Understanding the Connection Between Work and Health

Health Policy Institute of Ohio
What Works to Increase Self-Sufficient Employment

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December 13, 2018

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Filling the need for trusted information on national health issues.

Figure 1

Three takeaway points about the connection between work and health and implications for Medicaid work requirements:

1. Health and health coverage are a major causal factor in whether or not a low-income individual works.

2. There are major caveats to consider when applying limited study findings of an effect of work on health to likely outcomes among the Medicaid population.

3. Early implementation of work requirements in Medicaid have led to large coverage losses, with limited information on outcomes among those losing insurance

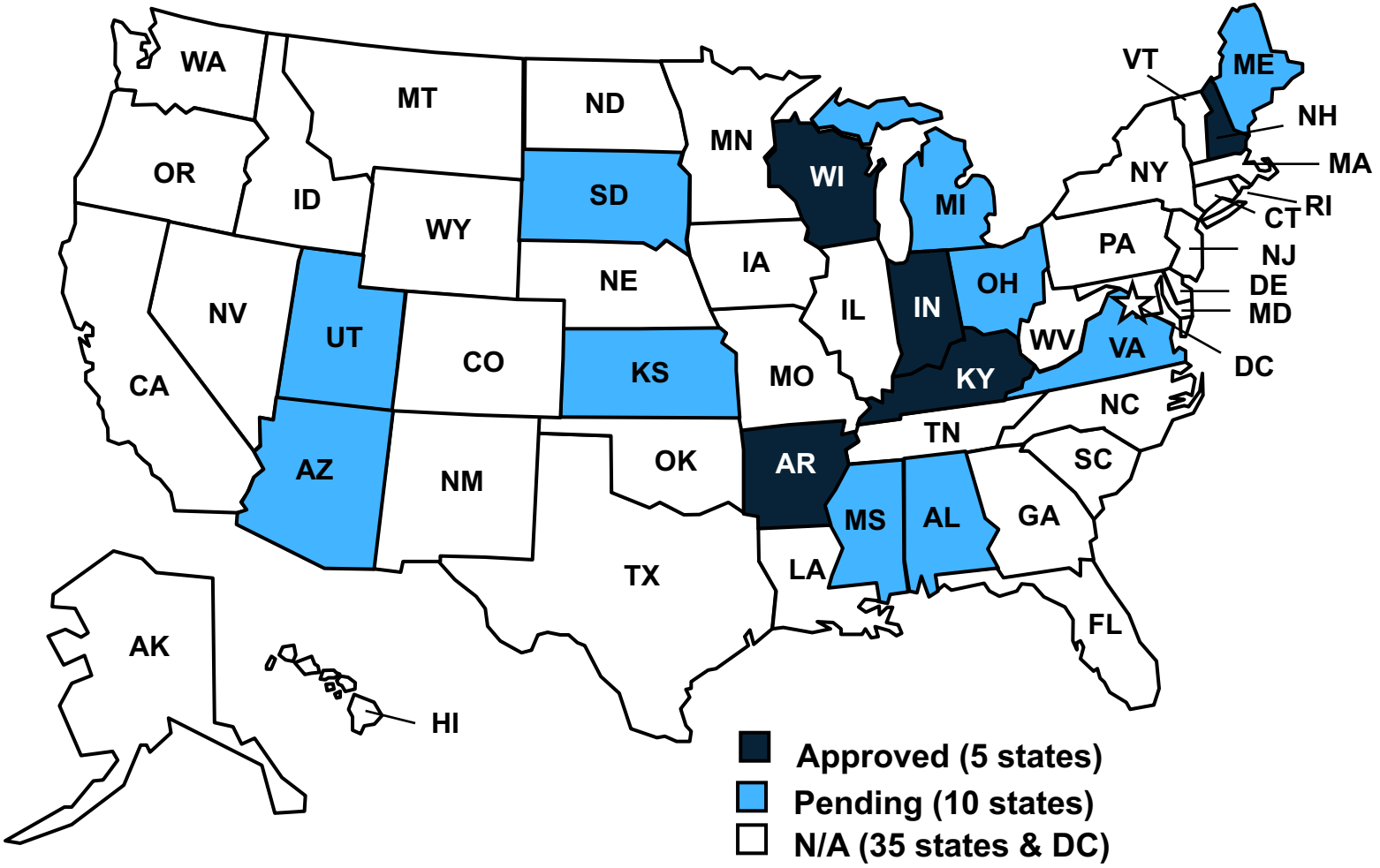
Figure 2

Recent interest in the connection between health and work linked to new activity in Medicaid waivers.

