



# Does employer-provided health insurance constrain labor supply adjustments to health shocks? New evidence on women diagnosed with breast cancer



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## ABSTRACT

Employment-contingent health insurance may create incentives for ill workers to remain employed at a sufficient level (usually full-time) to maintain access to health insurance coverage. We study employed married women, comparing the labor supply responses to new breast cancer diagnoses of women dependent on their own employment for health insurance with the responses of women who are less dependent on their own employment for health insurance, because of actual or potential access to health insurance through their spouse's employer. We find evidence that women who depend on their own job for health insurance reduce their labor supply by less after a diagnosis of breast cancer. In the estimates that best control for unobservables associated with health insurance status, the hours reduction for women who continue to work is 8 to 11% smaller. Women's subjective responses to questions about working more to maintain health insurance are consistent with the conclusions from observed behavior.

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## 1. Introduction

When workers are faced with serious health conditions that require expensive treatment and long periods of recovery, provision of health insurance through an employer can complicate their decisions. Although workers may want to invest in their health by taking time away from work for treatment and recovery, their demand for health insurance rises because of the increased risk of health care expenses. Employer-provided health insurance is often only offered to or taken up by full-time employees, in which case ill workers must also work enough hours to keep their health insurance benefits. The potential loss of insurance coverage (or an increased cost of health insurance if workers reduce hours and purchase coverage) therefore raises the cost of forgoing work for treatment (or recovery) (Bradley et al., 2006). The need to maintain labor supply at a level sufficient to keep health insurance could have adverse health consequences; work could conflict with

recovery, or it could influence treatment decisions or adherence with a treatment plan.

Workers who become ill and lose their employer-provided health insurance have limited alternative options to obtain insurance. One possibility is continuing coverage through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). However, former employees pay the full cost of group coverage, and the policy is usually limited to 18 to 36 months – making continuation of coverage via COBRA a prohibitively expensive option for many and only a temporary measure even for those who can afford it.<sup>1</sup> Alternatively, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) allows employees to add to their insurance policy a spouse or other dependent who loses job-related coverage, without waiting until the next open enrollment cycle. However, HIPAA offers no protection to many ill workers, including those

<sup>1</sup> The American Recovery and Reinvestment Act (ARRA) of 2009 provided a premium reduction (to 35% of premiums) for continuation coverage for eligible individuals who were terminated involuntarily from employment through May 31, 2010. Individuals who qualified paid reduced premiums for up to 15 months, as long as they were not eligible for another group health plan or Medicare (United States Department of Labor, Employee Benefits Security Administration, 2011).

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whose spouses are not employed and those with employed spouses whose employer does not offer health insurance coverage for family members.<sup>2</sup> The Family Medical Leave Act (FMLA) entitles eligible employees of covered employers to take unpaid, job-protected leave for specified family and medical reasons with continuation of group health insurance coverage (United States Department of Labor, Wage and Hour Division, 2012). However, not all workers are covered by FMLA and some workers may fear that using FMLA will result in adverse consequences at work. Nonetheless, FMLA seems likely to mute the extent to which people with health shocks are constrained to remain at work and not reduce their hours.

This paper studies labor supply changes following health shocks, comparing married women newly diagnosed with breast cancer and dependent on their own job for health insurance to similar women who are insured through a spouse's policy or with access to insurance through a spouse. We survey these women three times to cover three distinct periods: just prior to diagnosis (retrospectively) and two and nine months after initiation of treatment. By focusing on the time period immediately following treatment initiation, we observe labor supply behavior when treatment demands are greatest and therefore entail decisions about labor supply (including whether to remaining employed).

