

The Best Evidence Suggests the Effects of the ACA on Employment Will Be Small

Timely Analysis of Immediate Health Policy Issues

April 2014

Bowen Garrett and Robert Kaestner

Summary

A recent report by the Congressional Budget Office (CBO) concluded that the Affordable Care Act (ACA) will reduce the number of people working. Specifically:

“CBO estimates that the ACA will reduce the total number of hours worked, on net, by about 1.5 percent to 2.0 percent during the period from 2017 to 2024, almost entirely because workers will choose to supply less labor—given the new taxes and other incentives they will face and the financial benefits some will receive.”¹

Much has been made of the CBO report, but as we describe below, the extensive attention to the report’s conclusions seems misplaced. Qualitatively, the conclusion reached by the CBO is unsurprising because, as has been documented with similar social programs, reducing the receipt and quantity of low-income benefits as income increases provides an incentive for some

people to work less. Also, as the CBO emphasized, nearly all of the employment effect is caused by workers choosing to reduce how much they work and not because employers demand fewer workers. Unemployment—wanting to work but not being able to find a job—will be largely unaffected by the ACA. Moreover, those who decide that not working is better than working because of their greater access to health insurance are made better-off. Quantitatively, even though the CBO revised its initial employment effect estimates upward, its current estimates are still small relative to the overall workforce. At the same time, the revised estimates may be too large given what the recent evidence suggests.

In this report, we place the ACA and its employment effects in the context of other social programs. Second, we assess the evidence on likely employment effects from four recent and directly relevant studies that the CBO used to derive its prediction.

The ACA Is Similar to Other Means-Tested Programs

The ACA is not the first major, public policy to link the receipt and level of benefits to income. In fact there are many such “means-tested” programs. The Supplemental Nutrition Assistance Program (SNAP, formerly the Food Stamp Program) is a well-known program that provides food benefits for families with incomes below 130 percent of the federal poverty level (FPL). SNAP benefits are reduced as family income increases. Other programs that tie benefits to income include Temporary Assistance to Needy Families (TANF, formerly AFDC), the Housing Choice Voucher Program (formerly Section 8), and the Earned Income Tax Credit (EITC).

For each of these programs, research has shown that incentives embedded in the programs affects people’s choices about work. In some cases, evidence indicates very large effects (e.g., TANF), while

in other cases the evidence indicates little effect (e.g., SNAP).² Most of these programs decrease work effort because they provide more resources (e.g., income, food, and housing) to the family that allow them to work less without decreasing their consumption of goods and services, and because they make work less rewarding—greater work effort and income result in reductions in program benefits. However, the incentives in the EITC program causes, on average, people to choose to work more because benefits increase, at least for a while, with greater work effort.³

It is instructive to compare the EITC, a universally lauded program, to the ACA expansion of Medicaid to isolate the differences and the similarities between the programs and why one program (EITC) appears to be well liked and the other (ACA) has attracted increased scrutiny following the CBO report. The costs and benefits of the two programs are similar.⁴ The EITC will serve approximately twice as many people as the ACA Medicaid

expansions, but it provides about half the dollar value of Medicaid benefits. The main difference is that the EITC generates some cost savings because the greater work effort associated with the program increases tax revenue, whereas the expansion of Medicaid will generate some extra costs because some people will work less and reduce tax revenue. However, the Internal Revenue Service (IRS) estimated that approximately \$14 billion (25 percent of total expenditures) of EITC credits were fraudulent and a result of the complexity of the EITC. Despite this substantial cost relative to benefit, the EITC is widely believed to be successful because it causes some people to work more, although it also causes some people to work less.

The potential for the ACA to lead to fewer people working is a feature of almost all means-tested programs. In this regard, there is nothing special about the ACA and the adverse employment effects of the ACA are relatively small compared with some other social programs. Given this,

there is no reason to single out the ACA for special scrutiny, as has been done by some policy-makers and advocates. Any effort to provide benefits such as food subsidies, housing subsidies, wage subsidies (as in the EITC), and health insurance to low-income persons will inevitably come with unintended costs. While some program design features can minimize the unintended consequences, there is no feasible way to eliminate them.⁵ Those who do not like any means-tested social programs will not like the ACA, but these same people also do not like SNAP, TANF, unemployment insurance, and other hugely valued and important safety net programs. In sum, criticism of the ACA because of small employment effects common to all social programs is largely a straw man.