- January 2018 Section 1115 waiver guidance encourages states to test work requirements/community engagement in Medicaid
- Section 1115 allows the HHS Secretary to waive state compliance with certain Medicaid provisions that are:
  - "Experimental, pilot or demonstration projects"
  - "Likely to assist in promoting the objectives of the Medicaid program"
  - Budget neutral to the federal government
  - Subject to state and federal public notice and comment periods
- Pending litigation challenges legality of work requirements in Medicaid
  - DC federal district court invalidated Secretary's approval of Kentucky's waiver in June 2018, holding that consideration of whether waiver promotes health is not substitute for considering whether waiver promotes Medicaid's primary purpose of covering health costs
  - CMS re-opened public comment period and re-approved KY waiver in Nov. 2018
  - Litigation still pending for KY and AR waivers

Figure 3

Five states have approved Medicaid work requirement waivers as of December 7, 2018.



NOTES: Pending waivers include new applications, amendments to existing waivers, and renewal/extension requests. Pending waiver applications are not included in this tracker until they are officially accepted by CMS and posted on Medicaid.gov.
SOURCE: KFF, Medicaid Waiver Tracker (Dec. 7, 2018).

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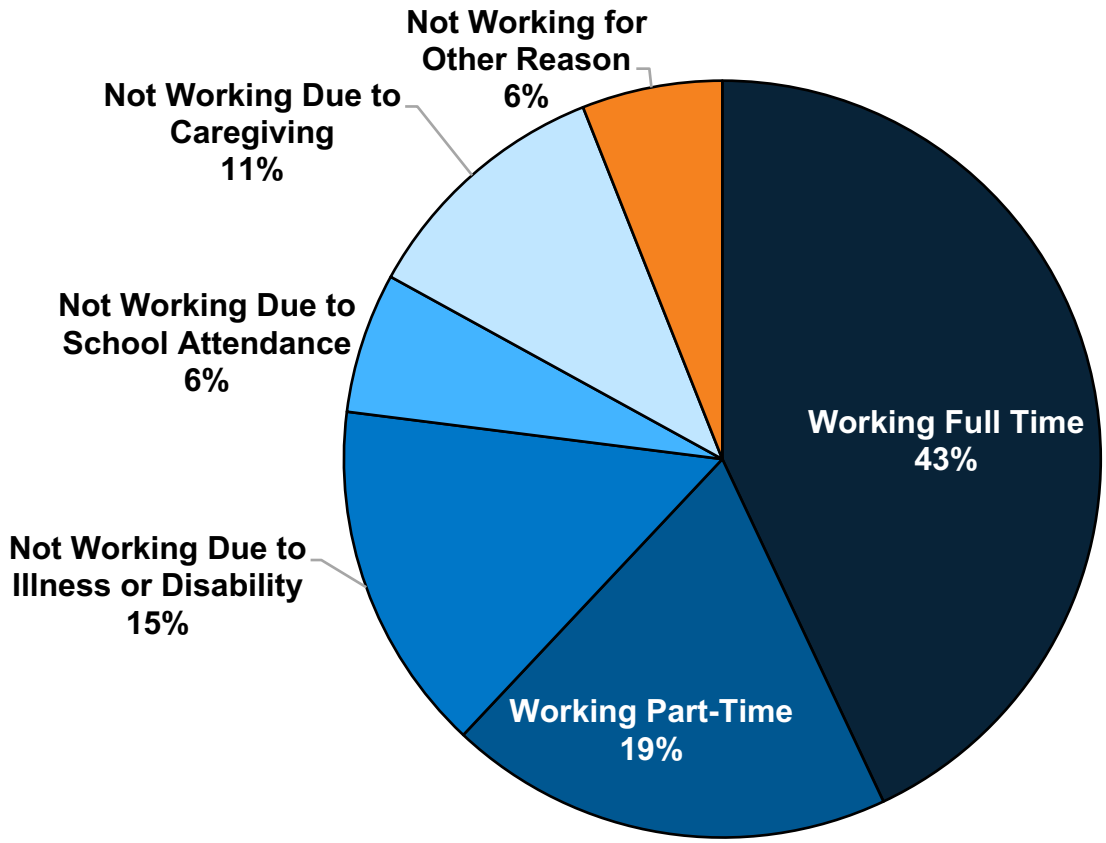
Figure 4

The large majority of Medicaid adults are working or face barriers to work.



