

Is the Affordable Care Act Affecting Retirement Yet?

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1. Background

Beginning in 2014, the Affordable Care Act (ACA) introduced new, subsidized health insurance programs that offer alternatives to employer-sponsored health insurance coverage. The ACA created a health insurance marketplace in every state where individuals are guaranteed the option to buy private non-group coverage at a community-rated premium; the majority of these families (those with incomes between 100 percent and 400 percent of the federal poverty level) qualify for advance premium tax credits that limit the amount they must pay for coverage. These changes to the private non-group market mean that for a typical individual, retiring from a job with employer-sponsored insurance no longer means giving up affordable coverage. The ACA also gave states the option of expanding Medicaid eligibility for very low-income individuals, which provides an additional coverage option. As of January 2014, 25 states had expanded Medicaid eligibility under the terms of the ACA to all non-elderly adults with family income below 138 percent of poverty; an additional seven states expanded between January 2014 and July 2018; and 19 have not yet expanded, as of July 2018.¹

Because numerous studies had documented the influence of retiree coverage on retirement (for a review, see Nyce et al. 2013), the ACA was widely expected to reduce the labor supply of older workers. Early studies of the ACA, however, have failed to find any such effect (Gustman, Steinmeier, and Tabatabai 2018; Levy, Buchmueller, and Nikpay 2016). In this paper, we revisit the question of whether the ACA has affected labor supply of older Americans, using data that span more than four years after the policy's implementation.

2. Results

We analyze trends in health insurance coverage and labor market outcomes for older Americans (ages 50 through 64) using annual data from the American Community Survey (ACS) and monthly data from the Current Population Survey (CPS). The most recent data available are for 2016 in the ACS and April 2018 in the CPS. Trends are presented separately for states that did and did not expand Medicaid under the ACA; note that the seven states that expanded coverage mid-year in 2014, 2015 or 2016 have been dropped from this analysis. If the ACA had affected outcomes as a result of the creation of health insurance marketplaces and associated

¹ States that expanded Medicaid by January 2014 are AZ, CA, CT, DC, DE, HI, MA, MN, NY, VT, AR, CO, IA, IL, KY, MD, ND, NJ, NM, NV, OH, OR, RI, WA, and WV. States that expanded mid-year in 2014, 2015, or 2016 are MI, NH, AK, IN, PA, LA, and MT. States that have not implemented expansion as of mid-2018 are AL, FL, GA, ID, KS, ME, MO, MS, NC, NE, OK, SC, SD, TN, TX, UT, VA, WI, and WI.

reforms (community rating, guaranteed issue, and premium tax credits), we would expect outcomes to change in both expansion and non-expansion states beginning in 2014. If the expansion of Medicaid in the states that implemented it had an additional effect, we should see a larger change in 2014 for the expansion states than the non-expansion states.

Figure 1 presents key health insurance outcomes from the ACS: the fraction with no coverage, Medicaid, private non-group coverage, and employer-sponsored coverage. There is a clear drop in uninsurance in both types of states in 2014. The drop is only slightly larger in expansion states because of larger gains in non-group coverage in non-expansion states that offset their much smaller increase in Medicaid coverage. The fact that both expansion and non-expansion states experienced similar drops in overall uninsurance in 2014 and later suggests that the “treatment” effect of Medicaid expansion, relative to not expanding, is minimal and consists primarily of the type of insurance (public vs. private) people gained rather than a greater increase in the overall level of coverage. Thus, in terms of labor supply outcomes, it is important that we look for changes in trends within each group of states in 2014 and not just the possibility of a differential trend in Medicaid expansion versus non-expansion states.

Figure 2 presents key labor market outcomes from the CPS: labor force participation, working for pay, working full time conditional on working at all, and being retired. For each of these outcomes, there is no discernible break in 2014 for either expansion or non-expansion states. Nor is there any evidence of a relative change in one group of states versus the other. In some cases in which the trends appear to be changing differentially over time (e.g. the gap between the trends in the fraction of workers who are full-time appears to narrow after 2014), it is not in the expected direction: older workers in expansion states become (insignificantly) more likely to work more than 30 hours, compare with their counterparts in non-expansion states. Thus, like the earlier studies, we find no apparent effect of the ACA on labor supply of older workers.

