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Abstract

In this study, we test whether the Affordable Care Act's (ACA) dependent care provision is associated with young adults' propensity to be in the armed forces and to have military health insurance. We use a difference-in-difference (DD) approach, comparing the outcomes of young adults targeted by the policy change (ages 23-25 years old) before and after the ACA was passed to those of a comparison group of slightly older young adults (ages 27-29 years old) who were not targeted. The findings indicate that the ACA dependent care provision is associated with statistically significant reduction in the likelihood that young adults have military health insurance. We also find that the ACA induced young adults to drop military health insurance even while they remained on active duty.

JEL-Codes: I180.

Keywords: affordable care act, ACA, dependent care, health insurance, military, armed forces.

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1. Introduction

As of 2016, about 3.5 million individuals served in the U.S. military, with the two largest groups being those on active duty (about 1.3 million individuals) and those who are part of the National Reserves (about 1.3 million individuals, including the Ready Reserve, the Standby Reserve, and the Retired Reserve) (US Department of Defense, 2016). Both of these groups are comprised mainly of young adults. About 50 percent of active duty military personnel are aged 25 or younger, and another 21 percent are aged 26 to 30 years old (US Department of Defense, 2016). Among the National Reserves, about 38 percent are 25 or younger, and an additional 21 percent are aged 26 to 30 years old (US Department of Defense, 2016). Young adults choose military service for many reasons, but one important reason may be access to health care. TRICARE, the U.S. military health care system, provides free or low-cost health care both during military service and after retirement from the military. This benefit is often cited as an advantage of joining the military (US Army, 2018; Military Wallet 2018; Military Advantage, 2018). We lack systematic evidence, however, regarding whether access to military health insurance affects individuals' decisions about joining, although there is some evidence that the military's educational benefits play a role in the decision to join (Kleycamp, 2006).

One reason military health insurance may be an important benefit of enlisting is the high rates of un-insurance among young adults. Young adults in the US historically have had the lowest rates of health insurance coverage of any age group, with about 32 percent of 19-25 year olds lacking any coverage in 2009 (Rodean, 2012). The Patient Protection and Affordable Care Act (ACA), enacted in March 2010, included a number of provisions to address this problem. One of the first provisions of the ACA to go into effect was the dependent care provision, which mandated that virtually all private health insurance plans that offer dependent coverage must allow young adults to stay on their parents' health insurance plans until the age of 26. The dependent care provision became effective on September 23, 2010 (6 months after the signing of the ACA), and applies to young adults regardless of their marital status, their status as students, and whether their parents claim them as dependents on their tax returns. An estimated 5.5 million young adults aged 19-25 years old gained insurance coverage due to the ACA dependent care provision between October 2010 and September 2015 (US DHHS, 2015). Prior studies show that the provision increased insurance coverage, expanded access to health care, improved some health outcomes, and possibly increased job mobility/flexibility among young adults (Antwi,

Moriya & Simon, 2013; Amuedo-Dorantes & Yaya, 2016; Colman & Dave, 2015; Bailey & Chorniy, 2016; Barbaresco et al., 2015; Heim et al. forthcoming).

In addition to the health and labor market-related outcomes that have been studied, the ACA dependent care provision also may have affected young adults' decisions about whether or not to serve in the military and the type of military service chosen. Since the dependent care provision allows young adults to stay on their parents' private health insurance plans until age 26, they may be less likely to join the military after the dependent care provision became law, if obtaining health insurance coverage is a primary factor in individuals' decisions to serve in the military. In other words, after the dependent care provision was passed, young adults may find themselves to be more mobile and less "locked into the military" if they can take advantage of the provision. This is important to study since one rationale for the dependent care provision was that it would reduce "job lock" among young adults, since they can now move freely between jobs and in and out of employment without being concerned about health insurance coverage. In this paper, we use data from the 2008-2016 American Community Survey to test whether the ACA dependent care provision is associated with participating in the military, being on active duty, participating in the National Reserves, and having military health insurance.

2. Background

Military personnel receive tangible and intangible employee benefits, such as tuition assistance, housing and food aid, and heath care. U.S Armed Forces military personnel, military retirees, and their dependents, including some members of the National Reserves, receive health care through TRICARE, formerly known as CHAMPUS. Young adults aged 23-29 can be two types of TRICARE beneficiaries: sponsors or dependents. If the young adults are on active duty or are National Guard/Reserve members, they can receive coverage as sponsors. If the young adults are spouses or children of eligible sponsors, they can receive coverage as dependents. Prior to 2011, young adult dependents were eligible for TRICARE until the age of 21 (or 23 for full-time college students). In 2011, the TRICARE Young Adult Program was established. It extends medical coverage of uniformed services sponsors' unmarried young adult children until the age of 26 (76 FR 23479-23485). Under this new policy, young adults aged 21-26 can

purchase various premium-based TRICARE plans, and maintain their TRICARE dependent status after aging out of the traditional plan.

TRICARE plans meet or exceed the requirements for minimum essential benefits under the Affordable Care Act (TRICARE, 2018). Active duty military personnel and their dependents can participate in TRICARE Prime, which is a free, HMO-based plan that includes dental coverage. Military personnel not on active duty (as well as their dependents) are eligible for a premium-based TRICARE Reserve Select program, which includes premium-based dental coverage, if they were on active duty for at least 90 days (The Balance, 2018).

There are almost no recent papers in the economics literature that focus on individuals' decisions about joining the military. Mann (2012) is a notable exception. In this paper, the author sets up a structural, life cycle model of career choice, including a military career as an option, and allowing for business cycle effects in the model. Mann (2012) estimates the model using a sample of males from the National Longitudinal Survey of Youth 1979, and conducts a number of counter-factual experiments that are useful in understanding what factors affect men's decisions to enter or stay in the military. The findings suggest that individuals respond to changes in base pay and to changes in enlistment and re-enlistment bonuses, but not to changes in pension payments, because individuals tend to discount these payments heavily. Promotion probabilities, business cycle fluctuations, and the risk of death in combat are also important factors in individuals' decisions to join and stay in the military (Mann, 2012). Mann (2012) does not consider health insurance benefits available to military personnel and civilians as a potential factor. To our knowledge, there is no prior study on this topic.

3. Data

Data for this study come from the 2008-2016 American Community Survey (ACS PUMS). The ACS is a yearly household survey that includes extensive information on demographic, social, economic, and housing characteristics of the US population. The ACS interviews individuals at about 3 million addresses per year. In the ACS, respondents are asked whether they have ever served on active duty in the US Armed Forces, or in the National Reserves/National Guard. Based on this question, respondents can report whether they are: (1) currently on active duty; (2) currently in the Reserves or National Guard; (3) not currently serving but served in the past; or (4) never served in the military. The ACS also contains

information on whether the individual has health insurance coverage, and, if so, the source of the coverage, including TRICARE and VA care. Unfortunately, the health insurance information in the ACS is not available until 2008; thus, we only have two years (2008 and 2009) as the pre-policy time period in this study. The ACS interviews both the civilian and military populations, but it only includes individuals who have been or will be in the sampled housing unit for more than 2 months.