What Does Recent Evidence Say About the ACA and the Labor Market?

Studies of Changes in State Medicaid Policy

The CBO was charged with the difficult task of making predictions about the future

impacts of the ACA on employment when there is relatively little in the past that provides direct guidance. This is why the CBO estimate represents a best estimate instead of a precise prediction, and the CBO report was quite explicit in stating that there is substantial uncertainty as to the accuracy of its estimate.

“CBO’s estimate of the ACA’s impact on labor markets is subject to substantial uncertainty, which arises in part because many of the ACA’s provisions have never been implemented on such a broad scale and in part because available estimates of many key responses vary considerably.”⁶

The CBO study relied on a few recent studies and a larger empirical base of evidence to draw its conclusions. It is worthwhile to review four recent studies that are most relevant and that provide the most direct evidence (i.e., not based on extrapolation from other types of social programs or populations) related to the possible effects of the ACA on the labor market (Table 1).

One of the most important of the recent studies is the analysis of the expansion of Medicaid to adults with incomes below FPL in Oregon in 2008.⁷ Notably, the Oregon study was based on an experimental research design, which is generally thought of as the gold standard, in which the option to enroll in Medicaid was determined by lottery (randomly). The affected group in Oregon is very similar to the group affected by the ACA Medicaid expansions, although the ACA income eligibility threshold is somewhat higher (138 percent of FPL) than the threshold in Oregon (100 percent of FPL).

The results of the Oregon study are compelling, not only because of the credibility of the research design, but also because of its findings. Enrolling in Medicaid was associated with very small and statistically insignificant changes in employment and earnings. For example, enrollment in Medicaid was associated with a 1.6 percentage point, or 3 percent, decline in the probability of working, and a \$195, or 3 percent, decrease in annual earnings. The change in employment and earnings

Table 1. Recent Studies of Effects of Subsidized Health Insurance on Employment

Study	Method	Main Findings	Quality of Evidence
Oregon Medicaid ("The Impact of Medicaid on Labor Force Activity")	Experimental research design. Compared applicants enrolled and not enrolled as determined by lottery (randomized).	Medicaid enrollment associated with 1.6 percentage point (3%) reduction in employment earnings (not significant) and \$195 (3%) decrease in earnings (not significant).	Strong. Direct evidence with compelling design and credible findings.
Wisconsin Medicaid ("The Effect of Public Insurance on the Labor Supply")	Natural experiment from WI instituting enrollment cap/waitlist. Compared Medicaid enrollees to applicants eligible for enrollment but on a waitlist.	Medicaid enrollment associated with a decline in employment between 0.9 and 9.6 percentage points (between 2% and 18%).	Limited. Carefully conducted non-experimental study, but findings sensitive to different methods and samples. Demographics of comparison group differed somewhat from enrollee demographics.
Tennessee Medicaid ("Public Health Insurance")	Natural experiment from TN discontinuing eligibility for uninsurable (sick) population. Changes in employment and health insurance coverage for broad demographic groups before and after policy change in 2005 in TN compared with change in other southern states. Further stratified into household with and without children (difference-in-difference-in-difference).	For childless adults, those with less than high school degree, change in Medicaid policy (disenrollment) associated with 12 percentage point increase in employment (25%). No effect for other education groups. Ages 19–39: no effect. Ages 40–64: 9% increase in employment. Excellent/very good health: no effect. Good/fair/poor health: 8% increase in employment.	Limited. Carefully conducted non-experimental study, but findings sensitive to different methods and samples. Substantial error in the measurement of insurance coverage. Unexplained differences in findings by demographic group.
Massachusetts Health Insurance Reform ("Will Health Reform Lead to Job Loss?")	Natural experiment from MA implementing broad Medicaid expansion and subsidized exchange coverage in 2006. Compared employment before and after 2006 in MA to changes in group of selected comparison states with similar pre-reform trends.	Massachusetts reform had no statistically or economically significant effect on employment in the state. Findings held true for subgroups based on age, industry, and firm size. Health insurance increased in MA relative to comparison states.	Strong. Valid research design with high-quality data. Though work disincentives may be somewhat smaller in MA compared with ACA, expansion of subsidized health insurance in MA was broad-based, so meaningful employment effects should be detectable if they exist.

