# The Effects of the Affordable Care Act on Health Insurance Coverage and Labor Market Outcomes

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## ABSTRACT

The Affordable Care Act (ACA) is designed to expand insurance coverage with policies that alter the connection between employment and health insurance. This paper exploits variation across geographic areas to estimate its effect on health insurance coverage and labor market outcomes in the first two years after the implementation of its main features. My analysis is a recreation of their analysis but is looking at three years after the implementation of the main features of the ACA, adding one new year of data. Impact of the ACA come from the preexisting percent of uninsured individuals within income groups within geographic regions. The results from two years after show that the majority of the increase in health insurance coverage since 2013 are from the ACA and that areas where potential enrollments were higher saw substantially larger increases in coverage. While there was no aggregate effect on the labor market. There were decreases in labor force participation in areas with higher potential exchange enrollment and similar increases in labor force participation in areas with higher potential Medicaid enrollment. Do these trends continue when three years after the main features of the ACA are implemented?

## I. INTRODUCTION

The Affordable Care Act (ACA) was passed in 2010 is the largest change to healthcare in the United States since the introduction of Medicare and Medicaid in 1965. The primary goal of the ACA was to reduce the number of uninsured. Several parts of this law try to achieve this goal; it expands Medicaid to cover low-income individuals, private health insurance subsidies provided to individuals with family incomes between 100 and 400% of the federal poverty line (FPL), requirements for employers to offer health insurance coverage, and penalties for not being insured. Many of these provisions were implemented in January of 2014. This caused uninsurance rates among non-elderly adults to fall substantially, from 20.1 percent in 2013 to 15.1 percent in 2014, and 12.6 percent in 2015. These numbers do not account for the counterfactual of the ACA not being implemented.

Many of these same provisions possibly weaken the tie between employment and health insurance coverage and might change the labor supply. In 2014 the Congressional Budget Office estimated that the ACA would reduce the size of the labor force by 1.5 to 2 percent by 2024. This comes from incentive effects from the availability of subsidies for private coverage and expansion of Medicaid. In aggregate there are no changes in labor force participation rates but these values also do not account for the counterfactual of the ACA not being implemented.

Because the ACA is a national reform it is difficult to disentangle the effects of the law from changes that would have happened without it. This is a problem with previous trend

effects and makes it hard to figure out how much of the increase in health insurance coverage was driven by the ACA and not from previous trends. To find out this effect the authors use data from the American Community Survey (ACS) to exploit geographic variation in the potential impact of the ACA. The paper focuses on the effect of two key provisions. First, the ACA expanded Medicaid to individuals in families with incomes below 138% of the FPL but only half of the states expanded Medicaid. Second, the ACA subsidized the purchase of private health insurance through state health insurance exchanges for individuals with incomes between 100% and 400% of the FPL. The data allows an estimation of the percent of each geographic region that was uninsured and below 138% of the FPL, and uninsured and between 139% to 399% of the FPL. These geographic regions are known as Public Use Microdata Areas (PUMAs) and there are about 1,000 of them across the United States.

Previous research was not as granular in terms of dataset size and geographic detail, but would predict that areas with large amounts of uninsured and people under 400% of the FPL would experience larger increases in health insurance coverage, and that the group below 138% FPL would be sensitive to Medicaid expansion. Duggen (2017) shows a substantial impact on overall health insurance coverage estimating that coverage increased by 4.2 percentage points in states that expanded Medicaid, and 2.6 percentage points in states that did not. In regions where the share of the population less than 138% FPL and uninsured is 10 percentage points higher the coverage increase was 4 percentage points higher in expansion states but not significantly higher in non-expansion states. In regions where the percent of population between 139% and 399% FPL and uninsured is 10 percentage points higher there is no significant difference between expansion and non-expansion states.

Because there are expansion and non-expansion states for Medicare most of the coverage increase in expansion states comes from Medicare and that most of the coverage increase in non-expansion states comes from privately-purchased health insurance from exchanges.

In terms of labor supply areas with high uninsured and individuals with incomes between 139% and 399% FPL, where private-purchase subsidies are available, labor force participation decreases. But in areas with high uninsured and individuals with incomes less than 138% FPL increase labor force participation.

Duggen (2017) builds on other literature exploring the effects of the ACA on health insurance coverage and labor market outcomes. The previous literature also shows that the ACA increased health insurance coverage and had little impact on the labor market Frean (2016) and Courtemanche (2016). Frean (2016) shows health insurance coverage is responsive to price subsidies and states with exchanges had larger gains in coverage. Courtemanche (2016) found that health insurance coverage increase was twice as large in states that expanded Medicaid.

