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The Effect of the Affordable Care Act on the Labor Supply, Savings, and Social Security of Older Americans

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The Affordable Care Act (ACA) is the most significant reform to the health care sector since the 1960s. The ACA's provisions fall into four main categories: (1) an expansion of Medicaid; (2) an overhaul of private nongroup insurance, including community rating, coverage standards, the introduction of exchanges, subsidies, and purchase mandates; (3) a mandate for large employers to offer health insurance coverage, and subsidies for smaller employers; (4) miscellaneous provisions including reforms to coverage standards, the tax code, and the management of Medicare. In this paper, we assess the impact of the Medicaid and private nongroup insurance provisions of the ACA on the labor supply and saving of Americans ages 50 and older. Using an estimated structural model of worker behavior, we focus on key provisions of the ACA that are likely to affect older workers.

We consider the following two sets of provisions. First, the ACA expands Medicaid eligibility for low-income households younger than 65. Prior to the ACA, low-income households nearing retirement qualified for Medicaid only if they were disabled. Moreover, under the ACA, Medicaid applicants no longer face an asset test, meaning that they can qualify for Medicaid even if they hold significant wealth. The ability to carry wealth into retirement should make Medicaid more attractive for older workers. Overall, the Medicaid expansion could either increase or reduce labor supply by the elderly. Perhaps most likely, fewer people will work, as they can now qualify for Medicaid if they retire.

The second set of provisions involves nongroup insurance. The ACA establishes exchanges where households without group coverage can purchase insurance. The policies offered on these exchanges must meet coverage standards, and they must be community-rated, i.e., insurers cannot price-discriminate by health. The ACA also requires uninsured households ineligible for Medicaid to purchase insurance, provides tax subsidies for most purchases, and levies penalties on those not complying. These changes should significantly alter the customer

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base and actuarial costs in the nongroup market. Although the subsidies will allow most households to purchase nongroup insurance more cheaply, healthy and/or lightly subsidized individuals may see their premiums rise. Because many workers lose their employer-provided insurance after they leave their job (and the COBRA buy-in period expires), changes in the price of nongroup insurance may change their retirement decisions. Because most people will be able to buy nongroup health insurance more cheaply, early retirement will probably increase. Balancing against this, the subsidies provided under the ACA will allow uninsured low-income workers to purchase cheap insurance in the nongroup market. Prior to the ACA these people may have used default on medical bills as a substitute for health insurance. However, default is a good substitute for insurance only when income and assets are low. Acquiring health insurance may encourage these workers to work and save more.

Because the subsidies decrease with income, they also generate work disincentives. Like most means-tested transfers, the ACA subsidies effectively impose a tax on income. Our goal is to assess the quantitative importance of these effects. To do this, we extend the structural labor supply and retirement model in French and Jones (2011) to account for these reforms. We extend their model by adding in a much more detailed model of medical spending and insurance. We model explicitly how different types of health insurance plans affect the premiums and coinsurance rates that households face. We use data from the Health and Retirement Study (HRS) and the Medical Expenditure Panel Survey (MEPS) to estimate the structural model. We use the MEPS data to measure current medical expenditures, as well as who pays for these expenditures (out of pocket, private insurance, Medicaid, etc.). We use this information to estimate a dynamic programming model of labor supply and retirement behavior where individuals face realistic medical expense risk. Upon estimating the model, we conduct counterfactual experiments, where we modify the premiums and co-insurance rates, net of subsidies and penalties, that households face.

We show differences in both total and out-of-pocket medical spending prior to the enactment of the ACA. We show that average total medical spending in MEPS is high for all groups. Perhaps surprisingly, those with no health insurance do not spend much more out-of-pocket than those with private insurance. Those uninsured receive health care through a variety of sources such as worker's compensation and default on medical bills, which we refer to as a "consumption floor." This floor protects low-income individuals against catastrophic medical spending. Those who appear to have the highest resources appear to be those who pay the most for health care, consistent with the view that those with low resources are covered by the consumption floor, whereas those with high resources face the most medical expense risk and might have the largest labor supply responses. We choose the consumption floor to match these, and other facts. Thus we model the ACA as a change in government insurance provisions rather than the provision of insurance where none existed before.

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