We considered other datasets for this study, such as the 2008 Survey of Income and Program Participation (SIPP) and the 2005-2014 Current Population Survey Annual Social and Economic Supplement (CPS ASEC). The SIPP excludes the population living in military barracks, and this survey does not track original respondents if they join the military and move to a barracks. Also, the sample sizes of military participants become small in the SIPP. The CPS offers a large sample size, and a long pre-policy time period relative to the ACS. However, an important disadvantage of the CPS is that only military personnel living in the same household with a civilian are included in the survey. The CPS does not include single military personnel, and this is the group most likely to have been affected by the dependent care provision.[1] Therefore, we primarily use the ACS for this study.

The dependent variables are binary indicators of the following: (1) whether or not the young adult has ever served in the military (active duty or training for Reserves/National Guard); (2) whether or not the young adult is on active duty now; (3) whether or not the young adult is involved in training for the Reserves or National Guard only; (4) whether or not the young adult is a TRICARE beneficiary (covered by own or others' TRICARE plan); (5) whether or not the young adult is a TRICARE dependent (covered by TRICARE but never served in the military) (6) whether or not the young adult is a TRICARE sponsor (broad definition); (7) whether or not the young adult is a TRICARE sponsor (narrow definition). Our definitions of "TRICARE sponsor" and "TRICARE dependent" are based on young adults' status of TRICARE coverage as well as their military participation status. If the respondent is on active duty now and covered by TRICARE, he/she is considered as a "TRICARE sponsor (narrow definition)." If the respondent is receiving TRICARE and serves in the military now or before, he/she is considered as a "TRICARE sponsor (broad definition)." Note that the new coverage option for young adult

[1] As a robustness check, we also estimated all models using the CPS. Results are shown in Appendix Table 3.

dependents introduced in 2011 may lead to mistakenly including dependents in the broad measure. If the respondent is receiving TRICARE coverage but never served in the military, he/she is considered to be a "TRICARE dependent," and most likely is covered by TRICARE Young Adult.

Table 1 shows weighted sample means for the full sample, the treatment group, and the comparison group. In the full sample, about 5 percent have ever served in the military. About 1 percent of respondents are on active duty now in the full sample, in the treatment group, and in the comparison group. Another 1 percent of the sample is in the Reserves/National Guard. In the sample, about 3 percent are covered by TRICARE, 2 percent are TRICARE sponsors using the broad definition, 1 percent are TRICARE sponsors using the narrow definition, and about 1 percent of the young adults are TRICARE dependents. These rates differ little across the treatment group and the comparison group.

4. Methods

Following many other papers in this area, we use a difference-in-difference (DD) approach to study the effects of the ACA dependent care provision on military participation and military health insurance coverage. The treatment group is comprised of young adults aged 23-25 years old; these individuals are covered by the ACA dependent care provision. The comparison group is comprised of young adults aged 27-29 years old; these individuals are not covered by the provision. In sensitivity checks, we experiment with a broader treatment group (aged 19-25) and a broader comparison group (aged 27-33), as well as with narrower treatment and comparison groups (age 24-25 vs. age 27-28; age 25 vs. age 27).

We estimate the following general specification:

$$Outcome_{ijt} = \beta_0 + \beta_1 Age23\text{-}25_{ij} + \beta_2 Post\_ACA1_t + \beta_3 Post\_ACA2_t + \beta_4 Age23\text{-}25_{ij} * Post\_ACA1_t + \beta_5 Age23\text{-}25_{ij} * Post\_ACA2_t + \alpha' State_j + \lambda' Year_t + \delta' X_{ijt} + \gamma' Y_{jt} + \omega' State_j * t + u_{ijt} \quad (1)$$

The data span 2008 to 2016. Since the dependent care provision was passed and became effective in 2010, we consider the years 2008-2009 to be the pre-period. We consider the years 2011-2014 as the first post-policy time period, and the years 2014-2016 to be the second post-policy period. We break the post-policy period into two parts because other, potentially confounding ACA-related changes began in 2014, such as the state Medicaid expansions and the

introduction of the Marketplaces.[2] We drop data from the year 2010 because it is not clear whether respondents interviewed in this year were interviewed before or after the dependent care provision was enacted (March 2010) and became effective (October 2010). As a sensitivity check, we also try including 2010 in the pre-treatment period.

We estimate a specification in which we drop data from 2014 onwards since other provisions of the ACA went into effect in 2014. The post-2014 time period is complicated in that the 2014 ACA provisions may have differing effects by age group. This specification which drops data from 2014 onwards is also useful in that it is possible that the existence of the dependent care provision at the time of labor market entry is more important to military decisions rather than whether the provision was in effect contemporaneously.

The dependent variable in Equation (1) is an outcome measure for young adult i, living in state j, in year t. On the right hand side of Equation 1, the model includes an indicator for whether the young adult is aged 23-25 years old (Age23-25); indicators for whether the ACS interview took place between 2011-2014 (Post_ACA1) or between 2014-2016 (Post_ACA2); interaction terms between Age23_25 and each of the two Post_ACA indicators; state fixed effects (Statej); interview year fixed effects (Yeart); a vector of characteristics of the young adults (Xijt,); and state time-varying characteristics (Yjt). The state fixed effects are included to capture time-invariant characteristics of states, while the interview year fixed effects are included to capture time-varying events that affect all young adults' outcomes. The vector of young adult characteristics includes dummy indicators for female (male as the baseline), dummy indicators for age, marital status (unmarried as baseline), and indicators for race/ethnicity (African-American, Latino and Asian with non-Latino white as the baseline). The state time-varying characteristics include the age-specific state-specific unemployment rate for the age groups 16-20, 21-25 or 26-30 (depending on the young adult's age), and the state-specific share of college graduates.[3] These latter variables are included to control for potentially confounding, age-

[2] Another approach would be an "event study" in which we interacted treatment group status (age 23-25) with each of the post year indicators (treat*2011, treat*2012, treat*2013 etc.). We estimated this specification for all outcomes and found that most effects were only statistically significant in 2011 and 2012, just after the dependent care provision became effective in October 2010. These findings are available upon request.

[3] Both age-specific state-specific unemployment rates and share of college students are estimated using ACS PUMS.

specific effects of the economic recovery that was taking place during the time period in which the dependent care provision was passed. We also include state-specific linear time trends in all models, which capture unmeasured state-level, time-varying factors.

The estimated coefficients of greatest interest in Equation (1) are β_4 and β_5, which are the DD estimates of the effect of the ACA dependent care provision on outcomes among young adults. The DD estimates capture the pre-post policy change in outcomes among young adults targeted by the policy change, differencing out the same pre-post policy change in outcomes among young adults slightly older/younger and thus not targeted by the policy, and adjusting for other potentially confounding characteristics and trends. Although our dependent variables are binary, we estimate Equation 1 using linear probability models (LPM) with survey weights to make interpretation of interaction terms straight-forward (Karaca-Mandic et al., 2012).[4] We estimate robust standard errors accounting for clustering on age (Bertrand et al., 2004). We also try clustering at the age/year level as a sensitivity check.

The DD model is based on the assumption that trends in outcomes among young adults aged 23-25 would have been similar to those of young adults aged 27-29 if the ACA policy had not been enacted. Figures 1-7 show trends in the main outcome variables. Figure 1 shows the percentage of young adults who have ever served in the military, and Figure 2 shows the percentage of young adults who are on active duty now. Figure 3 shows the percentage of young adults who are in the Reserves/National Guard, while Figure 4 shows the percentage of young adults who are TRICARE beneficiaries. Finally, the remaining figures show the percentage of young adults who are TRICARE dependents (Figure 5); the percentage of young adults who are TRICARE sponsors according to the broad definition (Figure 6); and the percentage of young adults who are TRICARE sponsors according to the narrow definition (Figure 7).