was small despite Medicaid benefits that constitute a large share of income. Gaining Medicaid coverage can be thought of as an increase in income, because of reduced out-of-pocket expenses and medical debt as a result of being insured. The average earnings of people in the Oregon study were \$6,513 in 2009, which is approximately 60 percent of the FPL, and the average annual spending on medical care was \$3,156.⁸ Thus, obtaining Medicaid coverage represented a 50 percent increase in income. In response to that, employment decreased by only 3 percent.

The small impact in the Oregon study is consistent with much previous evidence.⁹ It is interesting to note that the implied income elasticity¹⁰ of this example is roughly -0.06 (=3 percent/50 percent), which is very close to the -0.05 income elasticity used by the CBO in their analysis. Therefore, it is likely that similar changes in resources as a result of gaining health insurance and inexpensive medical care under the ACA will have similarly small effects on people's choices about work.

Another study examined a Medicaid expansion in Wisconsin in 2009 that allowed low-income, childless adults with incomes below 200 percent of the FPL to enroll in Medicaid.¹¹ However, budgetary considerations prevented the program from meeting demand, and enrollment was capped three months after it started. The capping of enrollment provided a natural experiment to study how enrollment in Medicaid affected employment because people continued to apply for the program and were put on a waitlist. Thus, the authors compared the experience of those enrolled in Medicaid to those eligible for enrollment, but who were on the waitlist. An important limitation of the study is that those enrolled in Medicaid come from a larger pool of applicants who were eligible, applied, and then enrolled. The comparison group consists of those who were eligible and applied, but it is not clear whether they would have enrolled. Consistent with this difference are socioeconomic and demographic differences between the two groups. Those enrolled (treatment group) were older, more likely to be female, less likely to work, and they had lower earnings

than those who were eligible and applied (i.e., comparison group).

The results of the Wisconsin study indicate that Medicaid enrollment was associated with a decline in employment of between 2 percent and 18 percent—a large range that reflects the sensitivity of estimates to changes in methods and samples. As noted above, the treatment and comparison groups were not perfectly matched so the “natural” experiment was not a true experiment. Therefore, different statistical methods were used to address likely confounding (bias) and these methods produced estimates that varied widely as described earlier. The wide range of estimates merits concern and is an important consideration when using this study to infer what may happen under ACA expansions of Medicaid.

Notably, the average incomes and employment rates in the Wisconsin sample were quite comparable to those in the Oregon sample. Also, there is overlap in the findings of the two studies, with the low-end of the estimates in Wisconsin (2 percent) being very close to the estimate found in Oregon (3 percent). Moreover, estimates in the upper range of those reported in Dague et al. (2013) are inconsistent with the large literature on the income elasticity of labor supply (McClelland and Mok 2012). While the Wisconsin study was carefully conducted, the non-experimental nature of the study and the potential bias in the analysis and variability of the estimates suggest that less weight should be placed on this study than the Oregon study.

A third study of the effect of a state Medicaid policy on employment focused on Tennessee, which in 2005 ended a policy that allowed any person who was uninsured or “uninsurable” to enroll in Medicaid, regardless of income.¹² As a result, approximately 170,000 people lost Medicaid coverage. Despite having no income eligibility threshold, those who lost Medicaid in Tennessee were thought to be overwhelmingly (93 percent) low-income (less than 200 percent of FPL), and therefore similar to those affected by the Oregon and Wisconsin changes. However, the figures on income and demographic characteristics of those who lost Medicaid

are uncertain because they were derived from administrative data from 1995 when the discontinued program was started. There was no similar information on the group affected in 2005 and this group may have been much different than the group that was first enrolled in 1995.¹³ If we assume that the income and demographic characteristics of the affected group in 2005 were the same as those in 1995, then the primary difference between the changes in policy between Oregon/Wisconsin and Tennessee was that the Tennessee Medicaid enrollees were selected partly on the basis of health—being uninsurable (sick).

