

How do disability and poor health impact proposed Medicaid work requirements?

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In January 2018, the Centers for Medicare and Medicaid Services (CMS) issued guidance that would allow states to use 1115 Waivers to add “work and community engagement” requirements for working-age Medicaid beneficiaries. In a letter to state Medicaid directors, CMS explicitly exempts beneficiaries eligible “on the basis of disability,” and also “recognizes that individuals who are eligible for Medicaid on a basis other than disability (and are therefore classified for Medicaid purposes as ‘non-disabled’) may have a disability under the definitions of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973, or section 1557 of the Affordable Care Act.” For such individuals, the guidance acknowledges, disability “may interfere with their ability to meet the requirements.”¹

CMS requires that states requesting 1115 Waivers that impose work /community engagement requirements must, in complying with the Americans with Disabilities Act (ADA) and other civil rights laws, “ensure that individuals with disabilities are not denied Medicaid for inability to meet these requirements, and have mechanisms in place to ensure that reasonable modifications are provided to people who need them.” States “must also create exemptions for individuals determined by the state to be medically frail and should also exempt from the requirements any individuals with acute medical conditions validated by a medical professional that would prevent them from complying with the requirements.”

This report examines the extent to which disability affects working-age Medicaid beneficiaries, and identifies the subset of

beneficiaries with disabilities and work-limiting health conditions who would likely be exempt from proposed Medicaid work requirements or would benefit from modified requirements. Findings come from the author’s analysis of 2014–16 data from the National Health Interview Survey, a nationally representative household survey on health and disability conducted annually by the Census Bureau for the National Center for Health Statistics.²

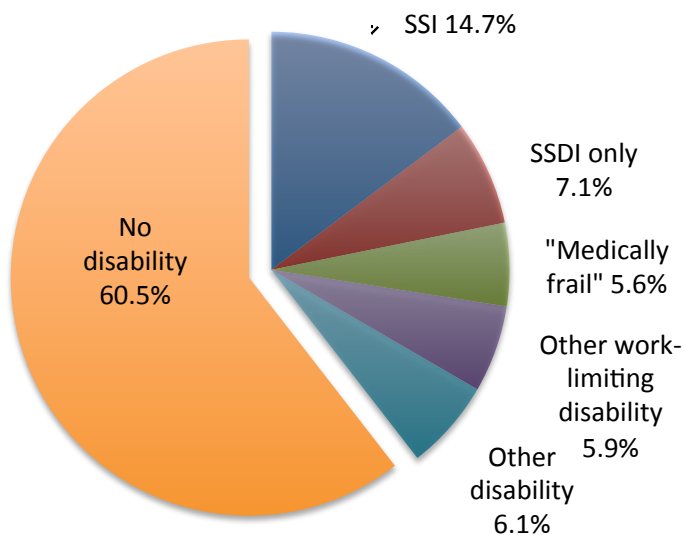
Disability among Medicaid beneficiaries

For the purpose of this analysis, disability is defined broadly to reflect the population referred to in the CMS guidance, including those regarded by the Federal government as unable to work, people considered by the states to be “medically frail,” others with disabilities limiting their ability to work, and people meeting a broader functionally based definition of disability rooted in the ADA. In the following, people with functional limitations (e.g., sensory, mobility, cognitive), potentially work-limiting chronic physical or mental health conditions, or other officially determined or self-assessed restrictions in the ability to work are considered as having disabilities.

