared to data from 2016 and 2018. We have four main findings. First, most of the Medicaid coverage losses in 2018 were reversed in 2019 after the court order. Second, work requirements did not increase employment over 18 months of follow-up. Third, 30- to 49-year-olds in Arkansas who had lost Medicaid in the prior year experienced adverse consequences – 50 percent reported serious problems paying off medical debt; 56 percent delayed care due to cost; and 64 percent delayed medications due to cost. These rates were significantly higher than among Arkansans who remained in Medicaid all year. Finally, awareness of work requirements remained poor, with more than 70 percent of Arkansans unsure whether the policy was in effect.

# The Effect of Disenrollment from Medicaid on Employment, Insurance Coverage, Health and Health Care Utilization

Thomas DeLeire

NBER Working Paper No. 24899

August 2018

JEL No. I11,I13,I18,J22

## **ABSTRACT**

This study examines the effect of a Medicaid disenrollment on employment, sources of health insurance coverage, health, and health care utilization of childless adults using longitudinal data from the 2004 Panel of the Survey of Income and Program Participation. From July through September 2005, TennCare, the Tennessee Medicaid program, disenrolled approximately 170,000 adults following a change in eligibility rules. Following this eligibility change, the fraction of adults in Tennessee covered by Medicaid fell by over 5 percentage points while uninsured rates increased by almost 5 percentage points relative to adults in other Southern states. There is no evidence of an increase in employment rates in Tennessee following the disenrollment. Self-reported health and access to medical care worsened as hospitalization rates, doctor visits, and dentist visits all declined while the use of free or public clinics increased. The Tennessee experience suggests that undoing the expansion of Medicaid eligibility to adults that occurred under the Affordable Care Act likely would reduce health insurance coverage, reduce health care access, and worsen health but would not lead to increases in employment.