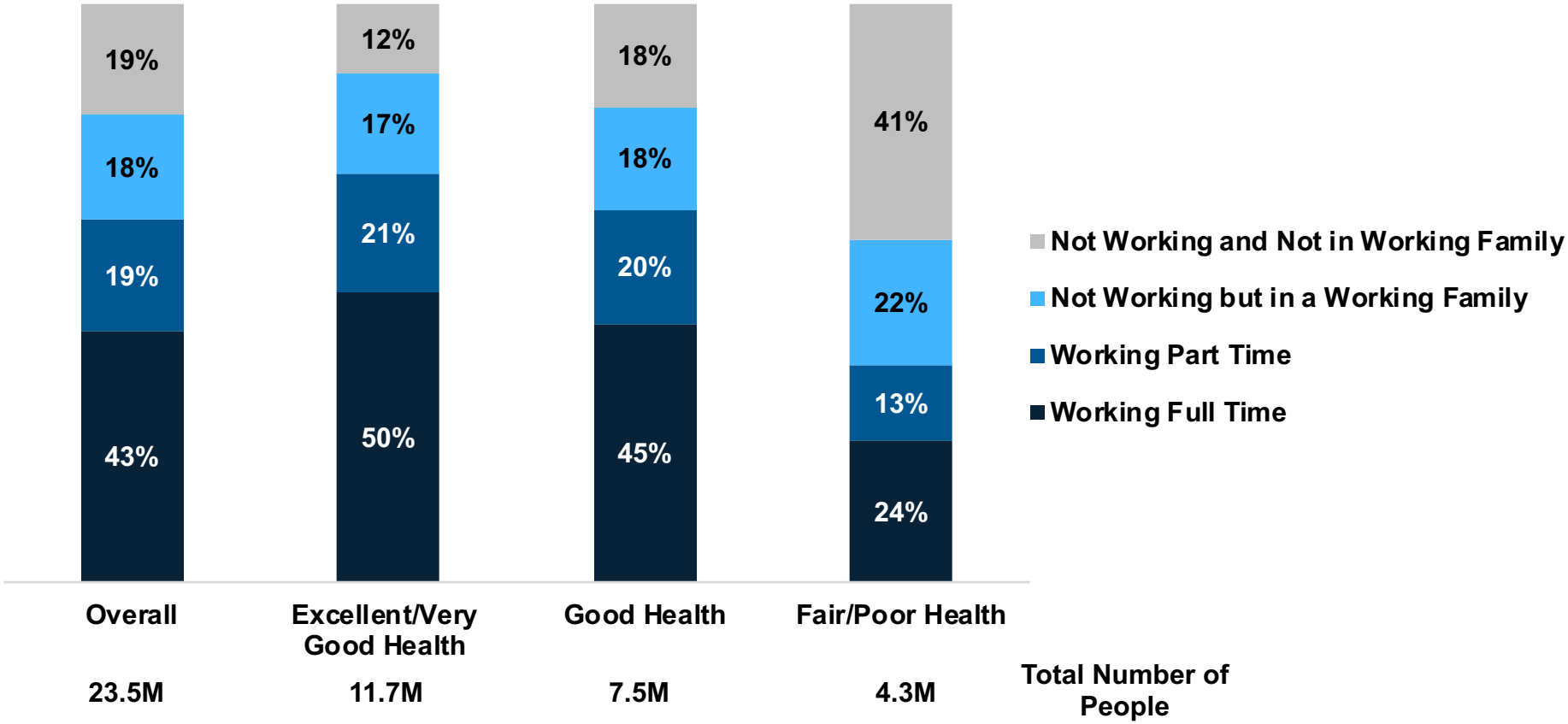
Total = 23.5 million Non-SSI, Non-Dual Eligible, Nonelderly Medicaid Adults

NOTES: "Not Working for Other Reason" includes retired, could not find work, or other reason. Working Full-Time is based on total number of hours worked per week (at least 35 hours). Full-time workers may be simultaneously working more than one job.
SOURCE: Kaiser Family Foundation analysis of March 2017 Current Population Survey.

Figure 5

Health status is strongly associated with work among Medicaid enrollees.

Work Status among Non-SSI, Non-Dual, Non-Elderly Adult Medicaid Enrollees by Health Status, 2016



NOTE: Includes nonelderly adults who do not receive Supplemental Security Income (SSI) and are not dual eligibles. Data may not sum to 100% due to rounding. All values for people in fair/poor health significantly different from those for people in excellent/very good health at p<0.001 level. Share of people in good health working full time or not working and not in working family significantly different from excellent/very good at p<0.001 level.
SOURCE: Kaiser Family Foundation analysis of March 2017 Current Population Survey.