Working-age Medicaid beneficiaries with disabilities, as defined above, comprise the following populations:

- **SSI** (14.7 percent of working-age Medicaid recipients; see Figure 1): People receiving Supplemental Security Income as a consequence of their own work disability (“inability to engage in any substantial gainful activity”), the population typically

Figure 1. Disability and work limitation status of working-age U.S. Medicaid beneficiaries

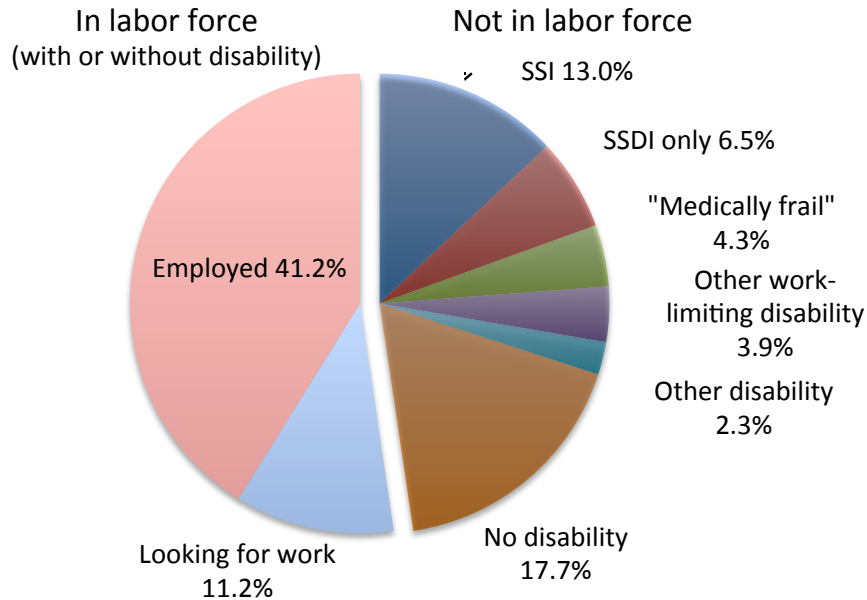


qualifying for Medicaid “on the basis of disability,” who would be automatically excluded from any proposed work requirements.

- **SSDI only** (7.1 percent): Those not receiving SSI, but instead Social Security Disability Insurance payments as a result of their own work disability. Eligibility for SSDI is based, in part, on the same disability definition as used for SSI: “inability to engage in any substantial gainful activity.” People on SSDI but not SSI do not qualify for Medicaid on the basis of disability.
- **“Medically frail”** (5.6 percent): CMS allows the states to define the term, but lists minimum criteria, including disabling mental health conditions, people with “serious and complex medical conditions,” and “individuals with physical and/or mental disabilities that significantly impair their ability to perform one or more activities of daily living.”³ State interpretations vary, but for this analysis, “medically frail” is operationalized as having a self-reported, work-limiting disability caused by a mental health condition, substance abuse, heart disease, stroke, lung disease, or cancer; or needing assistance in “personal care activities, such as eating, bathing, dressing, or getting around inside [the] home,” without regard to the condition causing the limitation.
- **Other work-limiting disability** (5.9 percent): People not in the above categories who nonetheless self-report as having “a physical, mental, or emotional problem” that either keeps them from working at a job or business or limits the kind or amount of work they can do.
- **Other disability** (6.1 percent): Others not meeting any of the above criteria who are reported as having significant functional limitations. This measure is based upon the six standard disability questions appearing in many Federal surveys. Questions refer to sensory impairments (deaf or with “serious difficulty hearing; blind or with “serious difficulty seeing”), cognitive impairments (“serious difficulty concentrating, remembering, or making decisions”), mobility impairments (“serious difficulty walking or climbing stairs”), or limitations in self-care activities (“difficulty dressing or bathing”) or other routine activities (“difficulty doing errands alone such as visiting a doctor’s office or shopping”).

Overall, about two-fifths (39.5 percent) of Medicaid beneficiaries have broadly defined disabilities, most of whom are not readily identified as such through administrative records. The remaining three-fifths have no reported disability.

