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Executive Summary

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HEALTH INSURANCE AND THE LABOR SUPPLY DECISIONS OF OLDER WORKERS: EVIDENCE FROM THE U.S. DEPARTMENT OF VETERANS AFFAIRS

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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 expectancies. 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. Determining the effects of health insurance on labor supply in the United States is a challenge, since many individuals receive insurance through their employers. In addition, most United States public health insurance programs are tied to other social programs, making it difficult to isolate the impact of health insurance specifically.

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 change allows us to study 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. 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.

Utilizing data from the March *Current Population Survey* for the years 1992-2002, we compare a treatment group of male veterans in the 55-64 age bracket to a control group of male non-veterans between the ages of 55 and 64. Using various statistical techniques, we ensure that the treatment and control groups are comparable along observable dimensions. We utilize a methodology known as "difference-in-differences" regression, which allows us to compare the treatment and control groups before and after the policy change. The "before" comparison captures any systematic differences between the studied veteran and non-veteran populations. By essentially differencing the "before" and "after" comparisons, we isolate the impact of the VA policy change on the treated population.

We find that the VA expansion decreases employment, increases retirement, and increases part-time work among older recipients. As a result of gaining VA coverage, the probability of working drops by 10% for the treated population, and there is a 2.3% increase in the probability that a treated individual reports being retired. Our results also suggest an increase in the use of bridge jobs, which are positions (often part-time) that people transition to after retiring from a main job (Ruhm 1994). We estimate a 12.3% increase in part-time work as a result of gaining public insurance.

In addition to the aforementioned outcomes, we examine the effect of public insurance receipt on the probability of self-employment. A story consistent with “job-lock,” or labor market stickiness caused by workers’ reluctance to change jobs because they are afraid of losing health insurance, would predict an increase in (or at least no effect on) self-employment. This is because prior to gaining public insurance, some individuals who preferred self-employment might have remained in a current full-time employment situation in order to retain health benefits. On the other hand, since the public insurance is an income transfer for its’ beneficiaries, the program could decrease self-employment as people potentially no longer need the extra income to self-insure (or pay for) health risks. We estimate that the policy change results in a 5% decrease in self-employment. Thus, our findings suggest that the income transfer effect dominates the reduction in job-lock.

It is important not to take these results as an indication that providing health insurance to these older workers is simply a productivity diminishing transfer to that group, as there are potential distributional differences in how people are affected. We test whether there are differential impacts of the policy change for married versus single veterans, and for low-income versus higher-income individuals. Unmarried men in this age group are more likely to be in poor health than married men (Lillard and Panis 1996). Additionally, low incomes may be highly correlated with poor health. We find some positive employment outcomes for these demographic groups following receipt of comprehensive public insurance, consistent with a situation in which increased medical care for more economically disadvantaged groups leads to health improvements and a corresponding increase in the ability to work. This result fits in with some Medicaid literature that finds health increases and positive labor market effects from Medicaid among the poorest populations (Currie and Gruber 1996, 2001, Moffit and Wolfe 2002).

Finally, we posit that the interaction between health insurance and labor supply may be one reason that retirement rates are higher in countries with national health care. To illustrate this, we compare the proportion of non-working males in the 55-64 age bracket in the United States and Canada (in Canada the proportion is .4333, in the U.S. it is .3450). Based on the results of our study, we estimate that roughly 10% of the difference can be explained by the availability of government provided health insurance in Canada. Thus, to the extent that younger workers subsidize national health insurance for older workers, the income effect from universal coverage may be a reason that non-employment is higher for older people in countries with national health coverage. However, lower employment in these groups may not be a bad thing to the extent that it allows for more productive sorting into work and retirement.

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