



# Medicaid's effect on single women's labor supply: Evidence from the introduction of Medicaid

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## ABSTRACT

This paper examines the impact of the introduction of the Medicaid program on labor supply decisions among single women in the late 1960s and early 1970s. I use a differences-in-differences-in-differences methodology to estimate the effect of Medicaid on eligible women's labor force participation, using variation in the timing of Medicaid implementation across states and in eligibility across demographic groups. Using March supplements to the CPS from 1963 to 1975, I find no evidence that women who were eligible for Medicaid decreased their labor supply relative to ineligible women, in contrast to clear theoretical predictions of a negative supply response. Positive point estimates suggest that health benefits from health insurance coverage may have contributed to relative increases in labor supply. These results add to an emerging consensus that public health insurance programs for low-income parents and children may be able to improve access to care without substantial indirect costs from labor supply distortions.

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## 1. Introduction

The Medicaid program has provided health insurance coverage to low-income adults and children in the U.S. for over 40 years. Eligibility expansions to the program have been a central strategy in recent years to increase rates of health insurance coverage, even while the program is a major and growing cost component of Federal and state budgets. As policymakers try to balance the costs and benefits of Medicaid, it is worthwhile to note that the direct costs for young women and their children are relatively low.<sup>1</sup> There may be indirect costs, however, through distortions to labor supply and family structure, increases in caseloads for cash assistance programs, and crowd-out of private health insurance. While the relevant incentives driving the first two of these distortions have been

weakened by the decoupling of Medicaid and cash assistance in the 1980s, concern remains about the disincentives associated with providing health insurance coverage to the poor (Cannon, 2005).

This paper examines the impact of the introduction of the Medicaid program on labor supply decisions among single women in the late 1960s and early 1970s. Title XIX, the Federal law authorizing the Medicaid program, was passed in 1965 and states implemented the program between 1966 and 1970. Medicaid eligibility was closely tied to welfare receipt at this time, which generates a clear theoretical prediction of a negative labor supply response based on a budget constraint analysis. However, if health insurance coverage has positive effects on health for mothers or their children, there could be positive impacts on labor supply that might outweigh the negative incentives in the budget constraint. I use data from the 1963 to 1975 Current Population Survey (CPS) to test these theoretical predictions.

Little is known about the effects of this major public health insurance program on labor supply at its inception.<sup>2</sup> While other research has used Medicaid expansions in the 1980s or measures

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<sup>1</sup> In 2003, adults (primarily poor working parents) and children comprised 75% of Medicaid beneficiaries and 30% of Medicaid spending (approximately \$70 billion). Per capita spending was approximately \$1410 per child and \$1799 per non-disabled adult (Kaiser Commission on Medicaid and the Uninsured, 2007).

<sup>2</sup> Decker (1993) focuses primarily on the effect of Medicaid implementation on AFDC enrollment, but also fails to find significant effects on labor force participation.

of the value of Medicaid to estimate the effect on labor supply, I exploit a source of variation that has not been used in this literature to date, namely variation in the timing of program implementation across states. Using the natural experiment generated by the introduction of the program takes advantage of a non-marginal change in the labor supply incentives facing women. It also contributes to the generalizability of the existing results based on changes to the program design. My preferred estimates of the effect of Medicaid on eligible women's labor force participation come from a difference-in-differences-in-differences (DDD) model. It takes advantage of variation in implementation timing across states that is plausibly exogenous to individual's labor supply decisions. The third difference is based on eligibility restrictions during this period that essentially meant that only single women with children were eligible for the program. I also present estimates from a difference-in-differences (DD) model, which measures average effects across demographic groups and allow us to evaluate the plausibility of the identification restrictions.

I address possible endogeneity of implementation by examining the determinants of the timing of Medicaid enactment among the states in the CPS sample. While Southern states generally implement the program later, 1960 state characteristics such as percent black, urban, under age 5, male share of the civilian labor force, or the level of local government's spending on public welfare are not statistically significant determinants of state Medicaid implementation. Furthermore, they explain a modest amount of the overall variation in implementation timing. The results are robust to inclusion of interactions of linear time trends with these pre-treatment state characteristics to control for different trends across states. Potential endogeneity of family structure is addressed by estimating placebo tests of impacts of the program on single women without children and married women, who were not eligible for Medicaid. Both tests indicate no labor supply response among these women, suggesting no endogenous family structure response to the program.