Figure 2. Labor force, disability, and work limitation status of working-age U.S. Medicaid beneficiaries



Labor force status and disability status

Nationally, just over half of working-age Medicaid beneficiaries are already in the labor force, and therefore should not be targeted by proposed work and community engagement requirements. Some 41.2 percent are employed, the vast majority of whom do not have disabilities. An additional 11.2 percent of all working-age Medicaid beneficiaries are looking for work. Job search is one of the activities CMS lists as an appropriate community engagement activity in lieu of work, along with skills training, education, caregiving, and volunteering.

As illustrated in Figure 2, the remaining 47.7 percent of beneficiaries are not currently participating in the labor force. Most of these non-participants, or 30.0 percent of all working-age Medicaid beneficiaries, can be identified as having disabilities. The rest, some 17.7 percent of working-age beneficiaries, have no identified disability or work-limiting health problem. This group, small though it is, would be a natural focus of work requirement proposals, depending on other factors, such as whether they would be excluded for other reasons or are already participating in alternative community engagement activities.

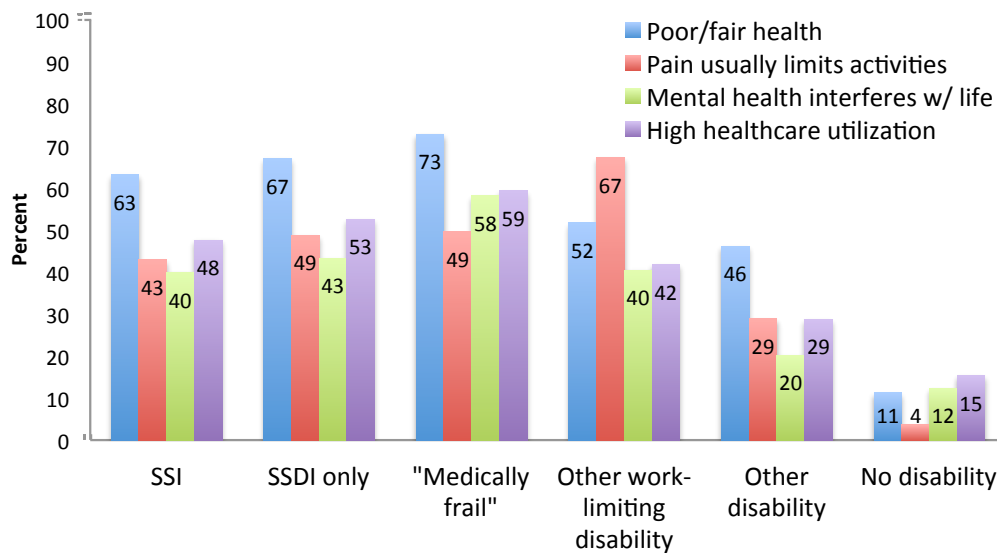
What categories of labor force non-participants *with* disabilities are potential candidates for

inclusion in proposed Medicaid work requirements? Probably the 2.3 percent of beneficiaries with “other disabilities” not regarded as limiting the person’s ability to work.

Work or community engagement rules should not apply to the remaining disability classifications: SSI recipients (13.0 percent or working-age Medicaid beneficiaries) would generally be exempted from such policies by virtue of being eligible for Medicaid on the basis of disability. SSDI recipients (6.5 percent) must meet the same strict Federal standards of extensive work disability as SSI recipients. Those deemed “medically frail” by virtue of the nature of the disability or complex health condition (4.3 percent) are also explicitly excluded in the CMS guidelines.

The 3.9 percent of beneficiaries with work-limiting disabilities—those who consider themselves as being prevented from working or limited in the type or extent of work they can perform—should also be excluded from work requirements, as demonstrated in the next section. This group would, at the very least, require modifications to the work rules, such as a reduction in required hours and assurance that needed accommodations would be available.