While the common trends assumption that underlies the DD method cannot be tested directly, we can test whether trends in outcomes differed between the treatment group (23-25 year olds) vs. the comparison group (27-29 year olds) before the ACA policy went into effect. To do so, we limit the sample to the pre-policy time period and, for each outcome, we estimate a version of Equation 1 which includes an interaction term between a linear time trend and

[4] We also estimated the models using probits. The findings were consistent with those shown in the paper and are available upon request.

Age23_25. These results are shown in Appendix Table 1. Overall, this table provides us with confidence in the assumption of similar trends between 23-25 year olds and 27-29 year olds in the absence of the policy change. During the pre-policy period, there are no statistically significant differences between the treatment and comparison group trends in the outcome variables.

5. Results

Tables 2 and 3 summarize DD findings, showing only the estimated coefficients on the interaction terms between treatment group and each of the two post-policy periods. In Table 2, the results indicate that the ACA dependent care provision is associated with a 0.2 percentage point decrease in the likelihood that a young adult has ever served in the military during the first post-policy period (2011-2013), and a 0.1 percentage point decrease during the second post-policy period (2014-2016); these effects translate to 4.5 percent and 2.3 percent reductions when evaluated at the pre-period treatment group means (Table 2, Panel A, Column 1). The results are driven by males. Among males, the dependent care provision is associated with a 0.5 percentage point decrease in having ever served in the military in the first post-policy period and a 0.4 percentage point decrease in the second post-policy period. The corresponding effects in percentage terms, based on the pre-period sample means, are 7 percent and 6 percent reductions in having ever served in the military (Table 2, Panel A, Column 2). There are no statistically significant effects for females (Table 2, Panel A, Column 3).

Columns 4-6 in Panel A of Table 2 show results for the "on active duty" outcome. The findings show that the provision is associated with a 0.2 percentage point reduction in both post-policy time periods. These effects represent 12.5 percent decreases measured at the pre-period sample mean (Table 2, Panel A, Column 4). The results are driven by males as well. Among males, the provision is associated with a 0.4 percentage point decrease in the first post-policy period and a 0.3 percentage point decrease in the second post-policy period, which represent 15 percent 12 percent reductions respectively, measured at the pre-period sample means (Table 2, Panel A, Column 5). Again, there are no effects among females (Table 2, Panel A, Column 6).

Finally, the results in Table 2 also show that the dependent care provision is associated with a 0.1 percentage point increase in the likelihood that the young adult is training for Reserves or National Guard in both post-policy periods. These effects represent 17 percent increases at the

pre-period sample mean of 0.006 (Table 2, Panel A, Column 7). The results among males and females do not differ substantially in the first post-policy time period, but during the second post-policy time period, the effects are driven by males. In sum, for the military participation outcomes, the findings suggest that the dependent care provision is associated with reduced levels of ever having military service and being on active duty, but increased levels of participation in the Reserves/National Guard, and these effects are driven by males.

Next, we consider military health insurance outcomes. The findings in Table 2 show that the dependent care provision is associated with a statistically significant 0.3 percentage point decrease in the likelihood that the young adult is a TRICARE beneficiary in the first post-policy period and a 0.2 percentage point decrease in the second post-policy period. These effects represent 10 and 7 percent reductions respectively at the pre-period sample mean (Table 2, Panel B, Column 1). The results are driven by males, as was the case with the military participation outcomes (Table 2, Panel B, Column 3).

The findings in Columns 4-6 in Panel B of Table 2 show that the ACA dependent care provision is associated with a statistically significant 0.1 percentage point increase in the likelihood that the young adult is receiving TRICARE coverage as a dependent among males in the first post-policy period, and a 0.1 percentage point decrease in the likelihood among females. The results of the sub-groups offset each other, and in the full sample, the results show no change in first post-policy period. During the second post-policy period, the results in all three samples indicate increases in the likelihoods that the young adult is a TRICARE dependent; the magnitudes of the percentage point increases are 0.1, 0.2 and 0.1 respectively. These effects, which may have resulted from the introduction of TRICARE Young Adult in 2011, represent 11, 100, 7 percent increases when evaluated at the pre-period sample means.

In the remaining columns of Table 2, we try to disentangle effects on being a military insurance plan holder versus being a dependent on a military insurance plan. We expect negative effects specifically on TRICARE sponsor participation if the dependent care provision induced young adults to move from military occupations to other occupations/school because they could now get health insurance from their parents. The findings in Table 2 are consistent with this idea. The results in Table 2, Panel C show that the dependent care provision is associated with a reduction in the likelihood that the young adult is receiving TRICARE coverage as a plan holder, regardless of how we define a TRICARE sponsor. The results using the broad definition indicate

that the policy is associated with a statistical significant 0.3 percentage point reduction in both post-policy period 1 and 2, which translates into a 14 percent decrease at the pre-period sample mean (Table 2, Panel C, Column 1). The results are driven by a 0.5 percentage point reduction in post-policy period 1 and a 0.6 percentage point reduction in post-policy period 2 (Table 2, Panel C, Column 2). These effects represent 15 and 18 percent reductions respectively at the pre-period sample means. If we follow the narrow definition of a TRICARE sponsor, the results show the provision is associated with a 0.2 percentage point reduction in both post-policy periods; these effects represent 13 percent decreases at the pre-period sample mean (Table 2, Panel C, Column 4). Thus, we conclude that the dependent care provision is associated not only with a decline in being on active duty, but also a reduction in being a sponsor on a TRICARE health insurance plan.

In Table 3, we test the robustness of our findings across three sets of sub-samples: racial/ethnic sub-samples (non-Latino white vs. non-white); disability sub-samples (with and without a disability); and whether young adults live in states that had or did not have a prior dependent care law prior to the passage of the ACA dependent care provision. Given that the dependent care provision targeted young adults with privately insured parents, one would expect a more robust pattern of findings among non-Latino whites vs. non-whites, since non-Latino whites have higher rates of private insurance coverage (Kaiser Family Foundation, 2013). In general, however, our findings are similar across both race sub-samples, with the exception of the TRICARE sponsor outcomes. In the non-white sample, the dependent care provision has a positive effect on being a TRICARE sponsor (although it is not statistically significant for the broad version of the outcome), which is counter-intuitive given the pattern of findings.

Individuals with disabilities are likely to have relatively extensive health care needs and as a result may be more likely to be "job-locked" into the military; therefore, young adults with disabilities may be more likely to be affected by the dependent care provision than non-disabled young adults. Our findings support this idea – the effects of the dependent care provision on military participation are larger in magnitude for individuals with disabilities vs. those without disabilities.[5] Also, the effects on being a TRICARE sponsor appear to be driven by individuals with disabilities.

[5] Disability includes veterans' service-connected disabilities as well as any self-care, hearing, vision, independent living, ambulatory, or cognitive difficulties.

