Has the Affordable Care Act Increased Part-Time Employment?

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Abstract

We examine the impact of the Affordable Care Act (ACA) on part-time employment. Because the ACA's employer health insurance mandate applies to individuals who work 30 or more hours per week, employers may try to avoid the mandate by cutting workers' hours below the 30-hour threshold in order to avoid having to provide them with health insurance. Although the employer mandate only went into effect in 2015, many observers have argued that forward-looking employers began to shift towards a part-time workforce well in advance of the mandate. To test this hypothesis, we examine relative shifts across two categories of part-time workers (25-29 hours and 31-35 hours). We find some evidence of a shift from the 31-35 hour category into the 25-29 hour category after the passage of ACA in March 2010. However, that shift is not more pronounced among low-wage workers or among workers in industries and occupations most likely to be affected by the mandate. Thus, there is little evidence that the ACA has *caused* the shift across hours categories, or led to an increase in part-time employment. However, the ACA could cause a shift towards part-time work in the future as the mandate takes effect.

Keywords: health insurance; Affordable Care Act; employment; part-time employment

JEL codes: I1, J2

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Introduction

There has been considerable debate among policy experts and commentators over whether the Affordable Care Act (ACA) has caused an increase in part-time work relative to what would have occurred in the absence of the law (e.g., Conover 2013; Bauman 2014a; Van de Water 2013; England 2013; Bernstein 2013; Mathur and Slavov 2014). Through its "employer mandate," the ACA requires large and medium employers to provide health insurance to workers working 30 or more hours per week. Though the ACA was signed into law in 2010, the employer mandate did not go into effect until 2015.[1] Did firms shift towards part-time workforces after the ACA became law but before the mandate went into effect?

The employer mandate makes full-time workers more expensive relative to part-time workers, suggesting that it may cause a shift towards a part-time workforce. A similar mandate in Hawaii appears to have had such an effect (Buchmueller, DiNardo, and Valletta 2011; Thurston 1997; Lee, Russo, Nitz, and Jabbar 2005). And if firms are forward looking and attempt to smooth the (potentially large) costs of adjusting the composition of their workforce over time, then we would see a shift towards part-time work after the passage of the law but before the employer mandate took effect. Anecdotes exist, reported in the press, to support these claims.[2] On the other hand, it is very reasonable to be skeptical that firms would alter the composition of their workforces years before the employer mandate went into effect. The ACA might eventually have an impact on part-time employment, but perhaps not in the years between the passage of the law and the employer mandate activating.

In light of the public attention these claims have received, and to better understand the extent to which firms are forward looking, this paper tests the hypothesis that employers began reducing workers' hours immediately after the ACA's passage. To this end, we utilize monthly Current Population Survey

[1] The mandate was initially scheduled to go into effect in 2014, but was postponed until 2015. It went into effect in 2015 for employers with 100 or more full-time equivalent employees during the previous year, and it will be extended in 2016 to employers with 50 or more full-time equivalent employees in the previous year (KFF, 2014). For employers who are affected in 2015, lookback periods for determining full-time status may begin as early as 2014.

[2] E.g., Caldeira (2013) and Bauman (2014b).

(CPS) data to provide an analysis of the ACA's impact on trends in part-time work over the period from its implementation through mid-2014 (the period before the mandate went into effect). We consider two groups of part-time workers: those working 25-29 hours, and those working 31-35 hours. We argue that these two hours categories are most likely to be affected by a mandate that applies to those working 30 hours or more: It is least costly for employers to avoid the mandate by shifting workers who are just above 30 hours to just below 30 hours. We examine how the relative probability of falling into each of these hours categories has shifted since the ACA's passage.

Of course, other factors besides the ACA could also cause a shift across these hours categories. To identify the causal effect of the ACA, we employ a difference-in-difference approach. We argue that an ACA-driven shift from the 31-35 hour category to the 25-29 hour category should be more pronounced among workers earning close to the minimum wage whose wages can't be cut to cover the cost of the required insurance (see Baicker and Levy 2008). The available evidence also suggests that the shift should be more pronounced among workers in the retail and hospitality industries, and among workers in building and grounds cleaning and maintenance, personal care and service, and food preparation and serving related occupations.

Data and Methodology

We use monthly CPS data from January 2008 through July 2014 in our analysis. We select a sample of individuals who are currently employed in private-sector, non-agricultural, non-self-employed jobs. These individuals provide information about their occupation, industry, and hours worked at their main job. A subset of this group is also asked to provide information about earnings.