The Tennessee analysis consisted of comparing changes in employment, hours of work, and health insurance coverage of persons in Tennessee before and after the 2005 change in policy to changes in the same outcomes of persons in other southern states (or all other states) before and after the change in policy. In the authors' preferred analyses, the comparison was further stratified into those households with and without children (i.e., difference-in-difference-in-differences).¹⁴ Notably, the analysis did not compare changes in employment and hours of work for groups with and without Medicaid, as in the Oregon and Wisconsin studies, but instead compared changes in outcomes for broader demographic groups (e.g., childless adults, or childless low-educated adults) of whom only a small fraction (e.g., 5 percent) lost Medicaid.

The results from the Tennessee study are mixed (Table 1). For childless adults with less than a high school degree (dropouts), the change in Medicaid policy (disenrollment) was associated with a 25 percent (12 percentage point) increase in employment, but there was no effect for other educational groups.¹⁵ Similarly, among childless adults, the results differed substantially by age group and self-reported health status. The authors can only speculate as to the cause of the heterogeneous results; they point to an unusually high value for health insurance among the relatively sick group of persons (“uninsurable”) who were disenrolled in Tennessee that caused them to seek full-time employment with health insurance benefits. However, as described earlier, the

authors do not know that those who were disenrolled were particularly sick because they cannot identify the demographic characteristics of the disenrolled persons. This speculation is based on data from 1995, which may or may not apply ten years after.

Unfortunately, the Tennessee study results are not comparable to those of the Oregon and Wisconsin studies because the Tennessee study did not examine changes in employment for those who were and were not on Medicaid, but rather examined changes of broad demographic groups. To make the results comparable, it is necessary to use the separate estimates of the effect of the policy change on the proportion of each group covered by Medicaid. This raises the question of how Medicaid is measured in the data. Garthwaite et al. (2013) use a measure that they refer to as “public” insurance, which includes Medicare, Medicaid and military coverage. This is, at a minimum, a broad definition of Medicaid. The authors also measured insurance coverage using data from the following year, for example, the insurance coverage of childless adults in Tennessee in 2006 came from data in 2007. The reason for this is that the insurance information in the survey (Current Population Survey) refers to the past year, but researchers have long debated whether this is in fact understood by respondents to the survey, and there is evidence that some portion of respondents refer to their current situation.¹⁶ The upshot is that the insurance status, as measured by Garthwaite et al. (2013), is likely measured with substantial error and estimates of the effect of Medicaid on labor supply that use this measure will reflect this problem.

One can see the importance of how insurance is measured in the range of estimates of the effect of Medicaid on employment reported by Garthwaite et al. (2013). If “public” coverage is used, then the authors reported an estimate indicating that 63 out of every 100 childless adults that lost “public” coverage found employment.¹⁷ This is a stunningly large effect. The effect size gets even larger if only Medicaid coverage is considered. Based on figures reported in the paper, the results imply that 90 out of every 100 childless adults that lost Medicaid found

employment.¹⁸ Are the Tennessee estimates plausible? They differ dramatically from estimates in studies of similar changes among similar persons in Wisconsin and Oregon. They also suggest employment responses to changes in income (treating the value of Medicaid as income) that are orders of magnitude larger than anything previously found.¹⁹ This response is 20 to 60 times the size of the normal employment response to similar changes in income (treating the value of Medicaid as income).²⁰

The extremely large estimates, along with unexplained heterogeneity of estimates and evidence of a problematic research design, suggest that much caution should be used before taking the results of the Tennessee study literally. While there appeared to be an increase in employment among childless adults associated with the disenrollment of persons from Medicaid in Tennessee, the magnitude of that change and its implications for the ACA are very uncertain. The range of uncertainty of estimates from the Tennessee study can be illustrated by using the confidence intervals of estimates reported in the study.²¹ Using various combinations of possible estimates of the change in employment and change in insurance coverage yields potential changes in employment among childless adults in response to the change in Medicaid policy of between 6 and 221 percentage points with the upper range of this interval clearly implausible.