This finding is interesting given the relatively high prevalence of disability among veterans – as of August 2015, 20 percent of all veterans had a service-related disability (BLS, 2016). Respondents in the ACS are asked whether they have physical difficulties in self-caring, vision, hearing, independent living, ambulatory, as well as cognitive difficulty, also whether these issues are related to military service. In our sample, 4 percent of active duty personnel and 6 percent of those training for national guard/reserves self-report disabilities, while the rate is 6 percent among those who have never served in the military. Among active duty military personnel, 2 percent self-report that they have cognitive difficulty (46 percent among the self-reported disabled active duty young adults), and 2 percent self-report veteran service connected disabilities. Among respondents who are training for national guard/reserves, 3 percent self-report that they have cognitive difficulty (54 percent among the self-reported disabled national guard/reserves members), and 4 percent self-report veteran service connected disabilities. Among respondents who have never served in the military, 4 percent self-report that they have cognitive difficulty.

Finally, one might expect larger effects of the dependent care provision among young adults living in states that did not have a similar, prior state law. Our findings for having ever served in the military and for currently being on active duty appear to be driven by young adults living in states without a prior law. However, for the military insurance outcomes, the findings become statistically insignificant and, in some cases, switch signs when we split the sample by whether the state had a prior dependent care law.

In Appendix Tables 2-4, we further explore the robustness of our findings (Appendix Table 2), conduct two falsification tests (Appendix Table 3), and estimate the same basic specification using data from the CPS, which only includes military personnel living with civilians, but offers the advantage of a longer pre-policy time period for all outcomes (Appendix Table 4). In Row A of Appendix Table 2, we find that dropping respondents from states that had prior state laws that covered young adults older than age 26, which includes respondents in our comparison group, does not affect the findings. In Rows B, C and D, we find that making the treatment and comparison groups broader or narrower does not affect the findings either. Notably, the results persist even when we compare 25 year olds to 27 year olds (Panel D). Clustering by age/year does not affect the statistical significance of the findings (Panel E), and using a longer pre-period time frame (2005-2009 instead of 2008-2009) does not change the

pattern of findings for the military participation outcomes (the prior years are not available for the health insurance outcomes) (Panel F). Finally, including 2010 in the pre-period (Panel G) and limiting the sample to data prior to 2014 (Panel H) does not affect the findings appreciably.

In Appendix Table 3, we show findings from two falsification tests. First, we limit the sample to 2008 and 2009, and use 2009 as the false "post-policy" period. When we do so, we find no effects of the dependent care provision, as one would expect (Panel A). Next, we consider "past military participation" as a dependent variable. This outcome is not a perfect falsification test since it may include participation in the recent past, which could be influenced by the dependent care provision. Nevertheless, we find no effects of the dependent care provision on prior military service, which is intuitively appealing.

Finally in Appendix Table 4, we show findings from the same model estimated with data from the CPS. The pre-period is 2005-2009, and the post period is 2011-2014. There is no information on participation in active duty vs. National Guard/Reserves. The general pattern of findings is the same as we found using the ACS, although the magnitudes are smaller. This could be because the military personnel in the sample must be living with a civilian.

6. Conclusions

The ACA dependent care provision was intended to address a persistent public policy and public health problem – the high rate of un-insurance among young adults. By allowing young adults to remain on a parent's private health insurance plan, the dependent care provision was expected to increase access to medical care, while also reducing "job lock" and giving young adults more flexibility regarding work hours and educational decisions. Empirical studies show that the provision so far has been successful with respect to insurance coverage and access to care, with mixed findings on job lock (Antwi, Moriya & Simon, 2013; Amuedo-Dorantes & Yaya, 2016; Colman & Dave, 2015; Bailey & Chorniy, 2016).

One unintended consequence of the dependent care provision is it may affect young adults' decisions about whether to participate in the military. Young adults with privately insured parents who are joining or staying in the military primarily to obtain health insurance coverage now may be induced to leave the military and join their parent's health insurance plan.

Our findings support this hypothesis. The dependent care provision is associated with reductions in the probability that young adults (mainly men) are serving on active duty and are sponsors on TRICARE health insurance plans. These effects are magnified for young adults with disabilities. There is a corresponding increase in participation in the National Guard/Reserves, suggesting that young adults may switch from active duty (which provides free and more comprehensive health insurance coverage) to the National Guard/Reserves (which provides low cost but not free coverage for some participants) once they can access their parents' health insurance coverage.

In sum, the findings from this paper suggest that gaining access to health insurance may be an important factor in young men's decisions to enlist in and stay in the active forces of the US military. Future research is needed to understand how other benefits of military participation, such as tuition benefits, may interact with health insurance, and how disability and access to services for disabilities, may play a role in these decisions.

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Table 1: Weighted sample means			
	Full sample	Treatment group	Comparison group
Dependent variables:			
Ever served in military	0.045	0.041	0.048
	(0.207)	(0.198)	(0.215)
On active duty now	0.012	0.013	0.010
	(0.107)	(0.115)	(0.099)
In reserves/national guard	0.007	0.007	0.006
	(0.082)	(0.084)	(0.079)
TRICARE beneficiary (sponsor or dependent)	0.029	0.031	0.026
	(0.166)	(0.173)	(0.159)
TRICARE dependent	0.010	0.010	0.009
	(0.097)	(0.101)	(0.094)
TRICARE sponsor (broad definition)	0.019	0.021	0.017
	(0.136)	(0.142)	(0.130)
TRICARE sponsor (narrow definition)	0.011	0.013	0.010
	(0.106)	(0.114)	(0.098)
Control variables			

Age 23	0.168	0.331	
	(0.374)	(0.471)	
Age 24	0.163	0.321	
	(0.369)	(0.467)	
Age 25	0.176	0.348	
	(0.381)	(0.476)	
Age 27	0.166		0.337
	(0.372)		(0.473)
Age 28	0.166		0.337
	(0.372)		(0.473)
Age 29	0.161		0.327
	(0.368)		(0.469)
Female	0.492	0.489	0.495
	(0.500)	(0.500)	(0.500)
White	0.576	0.572	0.580
	(0.494)	(0.495)	(0.494)
African-American	0.135	0.140	0.130
	(0.342)	(0.347)	(0.336)
Latino	0.199	0.200	0.199
	(0.399)	(0.400)	(0.399)
Asian	0.057	0.054	0.060
	(0.231)	(0.225)	(0.237)
Other	0.033	0.035	0.032
	(0.179)	(0.183)	(0.176)
	0.284	0.189	0.383
Married	(0.451)	(0.391)	(0.486)
	0.085		0.085
State-year unemployment rates for age group 26-30	(0.024)		(0.024)
	0.244	0.244	0.244
Share of college graduates in the current state	(0.035)	(0.035)	(0.035)
N of obs	1,721,770	861,478	860,292

Notes: Weighted sample means are reported. Weighted standard deviations are reported in the parentheses.