To see if the results from this paper hold the addition of data for the year 2016 is added to see if there are different results. The year ended with the election of Donald Trump, Republican majorities in both houses of congress, and 31 out of 50 governorships. The Republican Party was clearly committed to repealing and replacing the Affordable Care Act with the possibility of 20 million Americans losing health insurance if they were able to do so.

The uninsured rate in 2016 also hit an all time low of 8.9 percent, 20 million more people had health insurance than in 2010. However, during 2016 several major players in health insurance markets left the marketplaces created under the ACA leading to double-digit premium increases in some areas. Conversely, in the employer offered insurance market premium growth has slowed.

Another thing that affected insures was the Center for Medicare and Medicaid Innovation (CMMI) that decided to make participation in payment experiments mandatory, possibly causing price turbulence. Insurers were also claiming they wanted to drive down premium prices by proposing massive mergers that would have consolidated the industry.

There was also the prominent news stories about massive increases in drug prices. Congressional outrage followed but no action was taken on the solutions offered like drug price negotiation and importation of drugs from Canada. Was there any impact of these news events on health insurance rates? And does the analysis hold up with this new data?

## II BACKGROUND

### A. ACA and Health Insurance

Before the ACA Medicaid provided insurance to 57 million and Medicaid premiums are essentially zero in most states. Many previous studies on Medicaid showed that it improves health outcomes and enhances economic well-being. The ACA substantially expanded eligibility for Medicaid with the goal of expanding eligibility among non-elderly adults. The CBO projected

Medicaid enrollment would increase by 12 million as a result from the ACA, initial estimates were higher until the supreme court allowed states to opt out of health insurance exchanges.

The impact of the ACA Medicaid expansion is likely to vary across states for three reasons. First, only 25 states chose to expand Medicaid by 2014. Second, some states already covered a substantial fraction of adults below 138% FPL. Third, the fraction of individuals in poverty is different across states.

Subsides for private health insurance purchased on the ACA exchanges are driven by the percent of the FPL each individual is at. Then this percentage is mapped to a maximum percentage of income that one should spend on health insurance, 2% to 9.5%, at low and high incomes respectively. The subsidy is the cost of the second lowest cost "silver tier" plan available minus the maximum percentage of income is responsible for paying.

**B. ACA and Labor Market**

There are two channels for the ACA to reduce the labor supply; incentive effects and subsidies, and expanded Medicaid coverage. Medicaid provides a source of insurance coverage regardless of employment will reduce the labor supplied by workers and previous recent literature supports the idea that a Medicaid expansion decreases the labor supply. Medicaid's effect could be different with the ACA because a person would be eligible for subsidies even if their income rises above the Medicaid threshold. States that expand Medicaid allow individuals with less than 138% of FPL to get insurance where states that don't keep the previous level of individuals with less than 100% of FPL can get insurance under Medicaid. The states that expand also have competition between Medicaid and insurance subsidies between 100% and

138% FPL where individuals can decide if they want to work and get subsidies for insurance or stay unemployed and get Medicaid.

Subsidies for private health insurance exchanges could effect labor market outcomes through several channels. First, people would retire before 65 because it is less expensive for individuals to purchase coverage outside of employment through subsidies from exchanges. Second, the amount of subsidy decreases for an increase in income so workers might scale back their hours, shift to a different job, or drop out if their spouse is working. All of these strategies distort the total family income that is used to calculate percent of FPL each individual is at moving them between under 100%, between 100% and 138%, between 139% and 399%, and above 400%. Third, there is a kink in the subsidy levels at 400% FPL where the subsidy goes from 2% to 0%. Fourth, subsides may encourage workers to shift to smaller firms or start their own business.

The ACA may also drive firm behavior. The ACA mandates that firms with 50 or more full-time employees has to offer health insurance coverage. This might cause them to stay below the threshold, or hire more part-time workers. The ACA also has a Small Business Tax Credit that encourages firms with 25 or fewer employees and with low-wage workers to provide health insurance coverage to their employees. This might lead to an increase in firm offering and make jobs at smaller employers more attractive. Additionally, smaller firms might drop coverage and send workers to the exchange which will increase wages and employment. Some employers also might “contract out” for low-wage workers. The effects of the ACA on labor supply are theoretically ambiguous because of all of these channels.