Studies of Massachusetts Reform

Because Massachusetts implemented health care reform in 2006 with many of the same provisions that characterize the ACA, the employment experience before and after the change in policy in Massachusetts provides useful guidance as to possible employment consequences of the ACA. Dubay et al. (2012) compared changes in employment in Massachusetts before and after reform (2006) to changes in employment in a group of comparison states.²² The study used an innovative statistical matching method to identify comparison states with employment trends very similar to those in Massachusetts in the pre-reform period.²³ The findings are clear. Massachusetts reform substantially

increased insurance coverage, but had no statistically or economically significant effect on employment in Massachusetts. This conclusion held for subgroups defined by age, industry, and firm size.

The Massachusetts results imply that the ACA will have similarly minor effects on employment. Mulligan (2013),²⁴ however, argued that while there are similarities between the Massachusetts reform and the ACA, the degree to which the Massachusetts reform affected incentives to work is much less.²⁵ Yet the changes in work incentives in both Massachusetts and the ACA are sufficiently similar and the Massachusetts changes are sufficiently sizable in magnitude that, if there were large employment responses to such reforms, we would expect to see some measureable effect in Massachusetts. Instead, data from the best available analog to the ACA suggests its employment effects will be small to none.

Conclusion

There has been extensive debate over the potential effects of the ACA on the labor market. The recent CBO report has renewed the vigor of the debate and has led to some strong claims that the ACA will harm the economic recovery or even induce another recession. In this brief, we have put this debate in context, first by showing that the ACA is not a new, or a particularly different type of social program, and second by reviewing the most direct evidence of the likely effects of the ACA on the labor market.

The ACA is a means-tested program intended to provide health insurance to low-income persons. It is similar to other social programs that provide food, shelter, and income to low-income families. All means-tested programs have incentives that discourage work (including the EITC) or generate unintended costs. So the ACA is not different and not a program with unusually large work disincentives. More importantly, the decline in employment in the ACA will most likely stem from voluntary choices of people not to work because of the access to health insurance benefits makes them better off, and not because employers demand fewer workers.

Indeed, the best and most direct evidence to date suggests that the labor market consequences of the ACA are likely to be small. The Medicaid expansions are likely to have a very small effect on employment. The effect of the ACA expansions can be simulated using the Oregon results. If we use the 3 percent estimate from the Oregon

study, assume that half of those affected were working, as in Oregon and Wisconsin, and apply it to the 11 million new Medicaid enrollees expected, the result is 165,000 fewer people working because of the ACA expansion of Medicaid. This represents a small fraction of the total decrease in employment predicted by the CBO.²⁶

In regard to other aspects of the ACA, if Massachusetts is a guide, the remaining influences of the ACA are unlikely to have a substantial effect.²⁷ In this regard, the CBO estimate may be toward the high end of the potential employment effects of the ACA.

The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders.

About the Authors and Acknowledgments

Bowen Garrett is a senior fellow at the Urban Institute's Health Policy Center. Robert Kaestner is a professor in the Institute of Government and Public Affairs of the University of Illinois and a professor in the Department of Economics of the University of Illinois at Chicago. The authors are grateful for the financial support of the Robert Wood Johnson Foundation and the careful review of Linda Blumberg, Genevieve Kenney, John Holahan, and Stephen Zuckerman.