Table 2: Main DD findings									
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
	Panel A								
	Ever served in military			On active duty now			In Reserves or National Guard		
	Full sample	Male	Female	Full sample	Male	Female	Full sample	Male	Female
Treatment*Year 2011-2013	-0.002	-0.005**	0.00000	-0.002***	-0.004***	-0.0001	0.001***	0.002***	0.001***
	(0.001)	(0.002)	(0.001)	(0.0004)	(0.001)	(0.0003)	(0.0002)	(0.0004)	(0.0002)
Treatment*Year 2014-2016	-0.001	-0.004	0.0002	-0.002*	-0.003**	-0.0004	0.001*	0.001	0.0004
	(0.002)	(0.002)	(0.001)	(0.001)	(0.001)	(0.001)	(0.0003)	(0.001)	(0.001)
N	1721770	868293	853477	1721770	868293	853477	1721770	868293	853477
Treatment, 2008-2009	0.044	0.070	0.017	0.016	0.026	0.005	0.006	0.008	0.004
Comparison, 2008-2009	0.050	0.079	0.020	0.011	0.018	0.004	0.006	0.008	0.004
Treatment, 2011-2013	0.041	0.065	0.016	0.013	0.021	0.004	0.006	0.009	0.004
Comparison, 2011-2013	0.049	0.079	0.019	0.010	0.017	0.003	0.005	0.007	0.003
Treatment, 2014-2016	0.039	0.064	0.014	0.012	0.020	0.004	0.008	0.013	0.004
Comparison, 2014-2016	0.046	0.075	0.017	0.009	0.015	0.002	0.008	0.011	0.004
	Panel B								
	TRICARE beneficiary			TRICARE dependent					
	Full sample	Male	Female	Full sample	Male	Female			
Treatment*Year 2011-2013	-0.003**	-0.004**	-0.001	-0.00004	0.001*	-0.0007			
	(0.001)	(0.001)	(0.001)	(0.0004)	(0.0004)	(0.0005)			
Treatment*Year 2014-2016	-0.002	-0.003**	0.0002	0.001*	0.002**	0.001**			
	(0.001)	(0.001)	(0.001)	(0.001)	(0.001)	(0.0003)			
N	1721770	868293	853477	1721770	868293	853477			
Treatment, 2008-2009	0.030	0.035	0.024	0.009	0.002	0.016			
Comparison, 2008-2009	0.023	0.025	0.021	0.008	0.002	0.014			
Treatment, 2011-2013	0.031	0.037	0.025	0.010	0.004	0.017			
Comparison, 2011-2013	0.028	0.031	0.003	0.009	0.002	0.017			

Treatment, 2014-2016	0.031	0.038	0.024	0.011	0.006	0.017	
Comparison, 2014-2016	0.026	0.030	0.023	0.009	0.003	0.016	
	Panel C						
	TRICARE sponsor (broad definition)			TRICARE sponsor (narrow definition)			
	Full sample	Male	Female	Full sample	Male	Female	
Treatment*Year 2011-2013	-0.003**	-0.005**	-0.0003	-0.002***	-0.004***	-0.0001	
	(0.001)	(0.001)	(0.0004)	(0.0004)	(0.0006)	(0.0003)	
Treatment*Year 2014-2016	-0.003**	-0.006**	-0.001	-0.002*	-0.003**	-0.0005	
	(0.001)	(0.001)	(0.001)	(0.001)	(0.001)	(0.001)	
N	1721770	868293	853477	1721770	868293	853477	
Treatment, 2008-2009	0.021	0.033	0.008	0.015	0.025	0.005	
Comparison, 2008-2009	0.015	0.023	0.007	0.011	0.017	0.004	
Treatment, 2011-2013	0.021	0.034	0.008	0.013	0.021	0.004	
Comparison, 2011-2013	0.018	0.029	0.007	0.010	0.017	0.003	
Treatment, 2014-2016	0.020	0.033	0.007	0.012	0.020	0.004	
Comparison, 2014-2016	0.017	0.027	0.007	0.009	0.015	0.002	

Notes: Table shows DD findings from a linear probability model with robust standard errors clustered on age. Table shows estimated coefficients on Age23-25ij* Post_ACA1t and Age23-25ij* Post_ACA2t from Equation 1. Full set of covariates not shown: age, gender (only for the full sample), race/ethnicity, marital status, age-specific year-state urates and its interaction with treatment group, state-specific share of college graduates, year fixed effect, state fixed effect and state linear trend. Table also shows weighted sample means of both treatment and comparison periods before ACA passage (2008-2009), after implementation but before the start of health exchange (2011-2013) and after implementation (2014-2016). The signs *, ** and ***denote statistical significance at 10, 5 and 1 percent.

Table 3: Sub-samples based on young adults' characteristics-Full sample								
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
	Panel A							
	Serves in the military now or before		On active duty now		Training for reserves/ national guard		TRICARE beneficiary	
Age group	21-23	24-25	21-23	24-25	21-23	24-25	21-23	24-25
Treatment*Post 1	-0.002	-0.002*	-0.003***	-0.002***	0.002***	0.002***	-0.004***	-0.003***
	(0.001)	(0.001)	(0.0002)	(0.0003)	(0.0003)	(0.0002)	(0.001)	(0.001)
Treatment*Post 2	-0.0004	-0.001	-0.003**	-0.002**	0.001**	0.001**	-0.004**	-0.003**
	(0.002)	(0.001)	(0.001)	(0.001)	(0.0002)	(0.0002)	(0.001)	(0.001)
N	1744082	2318212	1744082	2318212	1744082	2318212	1744082	2318212
Race/Ethnicity	White	Non-white	White	Non-white	White	Non-white	White	Non-white
Treatment*Post 1	-0.003***	-0.001	-0.003***	-0.001	0.002***	0.001*	-0.004***	-0.0002
	(0.001)	(0.002)	(0.001)	(0.001)	(0.0003)	(0.001)	(0.0005)	(0.002)
Treatment*Post 2	-0.002	-0.001	-0.002	-0.001	0.001**	0.001	-0.002	-0.001
	(0.002)	(0.001)	(0.001)	(0.001)	(0.0003)	(0.0005)	(0.002)	(0.001)
N	1057577	664193	1057577	664193	1057577	664193	1057577	664193
Education attainments	More than HS	HS or less	More than HS	HS or less	More than HS	HS or less	More than HS	HS or less
Treatment*Post 1	-0.002	-0.001	-0.002***	-0.003**	0.001**	0.002***	-0.002**	-0.003**
	(0.001)	(0.002)	(0.0003)	(0.001)	(0.0004)	(0.0003)	(0.001)	(0.001)
Treatment*Post 2	-0.001	-0.001	-0.001	-0.003***	0.00001	0.002**	-0.001	-0.002
	(0.002)	(0.001)	(0.001)	(0.001)	(0.0004)	(0.001)	(0.001)	(0.001)
N	1126460	595310	1126460	595310	1126460	595310	1126460	595310
Disability	With	Without	With	Without	With	Without	With	Without
Treatment*Post 1	-0.025***	-0.001	-0.004**	-0.002***	0.0002	0.002***	-0.004	-0.002**
	(0.006)	(0.001)	(0.002)	(0.0004)	(0.002)	(0.0003)	(0.003)	(0.001)
Treatment*Post 2	-0.027**	0.0005	-0.003**	-0.002	-0.003	0.001**	-0.008*	-0.001
	(0.007)	(0.002)	(0.001)	(0.001)	(0.002)	(0.0004)	(0.004)	(0.001)

