



## Medicaid Work Requirements: The Relationship between Work and Health

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February 2019

### Introduction

In 2018, the Centers for Medicare and Medicaid Services (CMS) announced support for state efforts to condition Medicaid coverage on fulfilling a work requirement. For the first time in the Medicaid program's history, some beneficiaries will be required to participate in work or work-related activities for a minimum number of hours in order to maintain eligibility for coverage in states that impose work requirements. In the past, such provisions have been denied on the basis that they do not further the program's purposes of promoting health coverage and access. To address this shift in policy, CMS maintains that work requirements can "improve better mental, physical, and emotional health in furtherance of Medicaid program objectives".<sup>1</sup> To date, CMS has approved Medicaid work requirements in eight states (KY, IN, AR, NH, WI, ME, MI, AZ) and eight other states are pending approval.<sup>2</sup>

Whether work requirements in Medicaid promote health and align with the aims of the program has become a central question in the current policy debate. CMS cites the negative health effects of unemployment, and the association between increased income and positive health outcomes as reasoning for Medicaid work requirements. However, in June 2018, the United States District Court for the District of Columbia blocked Medicaid work requirements in Kentucky on the basis that they do not support the program's primary purpose of providing affordable health coverage; the ruling also noted that the proclaimed health benefits of employment are unsupported by substantial evidence. This brief assesses the relationship between work and health by using longitudinal data to analyze the effects of employment and health status over time. We evaluate the effect of health on work and then examine whether work improves health. Policy implications of current Medicaid work requirements and recommendations follow based on our findings.

### Key Findings

- Health status predicts employment; those with better health were more likely to be employed.
- Mental health status is a strong predictor of employment, where one third of those with a mental health diagnosis reported fair or poor health.
- Of those previously unemployed, becoming employed was associated with a subsequent improvement in reported health; however, those who were in better health were more likely to become employed.
- This positive effect of employment on health was no longer significant among those who reported fair or poor health; this suggests that positive employment effects found for the general population may not apply to Medicaid enrollees, who report the poorest health.
- Additionally, employment did not improve the self-reported health of those with a mental health diagnosis; though not significant, employment may actually be harmful for those with a mental health diagnosis. The type of job likely matters for this population in particular.

### Data and Methods

A causal association of employment on health is difficult to determine due to the endogenous relationship of work and health. Whether improvements in health are a result of employment or whether employment is a result of improved health must be assessed. Longitudinal data is thus needed in order to examine the effects

of work on health temporally. The Panel Study of Income Dynamics (PSID) is a longitudinal household survey that began in 1968 with a nationally representative sample of over 18,000 individuals. Biennial interviews collect information on numerous topics including employment and health. Using data reported by heads and spouses of households who were less than age 65 from 1995 to 2015, we evaluated the relationship between work and health using logistic regression analyses. The models control for sex, race, marital status, and education level, and findings are expressed as odds ratios (OR) with their 95% confidence intervals (95% CI).

We first assessed the effect of respondents' self-reported health status and mental health on subsequent employment status (n=34,834). Self-reported health status was categorized into excellent/very good, good, and fair/poor; mental health was classified based upon whether they had ever been diagnosed by a doctor or other health professional with any emotional, nervous, or psychiatric problems. Then, to evaluate whether work improves health, we analyzed whether becoming employed was a predictor of a subsequent improvement in health status among those who were unemployed in the previous survey year (n=1,154). However, we note that the biennial survey may not fully capture the timeline of health improvements and attainment of employment. We ran this analysis again for those who were both unemployed previously and reported fair or poor health to determine whether the effect of work on health remained the same among those with relatively poorer health (n=215). Finally, we assess whether becoming employed improves the self-reported health status of those who have a mental health diagnosis (n=108).

## Results

### Health as a Predictor of Work:

In our analysis, those who reported their health as good in the previous survey year were not significantly more likely than those who reported their health as fair or poor to be employed in the following survey year. However, those who reported their health as excellent/very good in the previous survey year were 35% more likely than those who reported their health as fair/poor to be employed in the following survey year. Additionally, those who did not have a mental health diagnosis (emotional, nervous, psychiatric) were almost twice as likely to be employed compared to those who have (Table 1).

