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Health insurance and the labor supply decisions of older workers: Evidence from a U.S. Department of Veterans Affairs expansion

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ABSTRACT

This paper exploits a major mid-1990s expansion in the U.S. Department of Veterans Affairs health care system to provide evidence on the labor market effects of expanding health insurance availability. Using data from the Current Population Survey, we employ a difference-in-differences strategy to compare the labor market behavior of older veterans and non-veterans before and after the VA health benefits expansion to test the impact of public health insurance on labor supply. We find that older workers are significantly more likely to decrease work both on the extensive and intensive margins after receiving access to non-employer based insurance. Workers with some college education or a college degree are more likely to transition into self-employment, a result consistent with "job-lock" effects. However, less-educated workers are more likely to leave self-employment, a result suggesting that the positive income effect from receiving public insurance dominates the "job-lock" effect for these workers. Some relatively disadvantaged sub-populations may also increase their labor supply after gaining greater access to public insurance, consistent with complementary positive health effects of health care access or decreased work disincentives for these groups. We conclude that this reform has affected employment and retirement decisions, and suggest that future moves toward universal coverage or expansions of Medicare are likely to have significant labor market effects.

1. Introduction

In the current political and demographic landscape of the United States, it has become increasingly important to measure the impact of public health insurance on labor supply. Encouraging work at later ages would help to ease the rising strain on Social Security caused by the aging of the baby boomers coupled with increased life expectancy. At the same time, a push toward universal health care coverage might conflict with this policy goal, should public insurance availability reduce the incentive for older workers to remain in the labor force. Economic theory predicts that public health insurance entitlement may affect job choice, income, and health. However, the magnitude and direction of the net effects of public provision on labor supply are ex ante ambiguous. Moreover, even where theory makes a clear prediction of the effect, empirical evidence has not always supported it. This paper evaluates the behavioral responses on labor force participation, full-time work, and self-employment from expanding publicly-provided health care for older Americans. We use new evidence from a U.S. Department of Veterans Affairs health care expansion to estimate the labor market effects of increasing public health insurance availability. By examining a health insurance expansion that is tied neither to employment nor to other public programs, we isolate the impact of an insurance offer on labor supply for older workers. Additionally, we are able to distinguish between two sometimes-competing effects of the receipt of public health insurance, the income effect from receiving the benefit and the ability to detach from employer-provided health insurance.

Previous research examining the effect of public health care on work behavior has not provided clear answers. For example, government-provided health insurance that is not linked to employment acts as a positive income transfer for those with low earnings or high health costs because it is paid for via taxes, and the employed subsidize the not employed. Theory therefore implies that universal insurance will likely decrease employment for these individuals. Empirical evidence for Medicaid, however, which not only is not conditional on employment but also is means-tested and therefore taxes earnings, is mixed (Winkler, 1991; Moffitt and Wolfe, 1992; Yelowitz, 1995; Meyer and Rosenbaum, 2001; Borjas, 2003). Depending on the population studied and the methodology used, studies find a range of outcomes.

Adding to the theoretical complexity, other effects of government-provided insurance might lead to increases in labor supply or labor

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productivity. Health insurance may increase employment overall by improving health and reducing the work disincentive from other means-tested public assistance programs, which may also result in increased labor productivity. In line with this prediction, Gruber and Hanratty (1995) find that employment increased in Canada after the introduction of national health insurance. Additionally, studies examining the introduction of the U.S. continuation-of-coverage mandates, such as COBRA (e.g. Gruber and Madrian, 1995), find resulting increases in job switching. By de-linking health insurance and employment (but not increasing income, since recipients must pay their own health premiums), these mandates may increase productivity not only by improving health but by enabling improved job matches, that is, reducing "job-lock".[1]

Most existing programs in the U.S. cannot provide the kind of policy experiment needed to distinguish the effects of expanding health insurance on the labor supply of older workers; in order provide this distinction, a policy change must not be directly tied to employment, income, or bundled with other program changes. In general, social insurance programs that increase income conditional on non-work, such as unemployment insurance (Krueger and Meyer, 2002) and disability insurance (Bound and Burkhauser, 1999), have been found to decrease employment.[2] However, the theoretical predictions and the results of previous research are mixed for the employment effect of government-provided health insurance programs. These programs are often structured so that they provide a mixture of income transfers, employment subsidies and/or taxes, and improvements in human capital (via health), leading to ambiguous net effects on labor supply.