We performed a number of supplementary analyses, available in the full paper, that confirm the pattern of results reported in Figures 1 and 2. These include: limiting the sample to those with less than a high school education (approximately 40 percent of the sample); limiting the sample to those in fair or poor health (approximately 20 percent of the sample); restricting the sample to only individuals who are ages 62, 63, or 64; analyzing labor market transitions instead of static outcomes; and adjusting for covariates such as race, ethnicity, gender, marital

status, education, and state-level unemployment rates. None of these analyses changes our conclusions based on Figures 1 and 2.

3. Discussion

We fail to find any effect of the Affordable Care Act's coverage provisions on the labor supply of older adults, four years after the law's implementation. The lack of a labor supply response stands in contrast to the large gains in coverage observed since 2014. These results suggest that for Americans approaching retirement the Affordable Care Act achieved its primary goal of increasing coverage without the unintended consequence of reducing labor supply.

4. References

- Gustman, Alan L., Thomas L. Steinmeier, and Nahid Tabatabai. 2018. "The Affordable Care Act as Retiree Health Insurance: Implications for Retirement and Social Security claiming." *Journal of Pension Economics & Finance* (2018): 1-35.
- Levy, Helen, Thomas C. Buchmueller, and Sayeh Nikpay. 2016. "Health Reform and Retirement." *The Journals of Gerontology: Series B* 73, no. 4 (2016): 713-722.
- Nyce, Steven, Sylvester J. Schieber, John B. Shoven, Sita Nataraj Slavov, and David A. Wise. 2013. "Does Retiree Health Insurance Encourage Early Retirement?" *Journal of Public Economics* 104 (2013): 40-51.

Figure 1

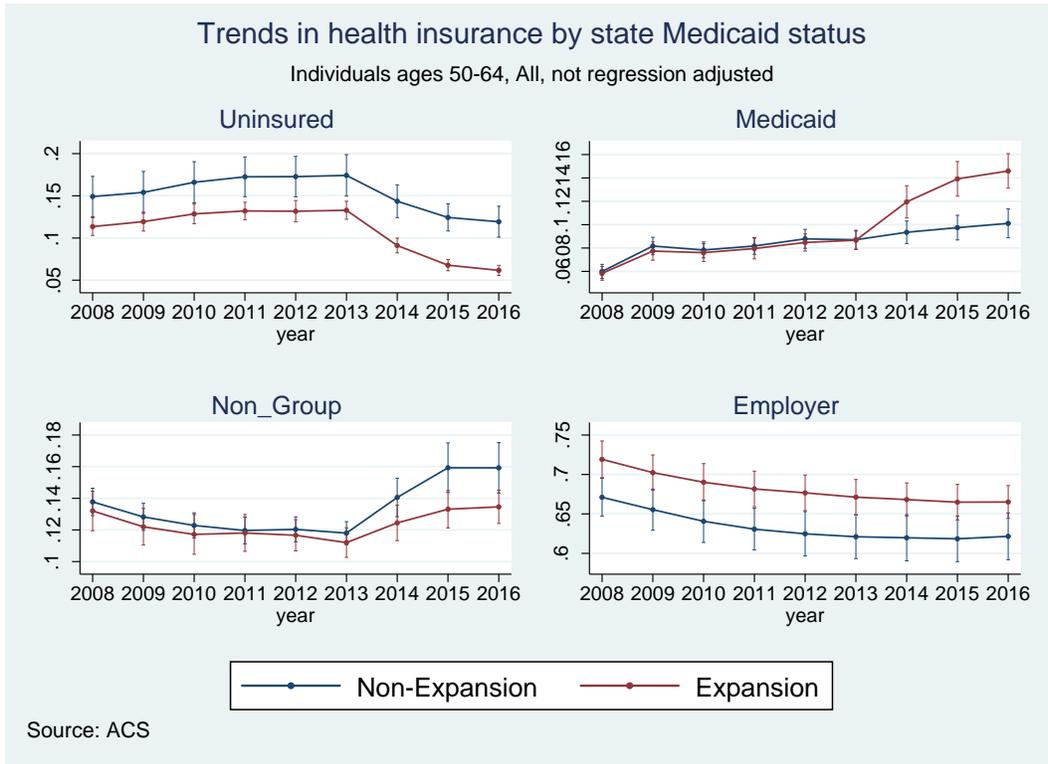


Figure 2