N	111210	1610560	111210	1610560	111210	1610560	111210	1610560
Similar prior state law	Yes	No	Yes	No	Yes	No	Yes	No
Treatment*Post 1	-0.001	-0.002	-0.001*	-0.004***	0.001***	0.002**	-0.001	-0.005**
	(0.002)	(0.001)	(0.0003)	(0.001)	(0.0003)	(0.001)	(0.001)	(0.001)
Treatment*Post 2	-0.001	-0.002	-0.001	-0.004**	0.001	0.001	-0.001	-0.003*
	(0.002)	(0.003)	(0.001)	(0.001)	(0.0004)	(0.001)	(0.001)	(0.001)
N	1077701	644069	1077701	644069	1077701	644069	1077701	644069
	Panel B							
	TRICARE dependent		TRICARE sponsor		TRICARE sponsor			
			(broad definition)		(narrow definition)			
Age group	21-23	24-25	21-23	24-25	21-23	24-25		
Treatment*Post 1	0.0002	0.0001	-0.004***	-0.003***	-0.003***	-0.002***		
	(0.0004)	(0.0004)	(0.0003)	(0.001)	(0.0002)	(0.0003)		
Treatment*Post 2	0.001	0.001*	-0.005***	-0.004***	-0.003**	-0.002**		
	(0.001)	(0.0004)	(0.001)	(0.001)	(0.001)	(0.001)		
N	1744082	2318212	1744082	2318212	1744082	2318212		
Race/Ethnicity	White	Non-white	White	Non-white	White	Non-white		
Treatment*Post 1	-0.0003	0.0004	-0.004***	-0.001	-0.003***	-0.001		
	(0.0004)	(0.001)	(0.001)	(0.001)	(0.001)	(0.001)		
Treatment*Post 2	0.002*	0.001	-0.003**	-0.001	-0.002	-0.001		
	(0.001)	(0.001)	(0.001)	(0.002)	(0.001)	(0.001)		
N	1057577	664193	1057577	664193	1057577	664193		
Education attainments	More than HS	HS or less	More than HS	HS or less	More than HS	HS or less		
Treatment*Post 1	0.0001	-0.0004	-0.003**	-0.002*	-0.002***	-0.003**		
	(0.0004)	(0.001)	(0.001)	(0.001)	(0.0002)	(0.001)		
Treatment*Post 2	0.001*	0.001	-0.003	-0.003**	-0.001	-0.003**		

	(0.001)	(0.001)	(0.002)	(0.001)	(0.001)	(0.001)	
N	1126460	595310	1126460	595310	1126460	595310	
Disability	With	Without	With	Without	With	Without	
Treatment*Post 1	0.002	-0.0002	-0.006**	-0.002**	-0.005**	-0.002***	
	(0.001)	(0.0004)	(0.002)	(0.001)	(0.002)	(0.0004)	
Treatment*Post 2	0.001	0.001*	-0.010***	-0.002*	-0.005**	-0.001	
	(0.002)	(0.001)	(0.002)	(0.001)	(0.001)	(0.001)	
N	111210	1610560	111210	1610560	111210	1610560	
Similar prior state law	Yes	No	Yes	No	Yes	No	
Treatment*Post 1	0.0004	-0.001	-0.001	-0.004**	-0.0004	-0.004***	
	(0.0003)	(0.001)	(0.001)	(0.001)	(0.0003)	(0.001)	
Treatment*Post 2	0.001	0.002*	-0.002**	-0.005**	-0.001	-0.004**	
	(0.001)	(0.001)	(0.001)	(0.002)	(0.001)	(0.001)	
N	1077701	644069	1077701	644069	1077701	644069	

Figure 1: Percentage of Young Adults Ever in the Military, ACS 2008-2106

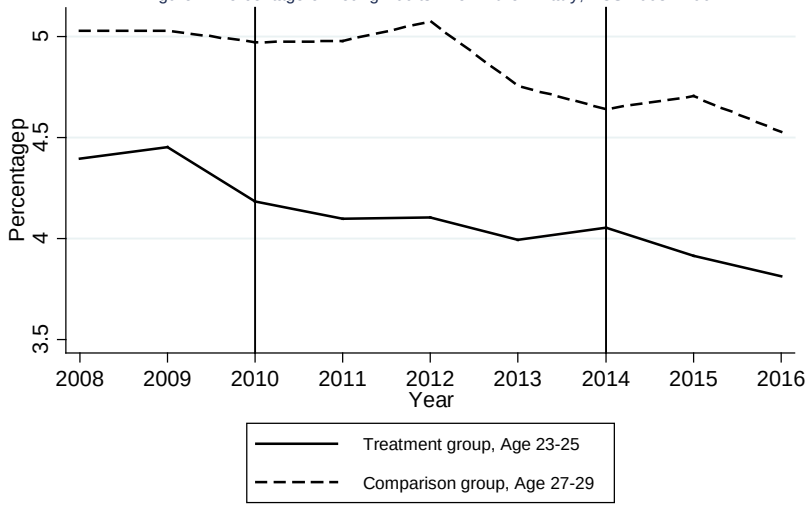


Figure 2: Percentage of Young Adults Now on Active Duty, ACS 2008-2016

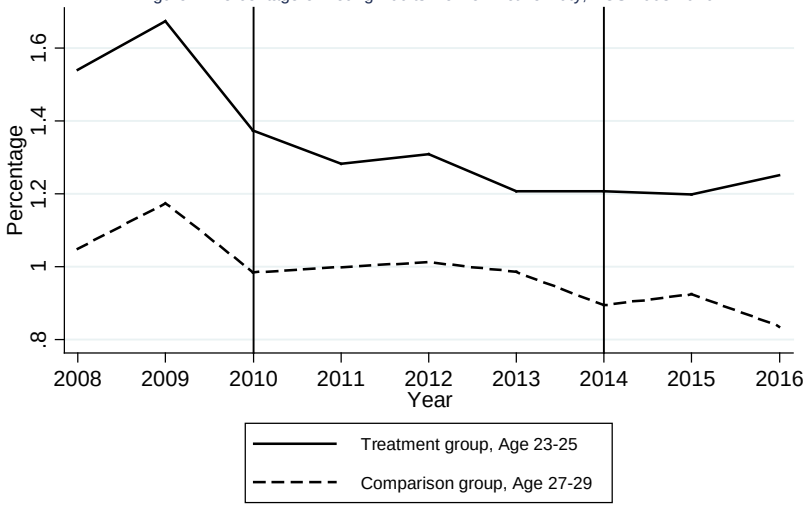


Figure 3: Percentage of Young Adults Training for Reserves/National Guard, ACS 2008-2016