Medicare is a health care income transfer that is not linked to employment and could therefore shed light on the relationship between labor supply and health. Some studies (Lichtenberg, 2002) suggest that Medicare improves health, though evidence is mixed depending on the time period studied (Finkelstein and McKnight, 2008). The empirical effects of Medicare on labor market outcomes, however, are difficult to disentangle from those of Social Security and other programs linked to the normal retirement age. Most papers that study the Medicare-work relationship use structural estimation to suggest that an expansion of Medicare will increase retirement (Rust and Phelan, 1997; Johnson et al., 2003; French and Jones, 2008; Blau and Gilleskie, 2008). Although these papers provide a solid theoretical framework for the question of what would happen to labor supply if older people were provided with health care at less than cost, our quasi-experimental approach allows for a more transparent empirical identification strategy.

A unique opportunity to better understand the effects of universal coverage on older workers' employment is provided by a major mid-1990s expansion in both the services offered and the population covered by the Department of Veterans Affairs health care system (VA). This expansion converted VA health care from a hospital-based system focused on treating veterans for conditions related to their military service to a comprehensive health care system with a focus on outpatient preventive care. In addition, VA health care coverage which was previously guaranteed only to veterans with service-connected conditions and low incomes, was offered to the entire U.S. veteran population. Comparing veterans to a control group of non-veterans before and after the policy change allows us to isolate the labor supply impact of a program that provides an income transfer and may have health effects for some recipients, but that is not tied to employment or income and is not bundled with other program changes. Provided that veteran and non-veteran health outcomes and other characteristics do not trend differentially over time due to causes unrelated to the VA expansion, this strategy enables us to isolate the treatment effect of expanding the availability of public health insurance. From a policy standpoint, the effects of this program change are likely comparable to the effects of expanding Medicare to Americans under age 65, a plan often proposed by politicians.

We find that the VA expansion decreases employment and increases part-time work among older recipients. In addition, it results in a drop in self-employment for men with lower levels of education and an increase in the probability of self-employment for more highly educated individuals. This outcome is consistent with a job-lock reduction (in which de-linking health care from employment would increase transitions from paid work to more flexible but uninsured self-employment) dominating for men with more education, and the effect of an income transfer (since recipients no longer need either employer-provided insurance or the earnings from employment to protect against adverse health shocks) dominating for men with less education. Additionally, we find suggestive evidence that veterans from certain disadvantaged groups increase their labor supply as a result of gaining public insurance, implying that for these groups, health improvements or decreased work disincentives from this insurance expansion complement work. Finally, we posit that health insurance may be one reason that retirement rates conditional on age are higher in countries with national health insurance.

The paper is organized as follows: Section 2 provides a theoretical background for the effects of health insurance on employment, Section 3 describes the VA program in detail, Section 4 describes the dataset and empirical strategies, Section 5 provides results, Section 6 discusses and provides implications and Section 7 concludes.

2. Predicted effects

The impact of VA health insurance on labor supply is theoretically ambiguous. First, an offer of public health insurance acts as an income transfer. With higher income but the same underlying wage rate, theory predicts that on average, labor hours will fall. Some workers may move from full- to part-time work because they no longer need the income to pay for insurance premiums or out-of-pocket medical costs, and thus substitute leisure for work. Similarly, in response to the income transfer, workers may drop out of the labor force entirely, either temporarily or permanently (i.e. earlier retirement). Finally, the income transfer would potentially lead to a movement out of self-employment, as individuals who were previously working in order to pay for health costs out-of-pocket will no longer need to do so.

Along with acting as an income transfer, the offer of public health insurance should reduce job-lock. Workers are no longer reliant on their employers for insurance coverage, and thus fluidity in the labor market should increase. Workers have the flexibility to change to job positions offering higher wages but lower benefits, and more productive employer–employee matches may result. Older workers who are no longer job-locked because of insurance coverage will have the option of retiring earlier or transitioning to retirement by moving to part-time work without benefits. Workers who prefer self-employment but were previously unable to afford insurance in the non-group market or payment of health costs out-of-pocket now have the flexibility to become self-employed. Thus, the reduction in job-lock may lead to an increase in self-employment that runs counter to the decrease caused by the income transfer, especially for those groups for whom employment provides consumption value or less disutility than for other groups.

However, while both a job-lock reduction and an increase in underlying wealth due to an income transfer would predict a drop in overall labor hours on average, it is also theoretically possible that labor supply will increase for some groups. An uninsured (or inadequately insured) worker with a chronic health condition that may previously have forced him out of the labor force may be able to continue working if the newly-acquired insurance improves his health. The addition of health insurance may also allow workers on the margin of applying for Social Security Disability Insurance (SSDI), and thus receiving Medicare

[1] For more information on job-lock, see Gruber and Madrian (2002).

[2] In related work, Chetty (2008) further separates the employment reduction effects of unemployment insurance into a "liquidity effect" and a "moral hazard effect."