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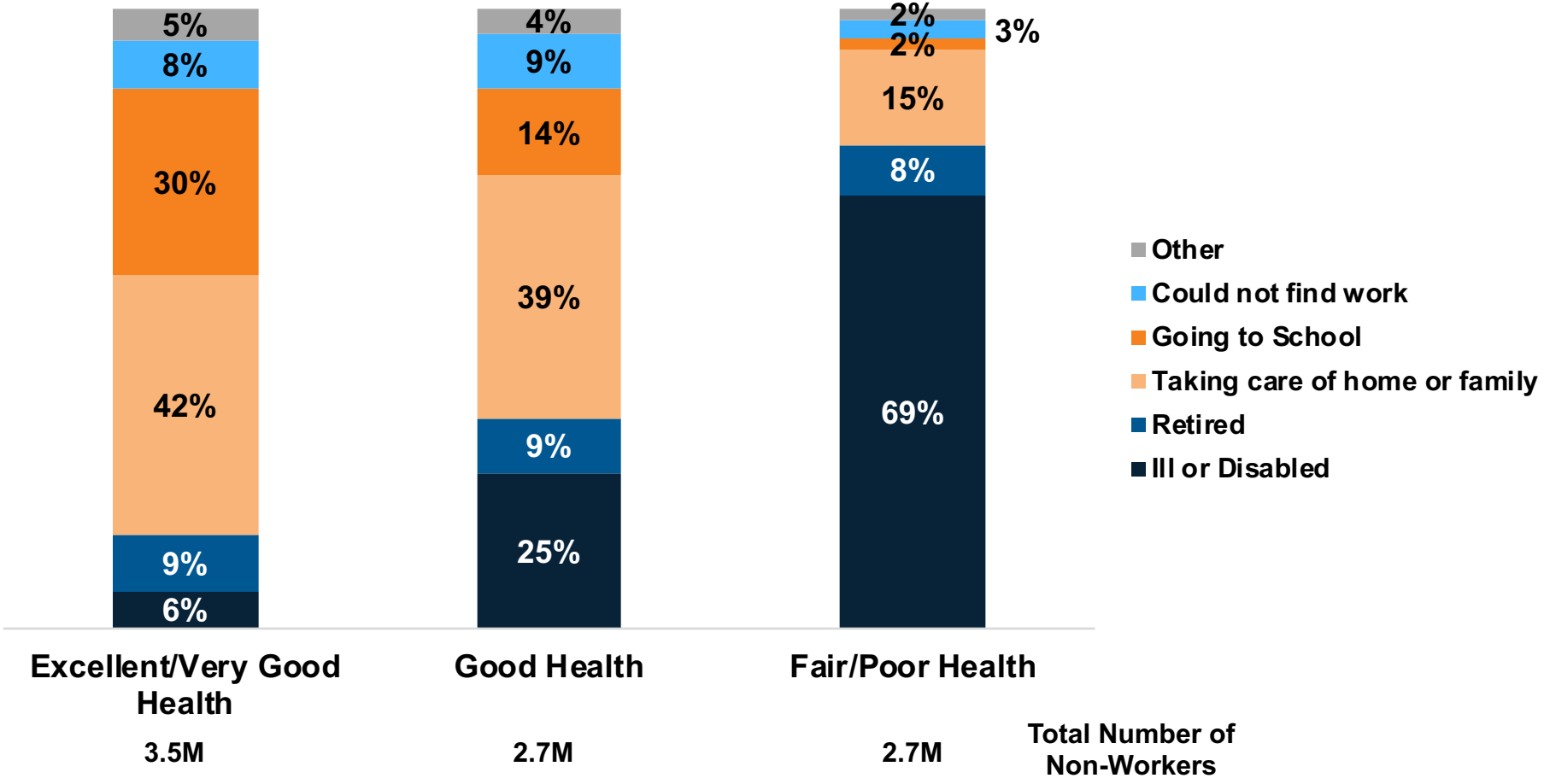
Figure 6

Illness/disability is most frequently-named reason for not working among those in fair/poor health.

Reason for Not Working Among Non-SSI, Non-Dual, Non-Elderly Adult Medicaid Enrollees, by Health Status



NOTE: Among those not working. Includes nonelderly adults who do not receive Supplemental Security Income (SSI) and are not dual eligible.
SOURCE: Kaiser Family Foundation analysis of March 2017 Current Population Survey.

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Figure 7

What is the effect of health (and health coverage) on work?

- **Poor health is associated with increased risk of job loss.**
  - For example, studies show that poor self-perceived health or poor mental health leads to increased likelihood of exiting paid employment or being unemployed
  - Unmet need for behavioral health services results in difficulty obtaining and maintaining employment
  - Individual characteristics may mediate this relationship
- **Access to affordable health insurance supports obtaining and maintaining employment.**
  - Studies of Medicaid expansion in OH, MI, and MT found that enrollees reported that coverage supported work or that employment increased among the expansion population

SOURCE: KFF, The Relationship Between Work and Health: Findings from a Literature Review (August 2018).

Figure 8

What is the effect of work on health (and health coverage)?

- **There is strong evidence of a link between *unemployment* and poor health outcomes, particularly poor mental health**
  - Many authors caution against inferring that the opposite relationship also holds
  - While unemployment is almost universally a negative experience and thus linked to poor outcomes, especially poor mental health outcomes, employment may be positive or negative, depending on the nature of the job (e.g., stability, stress, hours, pay, etc.).

- **There is mixed evidence on the effect of *employment* on health, with some studies showing a positive effect and others showing no relationship or isolated effects.**
  - Limited number of studies of *direct* effects of employment, particularly on mental health
  - Job availability and quality are important; transition from unemployment to poor quality or unstable employment options can be detrimental to health.
  - Selection bias in the research (e.g., healthy people being more likely to work) and other methodological limitations restrict the ability to determine a causal work-health relationship.
  - While work can help people access employer-sponsored health coverage, many jobs—especially low-wage jobs—do not come with an affordable offer of employer coverage.