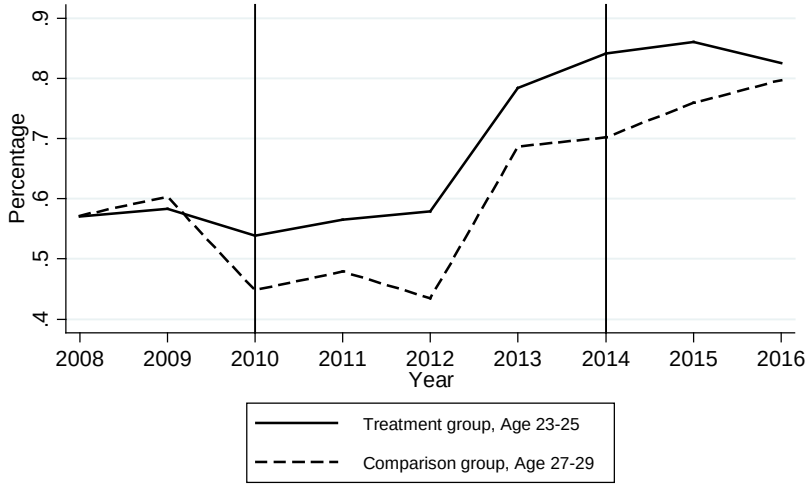
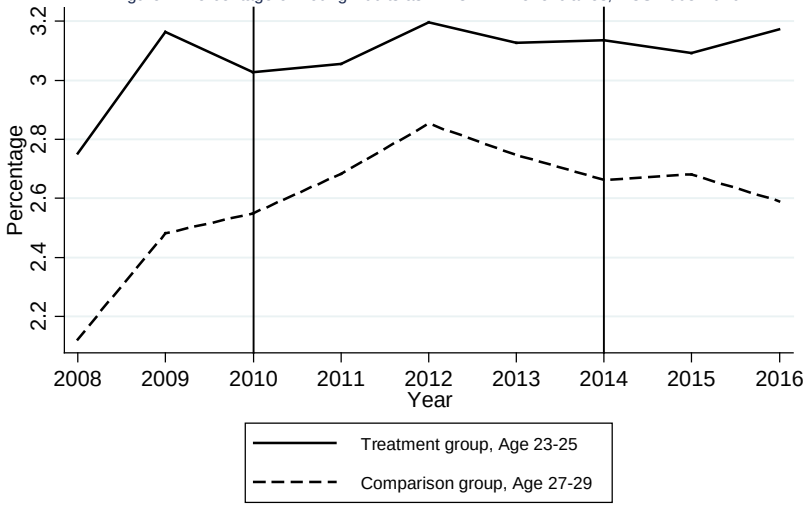


Figure 4: Percentage of Young Adults as TRICARE Beneficiaries, ACS 2008-2016



Notes: Sample weighted estimates from 2008-2016 ACS PUMS. The first vertical line indicates the year of 2010 when the ACA was passed and implemented. The second verical line indicates the year of 2014 when the health exchange started

Figure 5: Percentage of Young Adults as TRICARE Dependent, ACS 2008-2016

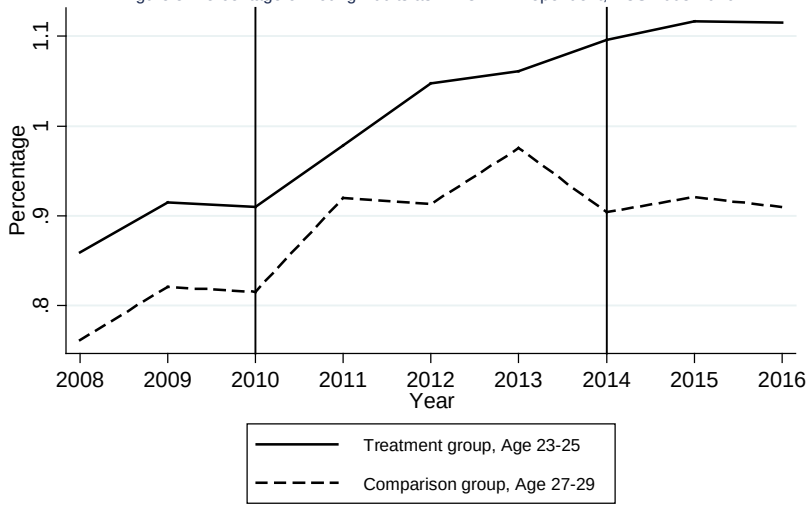


Figure 6: Percentage of Young Adults as TRICARE Sponsors (Broad Definition), ACS 2008-2016

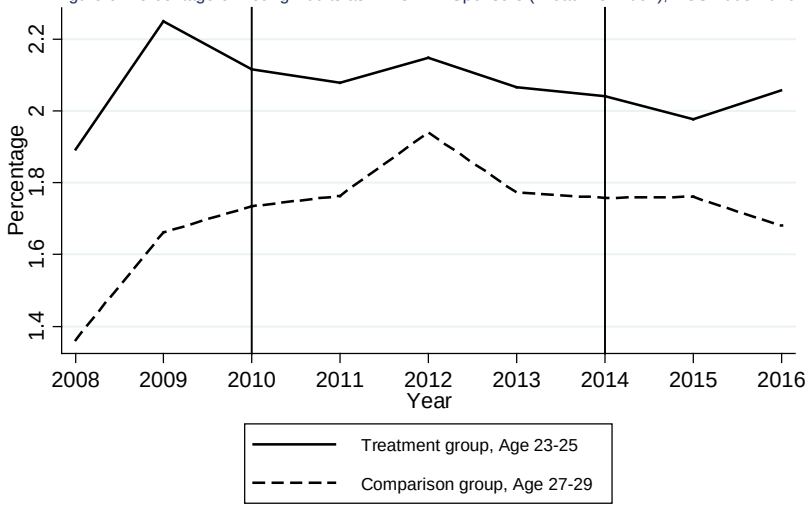
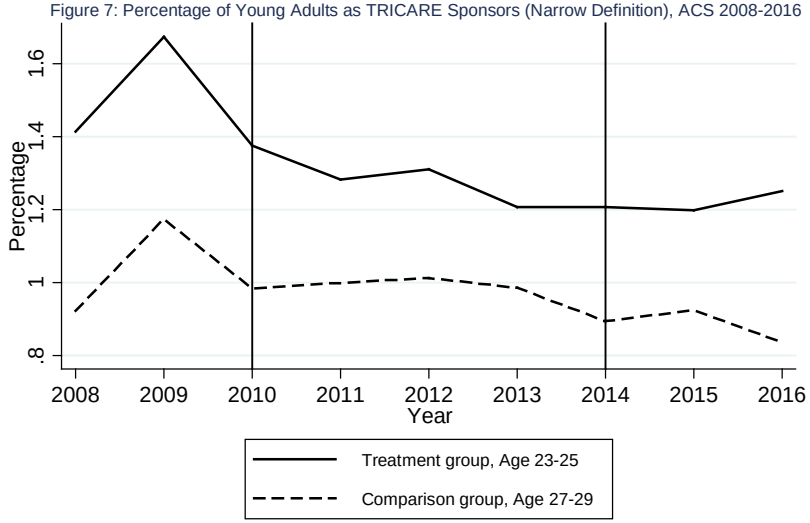


Figure 7: Percentage of Young Adults as TRICARE Sponsors (Narrow Definition), ACS 2008-2016



Notes: Sample weighted estimates from 2008-2016 ACS PUMS. The first vertical line indicates the year of 2010 when the ACA was passed and implemented. The second verical line indicates the year of 2014 when the health exchange started

Appendix Table 1: Tests for differences between treatment and comparison groups during pre-policy period				
	Panel A			
	(1)	(2)	(3)	(4)
	Ever served in the military	On active duty now	In Reserves/ National Guard	TRICARE beneficiary
Linear trend*	-0.001	0.000	0.000	-0.001
Treatment group	(0.002)	(0.001)	(0.001)	(0.001)
N	412168	412168	412168	412168
	Panel B			
	TRICARE dependent	TRICARE sponsor (broad definition)	TRICARE sponsor (narrow definition)	
Linear trend*	-0.001	0.001	0.000	
Treatment group	(0.001)	(0.001)	(0.001)	
N	412168	412168	412168	

Notes: All models from full sample limited to pre-policy enactment period. Findings from LPMs with robust standard errors clustered on age. Table shows estimated coefficients and standard errors from interaction of treatment group and linear time trend. This table does not show findings for the male and female samples; these results are similar to those shown here and are available upon request.