**Table 1. Odds of Employment by Prior Health Status**

	Odds Ratio (95% CI)
<i>Self-Reported Health Status</i>	
<b>Very good/ Excellent (compared to Fair/Poor)</b>	1.35 (1.12-1.62)*
<b>Good (compared to Fair/Poor)</b>	1.09 (0.91-1.31)
<i>Mental Health Diagnosis</i>	
<b>No (compared to Yes)</b>	1.94 (1.54-2.33)*

Note: Odds Ratios with \* are statistically significant

Those with no mental health diagnosis were also more likely to report better health. Table 2 below shows the distribution of self-reported health status for those who reported having a mental health diagnosis compared to those who did not. Sixty-two percent of those without a mental health diagnosis reported very good/excellent, and only 9% reported fair/poor health. Comparatively, more than one third of those with a mental health diagnosis reported fair/poor health and only 32% reported very good/excellent. These differences were statistically significant.

These results are consistent with previous research showing that being in poor health is associated with an increased risk of unemployment. A 2014 meta-analysis of longitudinal studies on the influence of poor health on exit from paid employment found that self-perceived poor health was a significant risk factor for unemployment.<sup>3</sup> Similarly, poor mental health can be a barrier to gaining and maintaining employment.<sup>4</sup>

**Table 2. Self-Reported Health Status by Mental Health Status (n=42,434)**

	No Mental Health Diagnosis n(%)	Mental Health Diagnosis n(%)	Chi Square p-value
<b>Very good/ Excellent</b>	24,860 (61.7)	694 (32.1)	<0.0001
<b>Good</b>	11,884 (29.5)	728 (33.7)	
<b>Fair/ Poor</b>	3,531 (8.8)	737 (34.1)	

**Work as a Predictor of Health:**

Research has also shown a strong association between unemployment and poor health outcomes, where unemployment is found to be associated with increases in depression and anxiety.<sup>5,6</sup> Although employment has been found to have a protective effect on depression and general mental health in these cases, evidence of a positive effect of employment on physical and general health is mixed and whether employment can cause improved health remains unclear.<sup>7</sup>

To evaluate whether work improves health, we analyzed whether becoming employed was associated with a subsequent improvement in health status. We found that among those who were previously unemployed, those who became employed in the following survey year were 48% more likely to subsequently report an improvement in their health status compared to those who did not become employed (Table 3). This significant effect of employment on improved health however disappears for those who initially reported poor/fair health. Among those who were previously unemployed that reported poor/fair health, an improvement in health status was not significantly more likely for those who became employed in the following survey year compared to those who did not become employed (Table 3).

Furthermore, employment did not significantly improve the self-reported health of those with a mental health diagnosis. Of those who were previously unemployed and reported having a mental health diagnosis, an improvement in health status was not significantly more likely for those who became employed compared to those who did not (Table 3). Supporting our findings from the previous section, those who became employed were also in better initial health than those who remained unemployed (Table 4).

**Table 3. Odds of an Improvement in Health for those Previously Unemployed by Employment Status**

	Odds Ratio (95% CI)
<i>All</i>	
<b>Becomes Employed (compared to Remaining Unemployed)</b>	1.48 (1.06-2.07)*
<i>Health Status-- Poor/Fair</i>	
<b>Becomes Employed (compared to Remaining Unemployed)</b>	1.33 (0.49-3.62)
<i>Mental Health Diagnosis-- Yes</i>	
<b>Becomes Employed (compared to Remaining Unemployed)</b>	0.96 (0.55-1.58)

Note: Odds Ratios with \* are statistically significant

**Table 4. Employment Status of Previously Unemployed by Self-Reported Health Status (n=1,154)**

Health Status (at time of Unemployment)	Became Employed in Following Survey Year N(%)	Remain Unemployed in Following Survey Year N(%)	Chi Square p-value
<b>Very good/ Excellent</b>	433 (53.1)	154 (45.4)	0.058
<b>Good</b>	283 (34.7)	138 (40.7)	
<b>Fair/ Poor</b>	99 (12.2)	47 (13.9)	

**Discussion and Policy Implications**

Our results suggest that for some, employment may improve health; unemployed individuals who became employed were more likely to report an improvement in health than those who remained unemployed.

However, the data also show that some individuals report worse health following employment. The significant effect of employment on health disappeared for those who reported fair or poor health, and though not significant, the effect of employment on self-reported health for those with a mental health diagnosis was negative. The positive effects of employment on health found for the general population may thus not apply to the Medicaid population who report poorer health than those with other forms of health insurance.<sup>8</sup> For the one in five adult Medicaid beneficiaries who had a behavioral health diagnosis in 2011, requiring employment of those unemployed could even potentially have a harmful effect.<sup>9</sup>