I find no evidence that women who were eligible for Medicaid decreased their labor supply relative to women who were not, in contrast to clear theoretical predictions of a negative supply response. The point estimates are positive, suggesting that positive health impacts from health insurance coverage may have contributed to relative increases in labor supply. The results are robust to a number of sensitivity tests, including alternate definitions of key variables, examining subgroups of states, and to placebo tests on groups who should not have been affected due to ineligibility for Medicaid. These findings add to an emerging consensus in the literature suggesting that public health insurance programs for low-income parents and children may be able to achieve health benefits and improve access to care without substantial indirect costs from labor supply distortions.

## 2. The Medicaid program in 1966: implementation and eligibility

### 2.1. Medicaid implementation and the potential endogeneity of timing

Several Federal programs to help finance medical care for the poor preceded Medicaid. The Social Security Amendments of 1950 provided direct reimbursement to physicians and hospitals known as vendor payments. In 1960, the Kerr–Mills Act provided more generous, open-ended Federal matching for these vendor payments and established Medical Assistance for the Aged, which provided assistance to states that elected to cover the elderly who did not qualify for public assistance based on their income but who were needy due to significant medical expenses. By the end of

**Table 1**  
Medicaid implementation dates.

	Implementation date	First year effective
California	3/1/1966	1966
Connecticut	7/1/1966	1967
District of Columbia	7/1/1968	1969
Florida	1/1/1970	1970
Illinois	1/1/1966	1966
Indiana	1/1/1970	1970
New Jersey	1/1/1970	1970
New York	5/1/1966	1967
Ohio	7/1/1966	1967
Pennsylvania	1/1/1966	1966
Texas	9/1/1967	1968
Alabama	1/1/1970	1970
Mississippi	1/1/1970	1970
Michigan	10/1/1966	1967
Wisconsin	7/1/1966	1967
Maine	7/1/1966	1967
Massachusetts	9/1/1966	1967
New Hampshire	7/1/1967	1967
Rhode Island	7/1/1966	1967
Vermont	7/1/1966	1967

Source: Characteristics of State Medical Assistance Programs under Title XIX, US Department of Health and Human Services, 1970.

Note: Since the CPS data is from March, a program is considered in effect if it was implemented before March 1st of that year.

1965, 50 states and 4 jurisdictions had federally approved vendor payment programs for medical care (Weikel and Leamond, 1976).

The Medicaid program, established under Title XIX of the Social Security Amendments of 1965, provided health insurance to the non-elderly poor, a benefit not provided by any pre-existing government programs and one that low-wage, low-skill jobs were unlikely to offer.<sup>3</sup> Medicaid was administered by the states and state expenditures were matched by Federal dollars at the rate of 50–83%, which varied inversely with state per capita income. In order to qualify for these matching funds, states were required to provide a basic benefits package to all beneficiaries (including inpatient and outpatient hospital services, laboratory and X-ray services, and physician services) with the option to provide more generous benefits (Greenfield, 1968).

Beginning in 1966, the Federal government offered more generous Federal matching rates for medical vendor payments than the earlier Kerr–Mills program to incentivize states to implement Medicaid programs. As of January 1, 1970, Federal match payments were no longer available under previous programs, creating a clear deadline for states to enact their Medicaid programs by this time (Weikel and Leamond, 1976). Table 1 presents the Medicaid implementation date in each state or group of states identified in the CPS data and the first year it was considered in effect for the purposes of this analysis.<sup>4</sup>

Since both the DD and the DDD estimates rely on the plausible exogeneity of the timing of states' Medicaid implementation, I conduct an analysis to understand whether observable characteristics that could potentially confound the estimates of the effect of the program are significant predictors of implementation timing. Specifically, I use state characteristics in 1960 to predict the date that states implemented Medicaid (following Hoynes and Schanzenbach, 2009). The dependent variable is the month and

<sup>3</sup> Medicaid coverage also applied to those eligible under the other public assistance categories: Aid to the Blind, Aid to the Permanently and Totally Disabled, and Old Age Assistance.

<sup>4</sup> Only 11 individual states are identified in these years of the CPS data, so I also use observations that are coded as either Michigan or Wisconsin, as Alabama or Mississippi and as Maine, Massachusetts, New Hampshire, Rhode Island and Vermont combined.

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