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WILL BETTER ACCESS TO HEALTH CARE CHANGE HOW MUCH OLDER MEN WORK?

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Introduction

The move toward universal health coverage in the United States is likely to impact the labor force decisions of older workers, but the size and direction of the effect is unclear. On the one hand, access to affordable insurance that is not tied to an employer may reduce work by encouraging workers to leave a current job, perhaps shifting to self-employment or retiring earlier than previously planned. On the other hand, such access could increase work among vulnerable groups, such as those with low incomes, by improving either their health or the work incentives that they face.

This *brief* provides some insights on how workers might respond by assessing the impact of a health care expansion by the U.S. Department of Veterans Affairs (VA). The first section describes the VA expansion and the possible impact of public health care insurance on labor force decisions. The second section explains the study's methodology, while the third summarizes the results. The final section offers a conclusion.

The main finding is that, for the average recipient, the VA reform decreases full-time work both by reducing the "job lock" associated with employer-based insurance and by boosting income through offering free coverage. More-educated workers take advantage of this health care to move to self-employment, while less-educated workers are more likely to leave the labor force completely. However, those in groups who typically have worse health than average actually increase their work upon provision of coverage.

With respect to implications for the new federal health care reform act, the income boost in the VA example does not apply for most individuals because health insurance under the new act will not be free. Thus, for the average worker, the finding on job lock is most relevant. However, for some workers, the new act may also have an income effect by subsidizing coverage or reducing the price of non-group market insurance.[1] Finally, our finding of increased employment rates for groups likely to be in worse health may also apply as states design programs to improve their access to health care.

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VA Health Care Expansion

The expansion of the VA health care system in the mid-1990s provides a unique opportunity to better understand the effects of public health insurance on older workers' employment. The reform converted VA health care from a hospital-based system focused on treating veterans for conditions related to their military service to a comprehensive system focused on outpatient preventative care, providing recipients with a good substitute for private care. In addition, as part of the expansion, coverage that was previously guaranteed only to veterans with service-related conditions and low incomes was offered to the entire veteran population.

Since an offer of free health insurance that is unrelated to employment serves to boost income, individuals may choose to work less. 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 costs, thus substituting leisure for work. Similarly, other workers may drop out of the labor force entirely, either temporarily or permanently (i.e., earlier retirement). Finally, the income transfer could potentially lead to a movement out of self-employment, as individuals who were previously working in order to pay for their health costs on their own will no longer need to do so.

Reducing job lock encourages older men to work less.

Along with acting as an income transfer, public health insurance should reduce "job lock" – the tendency for workers to remain in a job to retain their health coverage.[2] If workers no longer rely on employers for coverage, they can switch to jobs offering higher wages but lower benefits, and more productive employer-employee matches may result. Older workers who are no longer job-locked will also 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 health coverage will now have the flexibility to become self-employed. Thus, the reduction in job lock may increase self-employment, which runs counter to the decrease predicted by the income transfer.

While both the additional income and the reduction in job lock would suggest a drop in overall labor hours, labor supply could increase for some groups. For example, an uninsured worker with a chronic health condition who may previously have been forced out of the labor market may be able to continue working if the newly acquired insurance improves his health. The addition of health insurance may also allow workers receiving means-tested insurance like Medicaid or those who are on the margin of applying for Social Security Disability Insurance, and thus receiving Medicare after two years, to stay in the labor force.[3] In this instance, because the VA health insurance offer is not tied to an income test, it could allow them to escape a kind of "*no-job* lock" situation, in which they were not working (or working less than desired) in order to obtain health insurance. Hence, labor supply might increase for some groups after the expansion through improvements in health or reductions in work disincentives.

Experiment Methodology

To test the potential outcomes discussed above, we compared veterans with a control group of non-veterans before and after the VA policy changes, allowing us to isolate the labor supply impact of a program that provides an income transfer, and may have health effects for some recipients, but is not tied to employment or income and is not bundled with other programs.