Figure 3. Health problems and healthcare utilization among working-age Medicaid beneficiaries not in the labor force, by disability and work limitation status



Health and healthcare utilization among labor force non-participants

Disability is by no means synonymous with poor health. Among the population as a whole, a majority of people with disabilities report their health as good to excellent. But Medicaid recipients with disabilities, many of whom qualify in connection with a disabling chronic health condition, are a different story. Self-reported poor or fair health status is, in fact, quite common among beneficiaries with disabilities who do not participate in the labor force, as shown in Figure 3.

Among working-age Medicaid beneficiaries not participating in the labor force, 63 percent of those on SSI and 67 percent of those on SSDI report poor or fair health, as do 73 percent of “medically frail” beneficiaries. Among those others who self-report disability-related work limitations, just over half (52 percent) are in poor or fair health, as are 46 percent of those with disabilities not reported as work-limiting. In sharp contrast, only 11 percent of labor force non-participants without disabilities report poor or fair health.

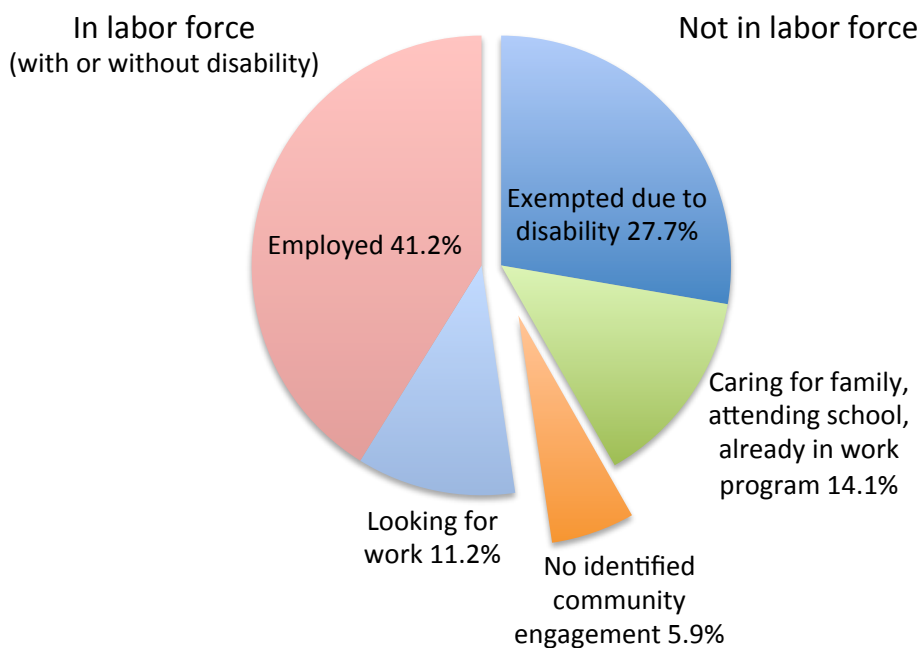
What does poor or fair health status mean for beneficiaries with disabilities who aren’t participating in the labor force? It typically means chronic health conditions like heart disease (33.5 percent, not including

hypertension), lung disease (29.6 percent), arthritis (57.3 percent), and diabetes (28.0 percent). When half of people who report that their disability prevents or limits work also assess their health status as poor or fair, they mean that they are affected by serious, variable health conditions that make work a real challenge for them, if not an impossibility.

Chronic pain is common among all of the disability classifications. Figure 3 shows the proportion of beneficiaries reporting that pain limits life activities “every day” or “most days”: 43 percent of those on SSI, 49 percent of those on SSDI or in the “medically frail” category, and two-thirds (67 percent) of others whose disability prevents or limits work. For those with other disabilities, 29 percent report that their activities are usually limited by pain, compared to 4 percent of those not identified as having disabilities.

Limitations in activities due to mental health problems are also common. About two-fifths of people on SSI or SSDI or with self-reported work-limiting disabilities say that mental health interferes “a lot” or “some” with their lives or activities. The proportion is even higher for the “medically frail” category, at 58 percent. People with non-work-limiting disabilities or without disabilities are substantially less likely to be affected, at 20 and 12 percent, respectively.