SOURCE: KFF, The Relationship Between Work and Health: Findings from a Literature Review (August 2018).

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Figure 9

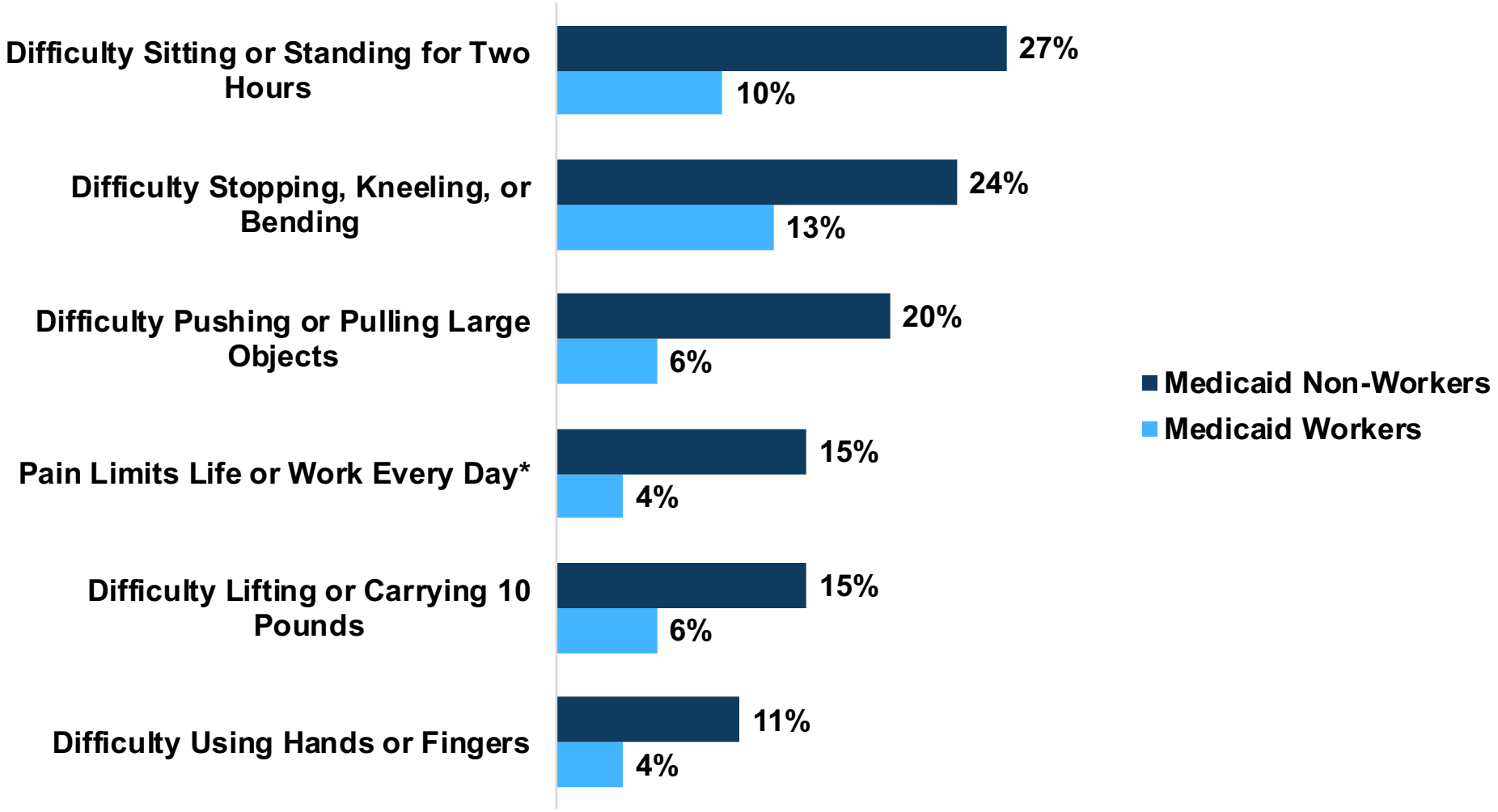
How do these findings apply to Medicaid?

- Medicaid enrollees report worse health than the general population and face significant challenges related to social determinants of health
- Limited job availability or poor job quality may moderate or reverse any positive effects of work.
- Work or volunteering to fulfill a requirement may produce different health effects than work or volunteer activities studied in existing literature.
- Loss of Medicaid under work requirements could negatively impact health care access and outcomes, as well as exacerbate existing health disparities.

Figure 10

Many Medicaid adults have physical limitations to work.

Physical Limitations Among Medicaid Adults by Work Status, 2016



NOTE: Includes non-elderly adults with Medicaid coverage who do not receive Supplemental Security Income (SSI) and are not dual eligibles. *Reference period is past 6 months. All differences between workers and non-workers significant at $p<0.05$ level.

SOURCE: Kaiser Family Foundation analysis of 2016 National Health Interview Survey.