## III. EMPIRICAL METHODS

The empirical approach leverages geographic variation in characteristics that were determined prior to the ACA and that influence the potential impact of different provisions in the law. They utilize variation in the share of an area that is uninsured, the area's income distribution, and the area's Medicaid expansion status. For each geographic area they calculate the pre-ACA share of the population uninsured and with incomes less than 138% FPL, denoting this M*. M* represents the potential increase in Medicaid enrollment. E* is defined as the pre-ACA share of the population uninsured and with incomes between 139% and 399% of FPL.

(1) $INS_{iast} = \alpha_1 POST_t \times M_a^* + \alpha_2 POST_t \times E_a^* + \beta X_{it} + \gamma_t + \mu_a + \emptyset_a t + \varepsilon_{iast}$

$INS_{iast}$ is an indicator for whether individual *i* living in area *a* and state *s* has any health insurance, private employer coverage, privately-purchased coverage, or Medicaid coverage in time *t*; $POST_t$ is an indicator equal to 1 in 2014 or later and 0 otherwise, $M_a^*$ and $E_a^*$ represent the pre-ACA measures of potential Medicaid and exchange enrollment for area *a*, $X_{it}$ includes demographic controls for gender, race, and ethnicity and age fixed effects, $\gamma_t$ represents year fixed effects, and $\mu_a$ and $\emptyset_a$ represent area fixed effects and area-specific time trends for area a, respectively. Both $M_a^*$ and $E_a^*$ are demeaned, giving the coefficients on other variables the interpretation of the effects for locations with an average level of the share uninsured within certain income bins. Note that because we include geographic area-level fixed effects, the main effects of $M_a^*$ and $E_a^*$ are not included in the regression, and the main effect of $POST_t$ drops out due to year fixed effects.

The second empirical specification includes interactions between $M_a^*$ , $E_a^*$ , and $POST_t$ with a binary indicator that indicates whether the region is in a state that expanded its Medicaid program prior to the beginning of the analysis year.

$$(2)\ INSiast = \theta_1 POST_t \times M_a^* + \theta_2 POST_t \times E_a^* + \rho_0 POST_t \times EXPANSION_s + \rho_1 POST_t \times EXPANSION_s \times M_a^* + \rho_2 POST_t \times EXPANSION_s \times E_a^* + \beta X_{it} + \gamma_t + \mu_a + \emptyset_a t + \varepsilon_{iast}$$

$EXPANSION_s$ represents whether state *s* expanded Medicaid on or before January 1, 2014.

Overall health insurance rates may change in several ways. First, health insurance rates increase after the ACA in areas with average M* and E* and differentially more in expansion states. Second, Areas with larger M* will have larger increases in Medicaid coverage. Third, areas with larger E* are expected to have larger increases in privately-purchased coverage.

Coverage increases might also be different for expansion and non-expansion states. First, expansion states will have a large increase in Medicaid where non-expansion states will have a smaller increase in Medicaid coverage. Second, non-expansion states will have a larger increase in privately purchased insurance than the increase for expansion states.

Their identification strategy isolates the impact of the ACA under the assumption that without the ACA areas with larger shares of individuals uninsured and under 400% FPL would have evolved similarly as those with smaller shares. In the second specification they assume areas with a given share of uninsured and under 400% FPL in expansion states would have evolved similarly as those with similar shares in non-expansion states, absent the ACA.

## IV. DATA

The data comes from the American Community Survey (ACS) and specifically the annual Public-Use Micro Sample (PUMS) files which contain individual and household level responses. The ACS is a household survey that focuses on demographics, social, and economic related questions. They restrict observations to the years 2010 through 2015 and I add the data from 2016 and for civilians age 26 to 64. This will provide data for four years prior and three years after the ACA. They focus on ages 26 to 64 because these are the ages most likely to be affected by the ACA.

The ACS provides each individual with a list of seven different types of insurance coverage and the individual indicates all the types of insurance they have. The types are insurance from current or former employer, insurance purchased privately, Medicare, Medicaid, Medical Assistance, Tricare or other military healthcare, VA, and Indian Health Service. Because of this wording there is the possibility of self-reporting measurement error.

Several labor market outcome variables are in the ACS. There is a variable where individuals can report being employed over the last week or out of the labor force. There is a self-employment variable that includes data about hours and income over the past 12 months. They construct an indicator for part-time employment that equals one for individuals employed last week whose hours are less than 30 per week over the past 12 months.