We include a core set of analyses that replicate Bradley et al. (2006), but we use a sample specifically constructed to address the relationship between labor supply and dependence on one's job for health insurance in a breast cancer context. Moreover, we present a number of new analyses based on comparisons of women who depend on their jobs for health insurance to subsets of women who are less dependent on their own employment for health insurance but who are more likely to be similar in terms of unobservables such as job characteristics and commitment to work. The alternative comparisons are intended to better account for unobserved heterogeneity associated with the prior choice of health insurance source that could affect labor supply changes over time, perhaps also including labor supply in responses to a new diagnosis of breast cancer. When we simply compare women offered health insurance through their employer (which we term ECHI, for "employment-contingent health insurance") to those without ECHI, differences in labor supply behavior may be driven by the other differences between women who do or do not have ECHI, or differences in their jobs. In contrast, for example, one new comparison we introduce restricts attention to women offered ECHI, and distinguishes between those who enrolled in ECHI and those who declined (and instead took insurance through their spouses' employers). Women offered ECHI are likely to have more similar types of jobs and careers, so among those offered ECHI, the difference between those women who do and do not enroll should better isolate differences in labor supply responses attributable solely to how dependent they are on their own job for insurance. A second comparison is again only among the more homogeneous group of women with ECHI, but contrasting those who have the option to switch to a spouse's policy with those who do not.

Finally, as an alternative method of accounting for unobserved heterogeneity associated with labor supply changes and the prior determination of the source of health insurance, we constructed a sample of demographically-similar women from the Current Population Survey (CPS) (United States Department of Labor, Bureau of Labor Statistics, 2002), who we assume were healthy and did not

get a cancer diagnosis. When we combine the two samples, we add another level of differencing that removes the potential influence of differences in how labor supply evolves over time for women with and without ECHI.

## 2. Research on labor market incentives and employer-based health insurance

The studies most relevant to our investigation directly examine changes in labor supply following a health shock, although only a handful of studies fit this description, implying a substantial gap in the literature that the current study can help to fill. There are also studies of "job lock" – the hypothesis that workers remain in their current job to retain health insurance. These studies are related because they link the need for health insurance to being "locked" into a job. The literature on job lock is larger, but because it does not pertain to health shocks per se, we focus in this brief literature review on studies that incorporate health status of the employee (or their dependents) into their analyses.

### 2.1. Labor supply and health conditions

We are aware of three studies of labor supply that report evidence on how workers with employer-provided health insurance respond to illness. In a study using primary data collected from a sample of married women in Detroit newly diagnosed with breast cancer, women with ECHI were significantly more likely to remain employed than were women with insurance provided by another source; similarly, ECHI moderated the negative impact of cancer on weekly hours worked (Bradley et al., 2006). Specifically, women with ECHI were 10 percentage points more likely to remain employed six months after diagnosis than women with insurance through another source, rising to 17 percentage points 18 months after diagnosis.

Paralleling these findings, Tunceli et al. (2009), using data from cancer survivors two to six years following diagnosis, and a non-cancer sample drawn from the Health and Retirement Study (HRS), reported higher employment rates after a cancer diagnosis for those with ECHI compared to those who had an alternative source of health insurance or who were uninsured. Relative to changes for those with and without ECHI in the non-cancer sample, they found positive influences of ECHI on remaining employed (or remaining employed full-time) and on staying in the same job.

Finally, using the HRS to identify respondents with a broad range of health shocks, and a comparison group without health shocks to control for differences in change in labor supply associated with insurance source, Bradley et al. (2012) found that for some specifications of health shocks ECHI encourages continued employment of men, although not of women. In particular, this was true for health shocks mainly associated with higher future costs of health care rather than current morbidity that could itself directly reduce employment. Thus this literature, although sparse, generally suggests that ECHI dampens the negative labor supply response to illness, presumably because employees with ECHI work at higher levels following illness to maintain their insurance.

One likely reason for the small quantity of research on how labor supply responses to illness are affected by employer-provided health insurance is that in national databases such as the HRS, the prevalence of illness and/or poor health status – especially among employed individuals – is too low to provide adequate sample sizes for study. Furthermore, illnesses are heterogeneous in type, severity, and treatment, and few studies collect sufficient detail on illness and treatment to adequately control for these differences. Thus, researchers seeking to study this topic are limited by the secondary data sources available. This motivates efforts to collect primary data

<sup>2</sup> Although not relevant to our study period, the Patient Protection and Affordable Care Act (ACA) will expand Medicaid coverage to very low-income workers who lose employer-provided coverage and allow others without employer-provided coverage to purchase health insurance on exchange markets (Kaiser Family Foundation, 2011).

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