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Figure 11

Work is one component of many social determinants of health.

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education			
Support	Walkability				

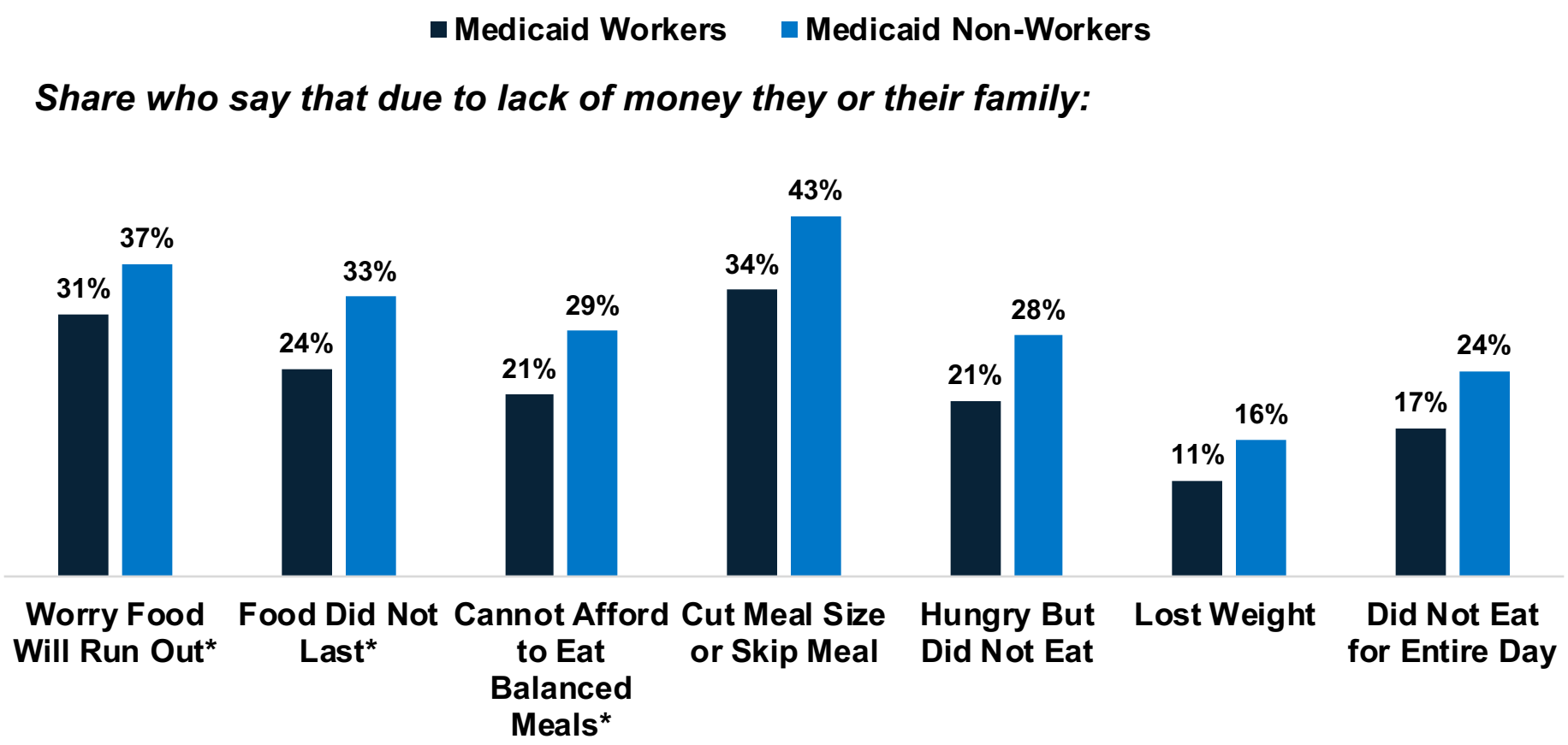
Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

Figure 12

Medicaid adults face other serious barriers to health, even when working.

Food Insecurity Among Working and Non-Working Medicaid Adults, 2016



NOTE: * Sometimes or Often true. Includes non-elderly adults who do not receive Supplemental Security Income (SSI). All differences between workers and non-works statistically significant at p<0.05 level.
SOURCE: Kaiser Family Foundation analysis of 2016 National Health Interview Survey.

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Figure 13

Occupations with the largest number of workers covered by Medicaid are low paying jobs without benefits.

Occupation	Number of Workers with Medicaid
Cashiers	647,000
Nursing, psychiatric, and home health aides	397,000
Personal care aides	374,000
Cooks	368,000
Waiters and waitresses	362,000
Retail salespersons	359,000
Janitors and building cleaners	347,000
Maids and housekeeping cleaners	327,000
Driver/sales workers and truck drivers	319,000
Customer service representatives	296,000

SOURCE: Kaiser Family Foundation analysis of 2016 American Community Survey.