Whereas work may be beneficial to the health of some, it may not be for all. The effect of work on health is thus mixed, and the assumption that work will improve the health of everyone must be cautioned. Policy that imposes work requirements on Medicaid enrollees uniformly can be harmful depending on the circumstances. Health status matters, and low-quality, unstable, or poorly paid jobs can have adverse effects on health and reverse any positive health effects that work can have, especially for mental health.<sup>10, 11</sup> This is especially pertinent to non-expansion states, as the Medicaid population subject to work requirements may not have access to quality jobs. In Missouri for example, 37% of the Medicaid adults not currently working have less than a high school degree.<sup>12</sup>

Comprehensive work support services are therefore critical for helping move low-income individuals into the workforce, and are rightfully required to be provided by states mandating work in Medicaid. However, the cost of essential work support services such as job training, transportation, and childcare can be substantial, and states cannot use federal Medicaid funds. Rather than forcing Medicaid recipients to fulfill work requirements, which would require substantial administrative and implementation costs<sup>13</sup>, targeting resources to support those who want to work could be a more effective program. For example, Montana's voluntary Health and Economic Livelihood Partnership Link (HELP-Link) program targets outreach and services to Medicaid enrollees who are looking for work or better jobs by connecting them with services such as career counseling, on-the-job training programs, and job openings in local communities. According to the Montana Department of Labor & Industry, 91% of participants were employed after completing training, and 51% had higher wages after completing the program.<sup>14</sup> Such programs that can move Medicaid enrollees into better jobs that offer health insurance or enough wages for them to afford insurance through the Marketplace not only have the potential to benefit enrollee health and wellness, but also to save the state money in the long term.<sup>12</sup>

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<sup>1</sup> Centers for Medicare & Medicaid Services (January 2018). <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf>

<sup>2</sup> Kaiser Family Foundation, *Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State, Table 2* (January 23, 2019).

<sup>3</sup> van Rijn, R., Robroek, S., Brouwer, S., & Burdorf, A. (2014). Influence of poor health on exit from paid employment: a systematic review. *Occup Environ Med*, 71(4), 295-301.

<sup>4</sup> Olesen, S., Butterworth, P., Leach, L., Kelaher, M., & Pirkis, J. (2013). Mental health affects future employment as job loss affects mental health: findings from a longitudinal population study. *BMC psychiatry*, 13(1), 144.

<sup>5</sup> McKee-Ryan, F., Song, Z., Wanberg, C., & Kinicki, A. (2005). Psychological and physical well-being during unemployment: a meta-analytic study. *Journal of applied psychology*, 90(1), 53.

<sup>6</sup> Paul, K., & Moser, K. (2009). Unemployment impairs mental health: Meta-analyses. *Journal of Vocational behavior*, 74(3), 264-282.

<sup>7</sup> van der Noort, M., IJzelenberg, H., Droomers, M., & Proper, K. (2014). Health effects of employment: a systematic review of prospective studies. *Occup Environ Med*, 71(10), 730-736.

<sup>8</sup> Gallup, Medicaid Population Reports Poorest Health (Dec 7, 2017). <https://news.gallup.com/>

<sup>9</sup> Medicaid and CHIP Payment and Access Commission (MACPAC), Behavioral Health in the Medicaid Program—People, Use, and Expenditures (June 2015). <https://www.macpac.gov/wp-content/uploads/2015/06/Behavioral-Health-in-the-Medicaid-Program%E2%80%94People-Use-and-Expenditures.pdf>

<sup>10</sup> Chandola, T., & Zhang, N. (2017). Re-employment, job quality, health and allostatic load biomarkers: prospective evidence from the UK Household Longitudinal Study. *International journal of epidemiology*, 47(1), 47-57.

<sup>11</sup> Butterworth, P., Leach, L., Strazdins, L., Olesen, S., Rodgers, B., & Broom, D. (2011). The psychosocial quality of work determines whether employment has benefits for mental health: results from a longitudinal national household panel survey. *Occup Environ Med*, 68(11), 806-812.

<sup>12</sup> Center for Health Economics and Policy, *The Demographics of Missouri Medicaid: Implications for Work Requirements* (Revised and Updated October 2018). [https://publichealth.wustl.edu/wp-content/uploads/2018/11/MO-Medicaid-Work-Brief\\_update11.29.18.pdf](https://publichealth.wustl.edu/wp-content/uploads/2018/11/MO-Medicaid-Work-Brief_update11.29.18.pdf)

<sup>13</sup> Center for Health Economics and Policy, *Weighing the Cost Savings of Medicaid Work Requirements in a Non-Expansion State* (May, 2018). <https://publichealth.wustl.edu/wp-content/uploads/2018/06/MO-Medicaid-Work-Fiscal-Brief-final.pdf>

<sup>14</sup> Montana Department of Labor & Industry. <https://montanaworks.gov/help-link>