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Notes

- 1 Congressional Budget Office. "Labor Market Effects of the Affordable Care Act: Updated Estimates." In *The Budget and Economic Outlook: 2014 to 2024*, Washington, DC: Congressional Budget Office, 2014. <http://www.cbo.gov/sites/default/files/cbofiles/attachments/45010-breakout-AppendixC.pdf>.
- 2 For reviews see Moffitt R. "Welfare Programs and Labor Supply." In *Handbook of Public Economics*, Auerbach AJ and Feldstein M, (eds). Elsevier, 2002; and Hoynes, HW and Schanzenbach, DW. "Work Incentives and the Food Stamp Program," *Journal of Public Economics*, 96(1): 151–162, 2010. <http://ideas.repec.org/a/eee/pubeco/v96y2010i1p151-162.html>.
- 3 Eissa N and Hoynes HW. "Behavioral Responses to Taxes: Lessons from the EITC and Labor Supply." In *Tax Policy and the Economy Volume 20*, Poterba JM (ed), 73–110. Cambridge, MA: National Bureau of Economic Research, 2006.
- 4 In 2013, the EITC program cost approximately \$60 billion, served 26 million households, and provided an average benefit of approximately \$2,300 (see Maag E and Carasso A. "Taxation and the Family: What is the Earned Income Tax Credit?" Tax Policy Center, last modified February 12, 2014, <http://www.taxpolicycenter.org/briefing-book/key-elements/family/eitc.cfm>). The expansion of Medicaid under the ACA is estimated to cost about the same when fully phased in by 2017, will serve approximately 12 million people, and provide an average benefit of approximately \$5,000 (see Appendix B in Congressional Budget Office. *The Budget and Economic Outlook: 2014 to 2024*. Washington, DC: Congressional Budget Office, 2014. http://www.cbo.gov/sites/default/files/cbofiles/attachments/45010-Outlook2014_Feb.pdf).
- 5 Indeed, the ACA has several program features designed to minimize the employment effects. These include the gradual (up to 400 percent) phase-out of marketplace subsidies with higher income and the requirement that marketplace subsidies are limited to those without employer-sponsored health insurance. A productive strategy would be to search for ways to refine the incentives of the ACA to further minimize the labor market distortions.
- 6 Congressional Budget Office. "Labor Market Effects of the Affordable Care Act: Updated Estimates." In *The Budget and Economic Outlook: 2014 to 2024*, Washington, DC: Congressional Budget Office, 2014. <http://www.cbo.gov/sites/default/files/cbofiles/attachments/45010-breakout-AppendixC.pdf>.
- 7 Baicker K, Finkelstein A, Song J, and Taubman S. "The Impact of Medicaid on Labor Force Activity and Program Participation: Evidence from the Oregon Health Insurance Experiment." NBER Working Paper 19547, Cambridge, MA: NBER, 2013.
- 8 Ibid.
- 9 McClelland R and Mok S. "A Review of Recent Research on Labor Supply Elasticities." Congressional Budget Office Working Paper 2012-12, Washington, DC: Congressional Budget Office, 2012. http://www.cbo.gov/sites/default/files/cbofiles/attachments/10-25-2012-Recent_Research_on_Labor_Supply_Elasticities.pdf.
- 10 The percent change in employment in response to a given percent change in income or resources.
- 11 Dague L, DeLeire T, and Leininger L. "The Effect of Public Insurance on the Labor Supply of Childless Adults." Unpublished manuscript. College Station, Texas: George Bush School of Government and Public Service, Texas A&M University, 2013.
- 12 Garthwaite C, Gross T, and Notodowidigdo M. "Public Health Insurance, Labor Supply, and Employment Lock." Unpublished manuscript. Chicago, IL: Booth School of Business, University of Chicago, 2013.
- 13 There were no administrative data for 2005 (only 1995), and the publicly available data (Current Population Survey) could not be used to identify those on Medicaid who were part of the group affected by the policy change. When the change in policy occurred, the affected group may have been quite different from the group that was first enrolled in the program in 1995.
- 14 The difference-in-difference-in-differences analysis is preferred because of evidence presented by Garthwaite et al. ("Public Health Insurance, Labor Supply, and Employment Lock") and in a reanalysis (unpublished, available from the authors) that the difference-in-difference research design was not valid. For example, in our reanalysis, difference-in-differences estimates obtained in periods before the policy change in Tennessee, for example 1998 to 2005, were statistically significant and of the same approximate magnitude as those obtained using the 2000 to 2007 period that spans the policy change. We were able to replicate the Garthwaite et al. estimates.