The U.S. Census Bureau's March *Current Population Survey* (CPS) for the years 1992 through 2002 provided pre- and post-policy data on employment and demographics, including veteran status. To focus on workers approaching retirement, we limited our sample to individuals ages 55-64 and, because of the small number of female veterans in this age group, the sample was restricted to males.[4] Since changes in VA health care were implemented throughout 1996 and 1997, we define 1992-1995 as the pre-policy period and 1998-2002 as the post-policy period.[5]

The CPS data allowed us to study labor market outcomes such as labor force exit, as well as movement into part-time work or self-employment. In addition to information about employment in the current year, the survey questions individuals about their labor market participation during the previous year. In order to test the effect of the policy change on individuals' decisions to alter their employment status, we restricted our sample to those who reported working at least one week in the previous year.[6]

For the results of the analysis to be meaningful, it is important that the veteran and non-veteran populations are reasonably similar before the health care expansion and that outside circumstances during the

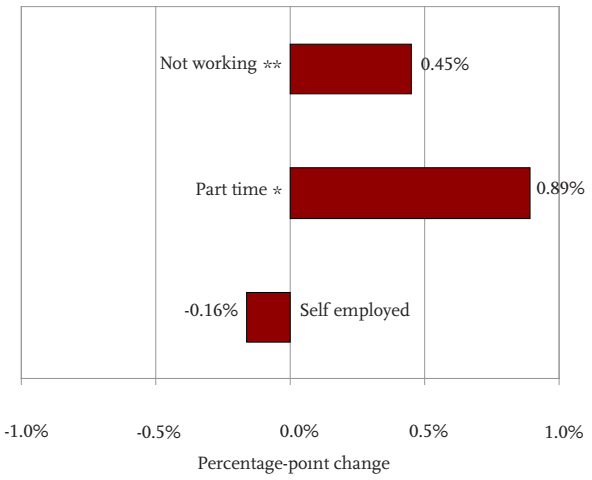
study period – for example, the welfare reform that occurred in the mid-1990s – are not expected to affect their labor force decisions differentially. As described in more detail in the full paper, these conditions hold true.[7]

Our results likely underestimate the impact of the expansion because we only measure the effects of *offering* the insurance, not the actual take-up of the insurance. Only about 25 percent of veterans enrolled in the new program during the period we studied. Among the majority who did not sign up, it is possible that some were still influenced by the change if they recognized that they could sign up and tap the benefits if needed. However, to the extent that some veterans may have been unaware of the insurance, the results underestimate the behavioral effect of full government coverage.[8]

Impact of VA Health Care Expansion on Employment

The VA health insurance offer appears to affect both the likelihood of working and the number of hours worked. First, as a result of gaining VA coverage, the probability of *not* working increases by .45 percentage points for an average individual (see Figure 1).[9] Relative to the pre-period average, this change represents about a 3.3 percent increase in the probability that an older worker ceases work. While this estimate is not large, it is likely to be a lower bound because, as noted above, many veterans did not actually enroll.[10]

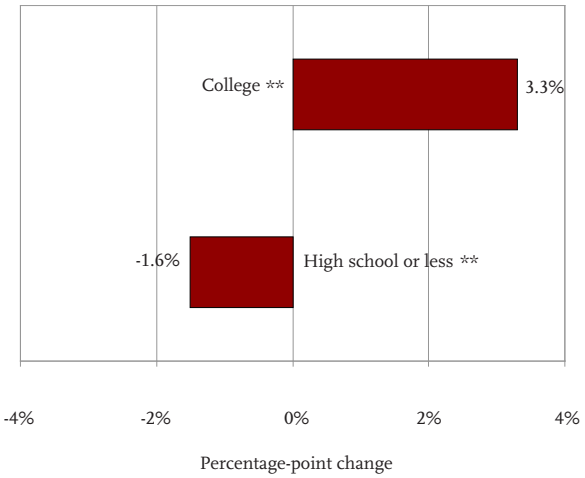
Figure 1. Effect of VA Insurance Receipt on Probability of Labor Supply Outcomes



Note: * statistically significant at 5 percent; ** statistically significant at 1 percent.
Source: Boyle and Lahey (2010).