PUMAs are defined to not cross state borders and are population based. Each PUMA has a population of at least 100,000 at the time of the census and the largest PUMA is approximately 280,000. PUMAs are redefined every ten years following the decennial census. In

the year 2000 there were 2,071 PUMAs and 2,351 PUMAs for the 2010 census. The ACS uses the 2000 PUMAs for its 2010 and 2011 and then for the years 2012 and later they use the 2010 PUMAs. To address this problem they use consistent PUMAs which aggregate 2000 and 2010 PUMAs. For the CPUMAS there are 1078 new defined regions because of this the regions have larger average populations.

## V. RESULTS

### A. Health Insurance Coverage

The estimations of equations (1) and (2) use demeaned measures for M* and E* the interpretation of the coefficient on $POSTt \times EXPANSION$ is now the difference in coverage in expansion relative to non-expansion states after the ACA for PUMAs with average shares of the population under 138% FPL and uninsured and between 139% and 399% FPL and uninsured.

The results, from both my estimation and Duggen (2017), show evidence that the ACA created statistically significant increases in insurance coverage in both expansion and non-expansion states. The specification does not show evidence that coverage changes varied significantly with the share under 138% FPL and uninsured.

Table 2 Column (1) shows that after controlling for PUMA level fixed effects and PUMA specific time trends, areas with a higher share of the population uninsured and between 139% to 399% of FPL had higher increases in health insurance coverage. It doesn't show that coverage rates changed significantly for regions under 138% FPL and uninsured.

In Column (2) with the new interaction terms we see several significant terms. First showing that states that chose to expand coverage led to increases in health insurance rates. Secondly, showing health insurance rates in states that choose not to expand Medicaid the increase in coverage was higher for regions with larger shares of the population between 139% and 399% FPL. In states that expanded Medicaid the increase in coverage is related to the share of population under 138% FPL and uninsured.

In Column (3) where there is no interaction term for expansion and non-expansion states it looks like there are no significant changes on Medicaid coverage. However; in Column (4), there is evidence that Medicaid coverage increases in areas with large amounts of uninsured and below 138% FPL, specifically in expansion states. Medicaid coverage does not change as much in non-expansion states. In areas with high uninsured and between 139% and 399% FPL Medicaid coverage declined in expansion states possibly because people decided to sign up for subsidized insurance under the exchanges.

Columns (5) and (6) the increase in privately purchased health insurance was significantly smaller in states that expanded their Medicaid programs. In areas with large share of the population between 139% and 399% FPL and uninsured in non-expansion states there was a large increase in privately purchased health insurance. Columns (7) and (8) show that the ACA had little effect on insurance coverage from employers.

**B. Labor Market Outcomes**

Table 4 shows how the ACA affected labor market outcomes on the extensive margin, and Table 5 shows the outcomes on the intensive margin. Table 4 shows there was an increase

in labor force participation in areas where uninsured and under 138% FPL is larger, and a decrease in labor force participation in areas where uninsured and between 139% to 399% FPL is larger. This increase in expansion states may come from preference for policies offered on exchanges and the subsidies that come with them compared to Medicaid. While in non-expansion states there would be a need to get to 139% FPL to receive any healthcare subsidy. Additionally, Column (2) shows there is no significance between expansion and non-expansion states on labor force participation.

Columns (3) through (6) show the ACA's effects on employment and unemployment. The results show that increase in labor force participation comes from and increase in employment in areas with high M* and a decrease in labor force participation comes from a decrease in employment in areas with high E*.

Table 5 in Duggen (2017) finds no real evidence that the ACA had an effect on part-time, self-employment, or hours worked. However, in my estimation I do find that the ACA had effects on those outcomes. For part-time work there is a significant increase in areas with high M* and significant decreases in self-employment in areas with high M*, interestingly similar enough in magnitude. There is also a significant increase in self-employment for areas with high E*, also similar in magnitude to the decreases in self-employment for areas with high M*.

Table 6 aggregates M* and E* with low significance that there was an increase in labor force participation for uninsured and incomes under 400% FPL. The low significance and proximity to zero shows that not being able to distinguish between M* and E* ratios for each area there might be very little effect on labor force participation found. The magnitudes for an

increase in employment and a decrease in unemployment are similar and lead to the overall small change in labor force participation.