Appendix Table 2: Sensitivity checks							
	Ever serves in the military	On active duty now	Training for reserves /national guard	TRICARE beneficiary	TRICARE dependent	TRICARE sponsor (broad definition)	TRICARE dependent (narrow definition)
A: Drop states with prior state laws covering young adults over age 26							
Treatment*Post 1	-0.003*	-0.002***	0.002***	-0.003**	0.000	-0.003**	-0.002***
	(0.001)	(0.000)	(0.000)	(0.001)	(0.001)	(0.001)	(0.000)
Treatment*Post 2	-0.002	-0.002*	0.001	-0.001	0.002*	-0.003*	-0.002*
	(0.002)	(0.001)	(0.001)	(0.001)	(0.001)	(0.001)	(0.001)
N	1339041	1339041	1339041	1339041	1339041	1339041	1339041
B: Broader treatment group (age 19-25) and comparison group (age 27- 33)							
Treatment*Post 1	-0.002*	-0.001**	0.001*	-0.002**	0.001	-0.002***	-0.001**
	(0.001)	(0.000)	(0.000)	(0.001)	(0.000)	(0.001)	(0.000)
Treatment*Post 2	-0.000	-0.001	0.001	-0.003***	0.000	-0.003***	-0.001
	(0.001)	(0.001)	(0.001)	(0.001)	(0.001)	(0.001)	(0.001)
N	4147247	4147247	4147247	4147247	4147247	4147247	4147247
C: Narrower treatment group (age 24-25) and comparison group (age 27- 29)							
Treatment*Post 1	-0.001	-0.002**	0.002***	-0.002*	-0.000*	-0.002	-0.002**
	(0.001)	(0.001)	(0.000)	(0.001)	(0.000)	(0.001)	(0.001)
Treatment*Post 2	-0.001	-0.001	0.000	-0.001	0.001	-0.002	-0.001
	(0.002)	(0.001)	(0.000)	(0.001)	(0.000)	(0.001)	(0.001)
N	1148465	1148465	1148465	1148465	1148465	1148465	1148465
D: Narrowest treatment group (age 25) and comparison group (age 27)							
Treatment*Post 1	0.001	-0.001**	0.002**	-0.001*	-0.000	-0.001*	-0.001**
	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Treatment*Post 2	0.000	0.001	-0.000	-0.000	0.000**	-0.000	0.001
	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
N	574899	574899	574899	574899	574899	574899	574899
E: Models clustered by age-year dummy							

Treatment*Post 1	-0.002*	-0.002***	0.001***	-0.003***	-0.000	-0.003***	-0.002***
	(0.001)	(0.000)	(0.000)	(0.001)	(0.000)	(0.001)	(0.000)
Treatment*Post 2	-0.001	-0.002***	0.001**	-0.002**	0.001***	-0.003***	-0.002***
	(0.001)	(0.001)	(0.000)	(0.001)	(0.000)	(0.001)	(0.001)
N	1721770	1721770	1721770	1721770	1721770	1721770	1721770
F: Longer pre-period (2005-2009)							
Treatment*Post 1	-0.003**	-0.001**	0.002***				
	(0.001)	(0.000)	(0.000)				
Treatment*Post 2	-0.002***	-0.001*	0.001***				
	(0.001)	(0.000)	(0.000)				
N	2312140	2312140	2312140				
G: Include 2010 in pre-policy period							
Treatment*Post 1	-0.0015	-0.0017***	0.0010***	-0.0019*	0.0001	-0.0020**	-0.0017***
	(0.0009)	(0.0004)	(0.0002)	(0.0008)	(0.0004)	(0.0006)	(0.0004)
Treatment*Post 2	-0.0009	-0.0015*	0.0003	-0.0012	0.0013**	-0.0025**	-0.0015*
	(0.0013)	(0.0006)	(0.0003)	(0.0007)	(0.0005)	(0.0007)	(0.0006)
N	1934703	1934703	1934703	1934703	1934703	1934703	1934703
H: Use only one post-policy period (2011-2013)							
Treatment*Post 1	-0.0023	-0.0023***	0.0013***	-0.0027**	-0.0000	-0.0027**	-0.0022***
	(0.0012)	(0.0004)	(0.0003)	(0.0010)	(0.0004)	(0.0009)	(0.0004)
N	1057498	1057498	1057498	1057498	1057498	1057498	1057498

Appendix Table 3: Falsification Tests							
Panel A: Falsification test using 2008 vs. 2009							
	Serves in the military now or before	On active duty now	Training for reserves/ national guard	TRICARE beneficiary	TRICARE dependent	TRICARE sponsor (broad definition)	TRICARE sponsor (narrow definition)
Treatment*Year 2009	-0.001	-0.000	0.000	-0.001	-0.001*	0.000	-0.000
	(0.002)	(0.001)	(0.001)	(0.001)	(0.001)	(0.001)	(0.001)
N	412168	412168	412168	412168	412168	412168	412168

Panel B: Falsification test using "served in military in the past" as dependent variable			
	All	Male	Female
Treatment * Post1	0.0000	-0.0003	0.0001
	(0.0012)	(0.0017)	(0.0010)
Treatment* Post2	0.0004	-0.0005	0.0006
	(0.0014)	(0.0020)	(0.0009)
N	1721770	868293	853477

Appendix Table 4: DD findings using CPS ASEC 2005-2014						
	In Armed Forces			TRICARE beneficiary		
	Full sample	Male	Female	Full sample	Male	Female
Treatment*Year 2011-2014	-0.002**	-0.004*	-0.001**	-0.002	-0.003	-0.002*
	(0.001)	(0.002)	(0.000)	(0.001)	(0.003)	(0.001)
N	129699	61717	67982	129699	61717	67982
Treatment, 2005-2009	0.010	0.017	0.002	0.027	0.028	0.026
Comparison, 2005-2009	0.009	0.016	0.001	0.022	0.022	0.021
Treatment, 2011-2014	0.010	0.019	0.002	0.031	0.032	0.029
Comparison, 2011-2014	0.011	0.020	0.002	0.028	0.028	0.029
	TRICARE sponsor (TRICARE beneficiary and in Armed Forces)			TRICARE dependent (TRICARE beneficiary but not in Armed Forces)		
	Full sample	Male	Female	Full sample	Male	Female
Treatment*Year 2011-2014	-0.002**	-0.005**	-0.001***	-0.000	0.002	-0.001
	(0.001)	(0.002)	(0.000)	(0.001)	(0.001)	(0.001)
N	129699	61717	67982	129699	61717	67982
Treatment, 2005-2009	0.010	0.017	0.002	0.017	0.011	0.024
Comparison, 2005-2009	0.008	0.016	0.001	0.013	0.007	0.020
Treatment, 2011-2014	0.010	0.017	0.002	0.021	0.015	0.027
Comparison, 2011-2014	0.011	0.019	0.002	0.018	0.009	0.027

Notes: Annual data come from CPS ASEC 2005-2014. Table shows coefficients of the interaction between the treatment group dummy and the indicator of post policy period. Year 2005-2009 are considered as pre-period since the ACA dependent care provision was passed and took effect in 2010. Post policy period spans from 2011 to 2014, after the implementation of the provision. The year of 2010 is dropped because it's not clear whether the interview took in pre-period or post policy period. Full set of covariates not shown are the same with those mentioned Table 2.