Second, the results show an increase in the likelihood of working part time, which could indicate the beginning of a transition from full-time work to retirement. We estimate a 0.89 percentage-point increase in the probability of working part time, which is an 8.4 percent increase relative to the pre-period veteran average. Similarly, results showed that veterans work, on average, fewer hours per week upon receipt of health insurance.[11]

Figure 2. Effect of VA Insurance Receipt on Probability of Self-Employment by Education

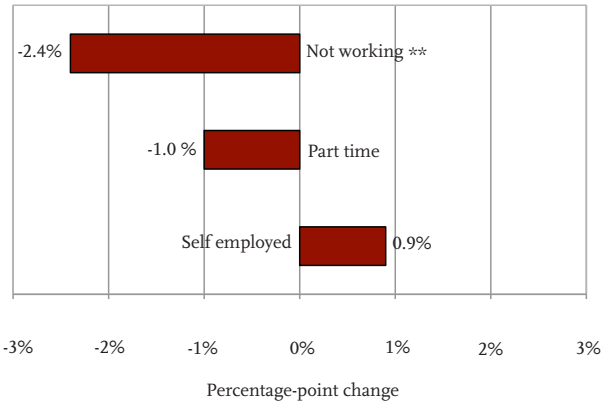


Note: ** statistically significant at 1 percent.
Source: Boyle and Lahey (2010).

Given these main findings, the analysis probed further to determine if the effects of obtaining health insurance vary by education level. The intuition here is that those with a higher education may be more likely to be job-locked by health insurance, while those with less education are more likely to be credit constrained. Cutting the sample by education group revealed two opposite and significant effects: men with some college education or a bachelor's degree are 3.3 percentage points more likely to be self-employed, an increase of 15.4 percent relative to the pre-period average (see Figure 2 above).[12] In contrast, men with a high school diploma or less are 1.6 percentage points less likely to be self-employed upon receipt of VA health insurance, a decrease of 8.5 percent from the pre-period average. These results suggest that the job-lock effect dominates for those with more education, while the income transfer dominates for those with less education.[13]

To further examine different impacts by demographic groups, the analysis also considered the effects of the VA health insurance expansion on those who typically have worse health than average, such as unmarried men and those with low incomes.[14] In these cases, the results suggest that the VA reform *increases* work effort. Single veterans are less likely to be self-employed or to work part time after the reform. Low-income veterans are less likely to not be working; their probability of not working declines by 2.4 percentage points (see Figure 3). Overall, these results are consistent with a situation in which better health care for economically disadvantaged groups either improves health or reduces the work disincentives for those formerly reliant on means-tested health insurance programs like Medicaid.[15] As states design insurance provision and subsidy programs under the new health reform act, it will be important for them to consider how work incentives may directly affect employment. De-linking health insurance from employment will be more likely to increase labor supply for vulnerable populations.

Figure 3. Effect of VA Insurance Receipt on Probability of Labor Supply Outcomes for Men with Low Incomes



Note: ** statistically significant at 1 percent.
Source: Boyle and Lahey (2010).

Conclusion

Providing free health insurance outside of employment decreases full-time work for older workers, increasing the number who work part time or exit the labor force entirely. A decrease in self-employment for those with less education implies that the income effect of receiving public insurance dominates the reduction in job lock for these individuals. However, for those with higher levels of education, self-employment increases, suggesting that job lock is more important than the income effect for this group. While the main effect of the VA health offer is to reduce labor force activity, it may *increase* activity among certain economically disadvantaged groups by improving their health or reducing disincentives to work.

In terms of the current health care reform, which ensures broad coverage regardless of employment status but does not focus on government-provision, there are several take-away points.[16] First, our results underscore the job lock reduction effect of this reform; educated workers will be more likely to move into self-employment and all workers will be better able to make economically efficient employment choices. Second, to the extent that reform decreases the costs of insurance through reduced adverse selection and other increased efficiencies, we will see some income effects on less-educated workers, although of a lower magnitude than what is found in the paper. Finally, as states add insurance coverage for economically disadvantaged populations, the availability of public and low-cost non-group market insurance options may result in increased labor force participation for these groups, generally improving productivity and welfare.