- 15 In a re-analysis (unpublished, available from the authors) of the Tennessee data, the change in policy was not associated with a change in employment for those with just a high school degree and there was substantial evidence that the triple difference research design was not valid for this group or for the group of persons with more than a high school degree. The evidence against the validity of the triple difference research design for these groups is statistically significant estimates obtained using data from periods when there was no policy change (e.g., 1998 to 2005). The expected effect is zero, which was not the case, and magnitudes of the estimates were similar in size to those reported in the text for these groups.
- 16 Congressional Budget Office. "How Many People Lack Health Insurance and for How Long?" Economic and Budget Issue Brief. Washington DC: Congressional Budget Office, 2003; Davern M, Davidson G, Ziegenfuss J, et al. "A Comparison of the Health Insurance Coverage Estimates from Four National Surveys and Six State Surveys: A Discussion of Measurement Issues and Policy Implications." Minneapolis, MN: University of Minnesota, 2007. http://www.shadac.org/files/shadac/publications/ASPE_FinalRpt_Dec2007_Task7_2_rev.pdf.
- 17 The 63 percentage point estimate is obtained by dividing the change in employment for childless adults, 0.046, by the .0073 change in "public" coverage of childless adults.
- 18 A reanalysis (unpublished, available from authors) using a contemporaneous measure of insurance status instead of the following year measure produces estimates that do not indicate a substantial disenrollment of persons on Medicaid in Tennessee. While this seems inconsistent with the administrative data presented in the Tennessee study, it illustrates the importance of the choice to use the following year to measure insurance status and highlights the potential measurement problem that underlies the estimates of the effect of Medicaid on employment.
- 19 Consider that the Tennessee policy had no income eligibility threshold. Therefore, it was possible to obtain Medicaid and continue working; there was no need to stop working because income was not a criterion for eligibility. So the availability of Medicaid was the equivalent of an increase in income (pure income effect).
- 20 Assume that Medicaid represented a \$5,000 value for the Tennessee group affected (slightly sicker than typical Medicaid expansion group) and that the average income of the affected group was \$15,000 (150 percent of FPL in 2005) in the absence of the program. The Tennessee estimates imply that this 33 percent increase in income associated with Medicaid benefits resulted in a decrease in the probability of employment of between 63 and 90 percentage points. Even if we assume an average income of \$8,000 instead of \$15,000, the labor supply response is 20 times larger than the CBO consensus estimate (McClelland and Mok 2012).
- 21 The confidence interval for the employment estimates is 0.006 to 0.086, and the confidence interval for the "public insurance" estimates is 0.039 to 0.107.
- 22 Dubay L, Long S and Lawton E. "Will Health Reform Lead to Job Loss? Evidence From Massachusetts Says No." Washington, DC: Urban Institute and The Robert Wood Johnson Foundation, 2012. <http://www.urban.org/UploadedPDF/412582-Will-Health-Reform-Lead-to-Job-Loss-Evidence-from-Massachusetts-Says-No.pdf>.
- 23 These states were Delaware, Nebraska, Minnesota and Wisconsin. This refined matching procedure (using cluster analysis) strengthens the credibility of the research design and can be seen in graphs that show very similar levels and trends in employment and health insurance in Massachusetts and the comparison states before reform in Massachusetts.
- 24 Mulligan C. "Is the Affordable Care Act Different From Romneycare? A Labor Economics Perspective." Cambridge, MA: National Bureau of Economic Research, 2013.
- 25 The difference in the magnitudes of the work incentives between Massachusetts and the ACA derived by Mulligan ("Is the Affordable Care Act Different From Romneycare?") are the most similar (although still smaller in Massachusetts) for the two aspects of the ACA (Medicaid and Marketplace subsidies) that the Congressional Budget Office claimed would account for most of the employment changes associated with the ACA.
- 26 This figure represents only the simulated employment response to the Medicaid expansion in the ACA. It does not include other aspects of ACA, such as the sliding scale subsidies that may also decrease employment and hours of work.
- 27 The studies of the effect of Medicaid on labor supply reviewed in this article do not rely on data from scenarios in which people reduced work to gain Medicaid coverage. The Oregon and Wisconsin studies were based on samples that were already eligible for Medicaid, and the Tennessee study was in reference to a policy that did not have an income threshold.