We use two alternative definitions of hours to construct our dependent variable. First, we consider actual hours worked last week. Second, we consider usual average weekly hours. We focus on the individuals in our sample who fall into the following two reported hours categories: 25-29 hours per week and 31-35 hours per week. Individuals who report working exactly 30 hours per week are excluded from the analysis as individuals tend to round their hours per week to the nearest five — for example, people

working 28 or 32 hours per week may report working 30 hours — and so we can't accurate categorize respondents who report working exactly 30 hours. In our analysis using hours worked last week, the sample is restricted to individuals who were at work the previous week.[3]

For our difference-in-difference analysis, we define three alternative treatment groups. The first treatment group includes individuals in the retail or hospitality industries. The second includes individuals in any of the following occupations: building and grounds cleaning and maintenance, personal care and service, or food preparation and serving. The third includes individuals earning less than $10 per hour (in January 2014 dollars, as determined by the CPI-U). As discussed in the introduction, individuals in these treatment groups should be disproportionately affected by the ACA's employer mandate.

For each treatment group and hours definition, we estimate the following regression:

$$log\left(\frac{S_{myg}^{25-29}}{S_{myg}^{31-35}}\right) = \beta_1 PostACA_{my} + \beta_2 Treatment_g + \beta_3\left(PostACA_{my}\right)\left(Treatment_g\right) + \alpha_m + \epsilon_{myg}$$

Here, S_{myg}^{h} is the share of individuals in group g (control or treatment) who fall into hours category h (either 25-29 or 31-35) during month m of year y. We utilize the CPS's composited final weights to compute these shares. Thus, the dependent variable is the log odds ratio of working 25-29 hours versus 31-35 hours in a group-month-year cell. $PostACA_{my}$ is an indicator for whether the ACA was in effect during month m of year y; it is set to 1 after March 2010 and zero otherwise. $Treatment_g$ is an indicator equal to 1 if group g is the treatment group and 0 if it is the control group. α_m is a month effect to capture seasonality, and ϵ_{myg} is a stochastic error term. The coefficient of interest is β_3, which measures the additional post-ACA shift across hours categories in the treatment group. We weight each observation by population in the month-year-group bucket.[4]

[3] We also exclude September 2009 due to the fact that Labor Day occurred during the reference week for the survey, resulting in an unusually high fraction of workers working 32 hours (a 4-day week).
[4] Unweighted regressions yield similar results.

Results

Results are shown in Tables 1 and 2. In Table 1, the dependent variable is constructed using actual hours. In Column (1), the treatment group is based on employment in the retail or hospitality industries. In Column (2), the treatment group is based on working in building and grounds cleaning and maintenance, personal care and service, or food preparation and serving. In Column (3), the treatment group is based on an hourly wage less than $10. In all three specifications, the post-ACA period is associated with significantly higher odds of falling into the 25-29 hour category versus the 31-35 hour category. All three treatment groups also have higher odds of falling into the 25-29 hour category versus the 31-35 hour category. However, the coefficient on the interaction term is insignificant in the industry and wage specifications. It is significant at the 10 percent level – but in the wrong direction – in the occupation specification. Table 2 presents results based on usual weekly hours. Again, all treatment groups have higher odds of falling into the 25-29 hour category versus the 31-35 hour category. Also, the passage of the ACA is associated with a shift towards the lower hours category. However, the coefficient on the interaction term is either insignificant or significant in the unexpected direction.

Conclusions

In this paper, we test whether the passage of the Affordable Care Act has already caused forward-looking employers to shift workers from just above 30 hours per week to just below 30 hours per week. While we find that the passage of the ACA is associated with a shift of workers out of the 31-35 hours category and into the 25-29 hours category, this shift is not more pronounced among low-wage workers, among workers in the retail or hospitality industries, or among workers in building and grounds cleaning and maintenance, personal care and service, or food preparation and serving. Thus, we conclude that the observed shift across hours categories is unlikely to have been *caused* by the ACA's passage. We speculate that if employers did not shift workers slightly above the 30-hour threshold to slightly below the threshold, they are unlikely to have shifted workers from 40+-weekly hours to below the 30-hour threshold. Of course, our analysis does not rule out the possibility that employers will shift towards a part-

time workforce in the future, when the employer mandate is fully activated. But our results imply that it is unlikely that firms began this transition well in advance of the employer mandate going into effect.