## VI. CONCLUSION

The ACA was a large disruption to the U.S. healthcare system and included a variety of provisions that tried to reduce the number of uninsured. Their paper shows that the majority of the drop in uninsurance that occurred after the main provisions of the ACA went into effect was due to the ACA and was different in regions where there were more individuals who were uninsured and eligible for Medicaid and private insurance subsidies.

The effects on the labor market are unclear in their paper. The CBO predicted a decrease of 12 million in the labor force because of the ACA. However, the results do not show that there was any change in labor force participation that would have been different absent the ACA.

My results compliment theirs, finding significance in the same areas they do for their analysis of health insurance rates. Where I only don't find significance in one estimate where they do. When it comes to the labor supply estimates at the extensive margin I find significance where they do in about half of the cases. But then I find it in some places where they don't and vice versa. For the labor supply estimates at the intensive margin they don't find any significance except for in one spot and I find it several places. However, the effects that are found to be significant are still countervailing showing ambiguity in labor force participation.

Using pooled income groups, the significance is matched in a few cases then I find it in a few more cases but the overall interpretation is similar.

This makes the most sense in the case that the effects from health insurance are relatively one sided and more predictable, moving towards more people being insured. While the labor supply effects are theoretically countervailing and might be more sensitive to the differences in summary statistics and addition of new data. Their model holds up very well when looking at health insurance rates and holds up relatively well when looking at the labor supply. The new significant terms in the labor supply tables must come from the additional power given by new observations along with more time for the insurance effect to affect labor market outcomes. What this does is further clarify the results at the intensive margin where people make small tweaks within the setting of still working, in Duggen (2017) they did not find anything interesting happening on the intensive margin.

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**APPENDIX**

**Table 1: Comparing Baseline Demographics and Labor Market Outcomes**

| | Ages | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 26-34 | | 35-44 | | 45-54 | | 55-64 | |
| | Duggen | Green | Duggen | Green | Duggen | Green | Duggen | Green |
| # of Observations (Unweighted) | 1,280,749 | 1,292,624 | 1,497,595 | 1,504,964 | 1,818,968 | 1,820,800 | 1,729,822 | 1,729,388 |
| Female | 50% | 50% | 50% | 51% | 51% | 51% | 52% | 52% |
| White | 72% | 73% | 73% | 75% | 77% | 79% | 81% | 82% |
| Black | 13% | 11% | 13% | 11% | 12% | 11% | 11% | 11% |
| Asian | 7% | 6% | 7% | 6% | 5% | 5% | 4% | 4% |
| Other | 8% | 9% | 7% | 8% | 5% | 6% | 4% | 4% |
| Hispanic | 20% | 18% | 19% | 16% | 13% | 11% | 9% | 18% |
| % of FPL | 287% | 292% | 309% | 316% | 336% | 341% | 344% | 347% |
| NILF | 18% | 19% | 18% | 18% | 20% | 20% | 36% | 36% |
| Employed | 74% | 70% | 76% | 72% | 74% | 71% | 60% | 56% |
| Self-Employed | 4% | 6% | 7% | 6% | 9% | 6% | 8% | 6% |
| Part-Time | 8% | 11% | 7% | 10% | 7% | 9% | 7% | 10% |
| Hours | 40% | 40% | 41% | 40% | 41% | 41% | 40% | 39% |
| Single Coverage | 86% | 69% | 72% | 74% | 74% | 75% | 74% | 75% |
| Double Coverage | 4% | 5% | 6% | 6% | 7% | 7% | 11% | 11% |
| # of Health Insurance Plans | 0.78 | 0.8 | 0.85 | 0.87 | 0.92 | 0.94 | 1.02 | 1.04 |