Figure 4. Labor force participation, disability status, and other community engagement among working-age Medicaid beneficiaries



High healthcare utilization is an important consideration for three reasons: (1) It tends to confirm self-reports of poor health and high prevalence of chronic conditions; (2) frequent healthcare visits or hospitalizations might interfere, in and of themselves, with the ability to maintain employment; and (3) the need for extensive healthcare emphasizes the importance of Medicaid coverage for these beneficiary groups. High utilization is defined here as having had ten or more provider visits, four or more home healthcare visits, two or more hospitalizations, or four or more emergency department visits during the prior 12 months.

Among working-age Medicaid beneficiaries, about half of SSI or SSDI recipients are heavy healthcare users, as are 59 percent of the “medically frail” category, 42 percent of those with other work-limiting disabilities, and 29 percent of those with other disabilities.

Other community engagement

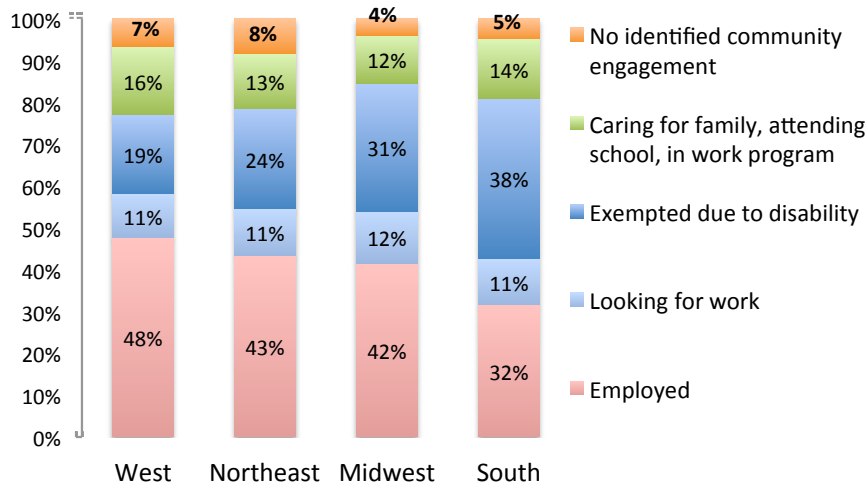
In its guidance to state Medicaid directors, CMS refers to pursuing an education and providing care for family members both as examples of “other community engagement activities” and as reasons for exemption from work requirements.

Existing survey data can provide a limited window to assess the extent to which such activities are engaged in by working-age beneficiaries who are neither participating in the labor force nor likely to be exempted from work requirements due to disability. Information on other relevant activities, such as volunteering, is not available, and caregiving and school attendance data are approximate and probably underestimated.

In Figure 4, the first four disability categories from Figure 2 (SSI, SSDI only, “Medically frail,” and Other work-limiting disability) have been combined into the 27.7 percent of working-age beneficiaries who would likely be exempted from work or community engagement activities because of disability status. The remaining 20.0 percent of labor force non-participants (combining the 2.3 percent with “other disability” and the 17.7 percent with no disability) have been divided into two groups based on the beneficiaries’ other community engagement activities. People doing one or more of the following are included:

- “Caring for family” means a person who is the only adult family member not participating in the labor force with

Figure 5. Labor force participation, disability status, and other community engagement among working-age Medicaid beneficiaries, by region of the country



- responsibility for children, elderly family members, or others needing personal assistance who are living in the home;
- “Attending school” refers to people who list school as the main reason for not working;
- “Work programs” means recipients of Temporary Assistance for Needy Families, which already includes a work requirement.

Some 14.1 percent of working-age beneficiaries, more than two-thirds of the 20 percent who are neither exempt nor labor force participants, are engaged in the above activities. This group does not seem an appropriate target for work requirements, because they are already performing alternative roles.