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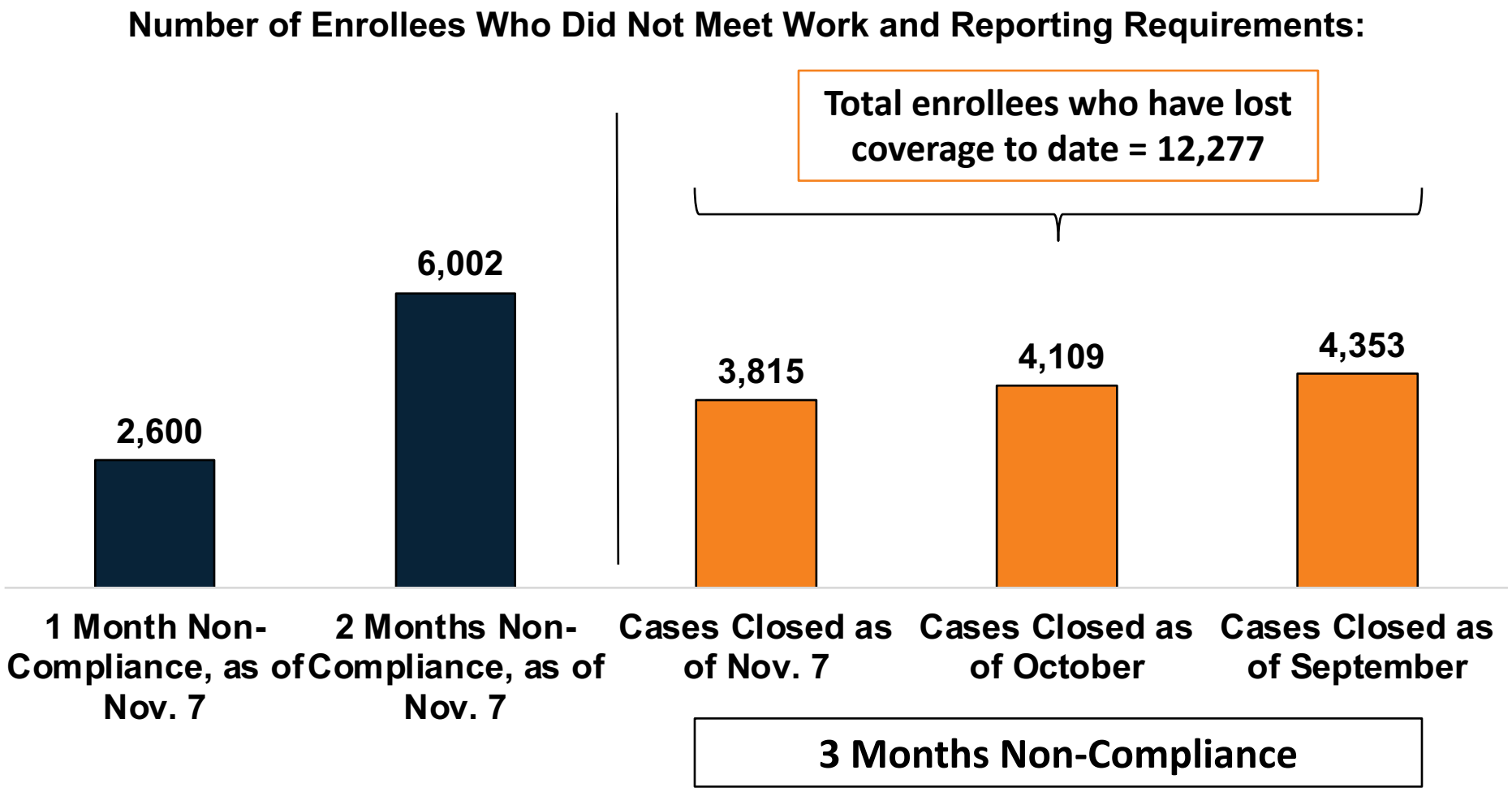
Figure 14

Nearly 12,300 AR Works enrollees have lost Medicaid coverage for not meeting work and reporting requirements.



SOURCES: Oct. case closure data from Ark. Dep't of Human Servs,. Ark. Works Program, Oct. 2018 Report (data as of Nov. 7, 2018, released Nov. 15, 2018); Sept. 2018 Report (data as of Oct. 8, 2018, released Oct. 15, 2018); Aug. 2018 Report (data as of Sept. 9, 2018, released Sept. 12, 2018).