Endnotes

1 In addition, some low-income individuals who were previously ineligible for Medicaid will qualify for free coverage.

2 For more information on job lock, see Gruber and Madrian (2002).

3 Thanks to David Autor for recognizing the Disability Insurance possibility.

4 Although it is not uncommon for individuals to continue to work past age 64, eligibility for Medicare at age 65 will alter the impact of other public health insurance on the work decision.

5 In January 2003, VA again revised the rules for obtaining health care. We therefore end our study period in 2002. For additional details on the methodology, see Boyle and Lahey (2010).

6 This strategy is consistent with many studies in the job-lock literature, including Gruber and Madrian (1995).

7 The full set of assumptions are that: 1) veterans and non-veterans are reasonably similar before the healthcare expansion; 2) only veterans are affected by the expansion; 3) no other shocks occur during this time period that differentially affect the two groups' labor supply choices; and 4) the two groups would not trend differentially in the absence of a policy change due to unobservable factors. Regarding the first assumption, summary statistics in the full paper demonstrate that the veteran and non-veteran samples are reasonably comparable. The second assumption is valid because non-veterans were not affected by the expansion. Regarding the third assumption, policy changes in 1996-97 are unlikely to affect the two groups differently. Finally, with respect to the fourth assumption, our testing suggests that there are no systematic differences between the two groups that would indicate that they would exhibit different trends in the post-period.

8 In a 2001 survey, 22 percent of veterans who did not sign up said that it was because they were unaware of the program (U.S. Department of Veterans Affairs, 2002).

9 All of the regression results presented in this *brief* use a full set of control variables, including standard demographic characteristics, participation in health insurance or pension plan in the prior year, and industry and occupation in the prior year. Separate regressions were run using partial controls; these results are included in Boyle and Lahey (2010).

10 As mentioned above, any veteran wishing to use VA care must first sign-up for benefits or "enroll" in the system. During our study period, some veterans enrolled but did not actually subsequently use VA care. The fact that these individuals enrolled indicates awareness of their eligibility and a potential desire to access the system at a later time. It is not clear what proportions of un-enrolled veterans are unaware of their eligibility, not interested in ever using VA care, or relying on the option of enrolling at a later date should they desire VA care.

11 While our findings suggest that the move toward universal health care coverage will decrease employment for older men, it may increase the labor supply of other groups, such as women and prime-aged men. See Boyle and Lahey (2010) for further details.

12 Education results with graduate degree-holders included are similar to those without. However, when the sample is limited only to those with graduate degrees, the sign is sensitive to the specification chosen. We therefore do not include graduate degree holders in the reported regressions.

13 Le (1999) has a literature review of the empirical evidence that more educated people have a higher probability than less-well educated of choosing self-employment. Lucas (1978) provides a theoretical background.

14 See Lillard and Panis (1996) for evidence on the relationship between marriage and health status. See Kiuila and Mieszkowski (2007) for evidence on the relationship between income and health status.

15 General applicability to the current health care reform assumes that take-up and labor supply effects for the general population will be similar to the effects that were estimated for veterans. See Boyle and Lahey (2010) for further details. For consistency with the empirical literature on job lock, our main focus is on the effect of the VA policy change on individuals in the labor force. However, there may be interesting effects on other labor market transitions, especially with the increasing trend towards "unretirement" among

older men (Maestas, 2010 forthcoming). Therefore, an additional analysis was conducted including men who were not currently in the labor force. The results show that those veterans not in the labor force before the VA insurance expansion were more likely to work after the expansion. See Boyle and Lahey (2010) for further details.

16 Our policy experiment is most like the effects of expanding Medicare to younger ages. Although this expansion has currently been shelved legislatively, with increased health expenditures at earlier ages and the recession increasing long-term unemployment for older workers under the age of 65, Medicare expansion may well be on the legislative table again in the future.

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