Table 1: ACA's Effect on Odds of Working 25-29 Hours versus 31-35 Hours (Actual Hours)

VARIABLES	Industry	Occupation	Wage < $10
$Treatment_g$	0.598***	0.551***	0.723***
	(0.0176)	(0.0180)	(0.0366)
$PostACA_{my}$	0.0683***	0.100***	0.119***
	(0.0150)	(0.0149)	(0.0371)
$(Treatment_g)(PostACA_{my})$	0.0393	-0.0464*	0.00219
	(0.0248)	(0.0253)	(0.0465)
Constant	-1.118***	-1.054***	-1.172***
	(0.0283)	(0.0213)	(0.0507)
Observations	156	156	156
R-squared	0.937	0.880	0.871

Notes: Standard errors in parentheses. All regressions include month dummies. Each observation weighted by population in the cell.
*** p<0.01, ** p<0.05, * p<0.1

Table 2: ACA's Effect on Odds of Working 25-29 Hours versus 31-35 Hours (Usual Hours)

VARIABLES	Industry	Occupation	Wage < $10
$Treatment_g$	0.473***	0.421***	0.585***
	(0.0155)	(0.0157)	(0.0340)
$PostACA_{my}$	0.0682***	0.110***	0.0903**
	(0.0129)	(0.0135)	(0.0349)
$(Treatment_g)(PostACA_{my})$	0.0373	-0.0699***	0.0307
	(0.0226)	(0.0241)	(0.0460)
Constant	-0.993***	-0.931***	-1.009***
	(0.0274)	(0.0259)	(0.0496)
Observations	158	158	158
R-squared	0.919	0.809	0.812

Notes: Standard errors in parentheses. All regressions include month dummies. Each observation weighted by population in the cell.
*** p<0.01, ** p<0.05, * p<0.1

References

Baicker, K., & Levy, H. (2008). Employer health insurance mandates and the risk of unemployment. *Risk Management and Insurance Review, 11*(1), 109-132.

Bauman, N. L. (2014a, February 24). Obamacare May Be Causing A Shift To Part-Time Workers In Illinois. *Forbes.* Retrieved May 25, 2014, from http://www.forbes.com/sites/theapothecary/2014/02/24/obamacare-may-be-causing-a-shift-to-part-time-workers-in-illinois/

Bauman, N. L. (2014b, July 15). ACA driving part-time nation. *Illinois Policy Institute.* Retrieved May 25, 2014, from http://www.illinoispolicy.org/aca-driving-part-time-nation/

Bernstein, J. (2013, August 22). The Affordable Care Act and Part-Time Work. *The New York Times.* Retrieved May 25, 2014, from http://economix.blogs.nytimes.com/2013/08/22/the-affordable-care-act-and-part-time-work/?_php=true&_type=blogs&_r=0

Buchmueller, T. C., DiNardo, J., & Valletta, R. G. (2011). The effect of an employer health insurance mandate on health insurance coverage and the demand for labor: Evidence from Hawaii. *American Economic Journal: Economic Policy, 3*(4), 25-51.

Caldeira, S. (2013, November 14). Business backlash: Obamacare's jobs problem. *CNBC.* Retrieved May 25, 2014, from http://www.cnbc.com/id/101196459#

Conover, C. (2013, July 31). Who Can Deny It? Obamacare Is Accelerating U.S. Towards A Part-Time Nation. *Forbes.* Retrieved May 25, 2014, from http://www.forbes.com/sites/theapothecary/2013/07/31/who-can-deny-it-obamacare-is-accelerating-u-s-towards-a-part-time-nation/

England, S. (2013, July 30). Obamacare and Employment. *Angry Bear Blog.* Retrieved May 25, 2014, from http://angrybearblog.com/2013/07/obamacare-and-employment.html

Employer Responsibility Under the Affordable Care Act. (2014, December 17). *The Henry J. Kaiser Family Foundation.* Retrieved May 25, 2014, from http://kff.org/infographic/employer-responsibility-under-the-affordable-care-act/

Lee, S. H., Russo, G., Nitz, L. H., & Jabbar, A. (2005). The Effect of Mandatory Employer-Sponsored Insurance (ESI) on Health Insurance Coverage and Labor Force Utilization in Hawaii: Evidence from the Current Population Survey (CPS) 1994-2004. *University of Hawaii Department of Economics Working Paper*, 05-12.

Mathur, A., & Slavov, S. (2014, January 2). Obamacare Hasn't Caused a Shift to Part-Time Work ... Yet. *U.S. News & World Report.* Retrieved May 25, 2014, from http://www.usnews.com/opinion/blogs/economic-intelligence/2014/01/02/obamacare-hasnt-caused-a-shift-to-part-time-jobs-yet

Thurston, N. K. (1997). Labor market effects of Hawaii's mandatory employer-provided health insurance. *Industrial & Labor Relations Review, 51*(1), 117-135.

Van de Water, P. (2013, October 12). Health Reform Not Causing Significant Shift to Part-Time Work But Raising Threshold to 40 Hours a Week Would Make a Sizeable Shift Likely. *Center on Budget and Policy Priorities.* Retrieved May 25, 2014, from http://www.cbpp.org/cms/?fa=view&id=4028