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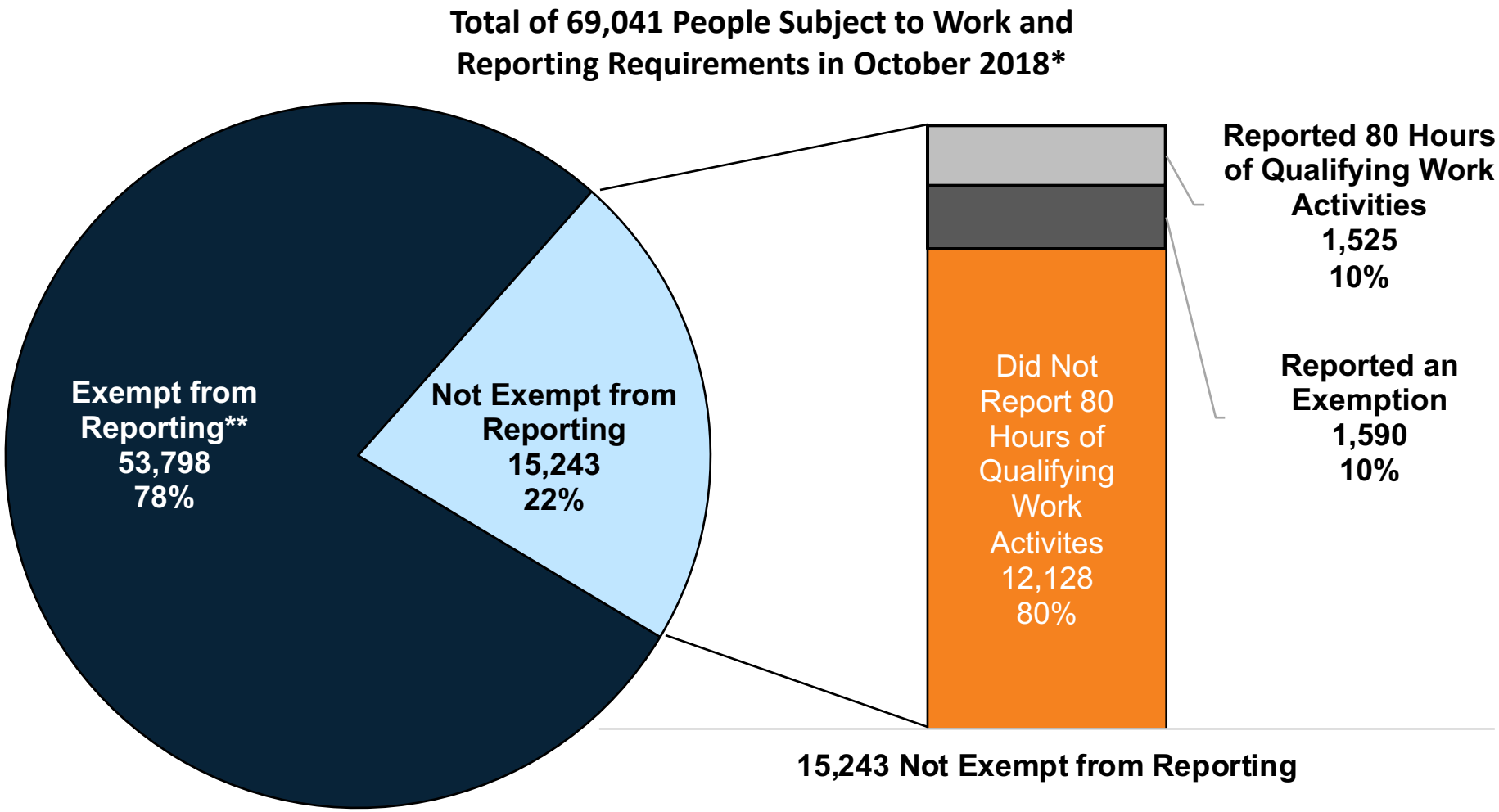
Figure 15

80% of non-exempt AR Works enrollees did not report 80 hours of qualifying work activities in October 2018.



NOTES: *Work requirement was phased in for those ages 30-49 from June-September, 2018. **Includes those identified as already working >80 hours and those identified as exempt from the work requirement.
SOURCE: Ark. Dep't of Human Servs., Ark. Works Program, Oct. 2018 Report (data as of Nov. 7, 2018, released Nov. 15, 2018).

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Figure 16

Early experience with work and reporting requirements in Arkansas can inform other states.

Early Implementation:

- Despite a robust campaign by the state, health plans, providers, and advocates, outreach is difficult, especially in rural areas and for vulnerable populations.
- The process for enrollees to set up an online account is complicated.

Ongoing Implementation:

- While state data matching to identify exempt enrollees is generally working well, implementation is complex and may result in increased administrative costs for the state and other stakeholders.
- For non-exempt enrollees, reporting exemptions or work activities requires multiple steps.
- Some enrollees who may qualify for an exemption but are not identified by state data matching may fall through the cracks, and others may face barriers to work.

Looking Ahead:

- Coverage losses could result in gaps in care as well as increases in the uninsured rate and uncompensated care costs for providers.
- Disenrollment of healthier enrollees could have implications for the risk pool that would result in higher premiums.

SOURCE: KFF, *An Early Look at Implementation of Medicaid Work Requirements in Arkansas* (Oct. 2018).

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Figure 17

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For more information, see:

www.kff.org/medicaid/