Excluding this group leaves us with only 5.9 percent of working-age beneficiaries to reasonably target for new work or community engagement requirements.

Medicaid expansion versus non-expansion states

A majority of states expanded Medicaid in 2014 or thereafter in accordance with the Affordable Care Act, which allowed additional, low-income residents to join the beneficiary roles without regard to disability status. As a consequence, people without disabilities make up a larger share of beneficiaries in those states than in non-expansion states.

Adoption of the Medicaid expansion varies greatly by region of the country. All but a few

states in the Census Bureau’s Northeast and West regions chose to expand Medicaid, along with most of those in the Midwest. More than 96 percent of working-age Medicaid beneficiaries in the Northeast and West, and 81 percent of those in the Midwest, live in expansion states. In contrast, in the South, where few states expanded Medicaid, only 20 percent of beneficiaries live in expansion states.⁴

As shown in Figure 5, there are large differences in the labor force and disability distributions of working-age Medicaid beneficiaries by region of the country. Labor force participation is much lower in the South, with less than one-third employed, than in the other regions, especially the West, where almost half have jobs. Conversely, twice as high a fraction of beneficiaries in the South are likely to be exempted due to disability (38 percent) as in the West (19 percent).

Despite these rather stark differences, the population appropriately targeted by work or community engagement requirements is a small segment of the beneficiary population regardless of Medicaid expansion status. If beneficiaries who are engaged in labor force or other community activities are removed from consideration, along with those appropriately given disability-related exemptions, only a tiny fraction remain to be targeted: 4 and 5 percent in the South and Midwest, and 7 and 8 percent in the West and Northeast.

Conclusions

About two out of every five working-age Medicaid beneficiaries can be classified as having a disability. Only one of those two would be readily identified through administrative data as having a disability, by virtue of either SSI or SSDI reciprocity. In states that have not expanded Medicaid, the disability population is an even larger share of beneficiaries.

For most of this broader disability population, the disability or underlying chronic health conditions limit their ability to work. For many, chronic pain and illness truly prevent work.

These beneficiaries, many of whom have a pressing need for healthcare to prevent worsening health and functioning, must not be dropped from the rolls in a rush to implement new requirements.

Instead, states need to carefully consider the ramifications of imposing work requirements on beneficiaries who cannot be readily identified as having disabilities. How will those not administratively classified as “disabled” qualify for exemptions or modifications to such rules in connection with disability or chronic health conditions, without unduly burdening them with bureaucratic barriers that will, inevitably, result in loss of coverage for many? Straightforward procedures must be in place to exempt as many beneficiaries with work-limiting disabilities as possible, and to give others the benefit of the doubt in the face of imperfect evidence of their limitations.

More than half of working-age Medicaid beneficiaries are already working or looking for work. More than one-quarter will need an exemption due to disability. Most of the rest are already engaging in other valuable activities, such as caregiving, attending school, or training for a job. A reasonable target population for work or community engagement requirements is about 6 percent, or 1 out of every 17 working-age Medicaid beneficiaries.

Considering the larger picture, one must wonder what states would gain from imposing work and community engagement requirements on Medicaid beneficiaries, when those requirements would probably cause only a tiny fraction of beneficiaries to transition to employment. Is it worthwhile for states to create a bureaucracy to certify the labor force, disability, and health status of all beneficiaries, not to mention other community engagement activities such as getting an education or job training, caring for family members, and volunteering?

It is hard to imagine any financial incentive for states to invest in an extensive infrastructure to enforce a work requirement, when so few beneficiaries would end up getting jobs. And it is hard to imagine that measurable health benefits would accrue as a result of new requirements, which would probably increase economic and community engagement for so few at the possible expense of dropping from the rolls many others who need health coverage but do not or cannot prove their disability status, labor force participation, or other community activities. States must tread very cautiously when contemplating such a substantial and potentially harmful policy change.

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