**Table 2: Effect of Potential Medcaid/Exchange Enrollment and Medicaid Expansion on Overall Health Insurance Coverage**

| | (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) |
|---|---|---|---|---|---|---|---|---|
| VARIABLES | Health Insurance Coverage | Health Insurance Coverage | Medicaid Coverage | Medicaid Coverage | Private Purchase | Private Purchase | Private Employer | Private Employer |
| Post x M* | 0.0380 | 0.0592 | 0.0347 | 0.1009* | -0.0399 | -0.1418** | 0.0783 | 0.1185 |
| | (0.1017) | (0.0618) | (0.1192) | (0.0471) | (0.0354) | (0.0585) | (0.0482) | (0.0897) |
| Post x E* | 0.3843*** | 0.2479*** | 0.0707 | -0.1752** | 0.2402*** | 0.3874*** | 0.0513 | 0.0346 |
| | (0.1356) | (0.0846) | (0.1851) | (0.0684) | (0.0730) | (0.1175) | (0.0611) | (0.1112) |
| Expansion x Post | | 0.0192*** | | 0.0322*** | | -0.0078*** | | -0.0029 |
| | | (0.0022) | | (0.0037) | | (0.0021) | | (0.0025) |
| Expansion x Post x M* | | 0.2798* | | 0.3971* | | 0.0969 | | -0.1412 |
| | | (0.1585) | | (0.2063) | | (0.0758) | | (0.11966) |
| Expansion x Post x E* | | 0.0153 | | 0.0729 | | -0.2100 | | 0.0842 |
| | | (0.1524) | | (0.1923) | | (0.1303) | | (0.1402) |

**Table 4: Effect of Potential Medicaid/Exchange Enrollment and Medicaid Expansion on Labor market Outcomes: Extensive Margin**

| VARIABLES | (1) Not in the Labor Force | (2) Not in the Labor Force | (3) Employed | (4) Employed | (5) Unemployed | (6) Unemployed |
|---|---|---|---|---|---|---|
| Post x M* | -0.0990*** | -0.0542 | 0.1290*** | 0.1156** | -0.0880** | -0.0615 |
| | (0.0355) | (0.0424) | (0.0349) | (0.0481) | (0.0351) | (0.0494) |
| Post x E* | 0.0960** | 0.0435 | -0.0837** | -0.0575 | 0.0342 | 0.0013 |
| | (0.0392) | (0.0457) | (0.0383) | (0.0503) | (0.0388) | (0.0520) |
| Expansion x Post | | 0.0025* | | -0.0015 | | 0.0011 |
| | | (0.0014) | | (0.0016) | | (0.0016) |
| Expansion x Post x M* | | -0.0597 | | 0.0045 | | -0.0414 |
| | | (0.0990) | | (0.0949) | | (0.0936) |
| Expansion x Post x E* | | 0.0836 | | -0.0333 | | 0.0567 |
| | | (0.0987) | | (0.0961) | | (0.0951) |

**Table 5: Effect of Potential Medicaid/Exchange Enrollment and Medicaid Expansion on Labor market Outcomes: Intensive Margin**

| VARIABLES | (1) Part-Time | (2) Part-Time | (3) Self-Employed | (4) Self-Employed | (5) Hours | (6) Hours |
|---|---|---|---|---|---|---|
| Post x M* | 0.0388** | 0.0404** | -0.0485** | -0.0760** | 0.3102 | -1.1617 |
| | (0.0188) | (0.0214) | (0.0206) | (0.0307) | (1.1669) | (1.6944) |
| Post x E* | -0.0346 | -0.0159 | 0.0453** | 0.0574* | 0.5753 | 0.2316 |
| | (0.0211) | (0.0279) | (0.0185) | (0.0287) | (1.1716) | (1.8143) |
| Expansion x Post | | 0.0000 | | 0.0001 | | -0.0580 |
| | | (0.0006) | | (0.0010) | | (0.0372) |
| Expansion x Post x M* | | -0.0078 | | 0.0656 | | 2.6713 |
| | | (0.0406) | | (0.0406) | | (2.4492) |
| Expansion x Post x E* | | -0.0272 | | -0.0376 | | 0.1909 |
| | | (0.0431) | | (0.0403) | | (2.6835) |

**Table 6: Effect of Potential Medicaid/Exchange Enrollment and Medicaid Expansion on Labor market Outcomes: Pooled Income Groups**

| VARIABLES | (1) Not in the Labor Force | (2) Not in the Labor Force | (3) Employed | (4) Employed | (5) Unemployed | (6) Unemployed |
|---|---|---|---|---|---|---|
| Post x (E*+M*) | -0.0088* | -0.0098 | 0.0305*** | 0.0373*** | -0.0314*** | -0.0330*** |
| | (0.0051) | (0.0070) | (0.0088) | (0.0111) | (0.0104) | (0.0087) |
| Expansion x Post | | 0.0030** | | -0.0020 | | 0.0014 |
| | | (0.0012) | | ( 0.0015) | | (0.0015) |
| Expansion x Post x(E*+ M*) | | 0.0116 | | -0.0185 | | 0.0073 |
| | | (0.0140) | | (0.0206) | | (0.0229) |