

Health Status and Health Care Outcomes in Ohio's Medicaid-Eligible, Non-Working Population

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INTRODUCTION

Employment is a central component of how people contribute to Ohio's society and economy. And because most adults receive health insurance through an employer, it can also have a profound effect on people's access to health care. Yet for a variety of reasons, many Ohio adults do not have a job. This policy brief uses data from the 2015 Ohio Medicaid Assessment Survey (OMAS) to describe Ohio's non-working population — who they are and how lack of employment is associated with health status and health care outcomes. It includes a special focus on lower income adults potentially eligible for Medicaid.

BACKGROUND

Economists have long studied labor force participation as an indicator of economic and social well being. Policymakers are often most interested in adults during their prime working years, especially those who are eligible for government transfers like Medicaid. As such, this policy brief focuses largely on adults age 25 to 64 in lower income households ($\leq 138\%$ of the Federal Poverty Level [FPL]) who are potentially Medicaid-eligible.

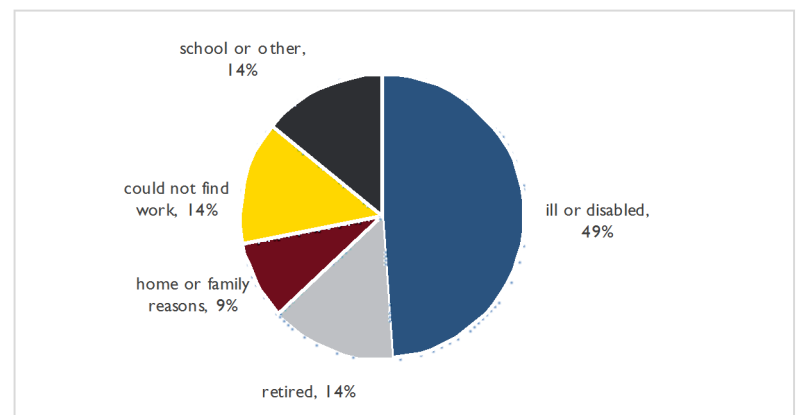
There are variety of reasons why people do not work (Chart 1). Many have a physical or mental disability that limits their employment options, or are unable to work because of their responsibilities caring for children and other family members. Others are retired, attending school full time, or simply cannot find a job.

A large body of research has described how lack of employment can affect health status. People with jobs are more likely to afford to live in healthier neighborhoods, afford healthier foods and access resources like child care and recreation activities that reduce stress and promote health.¹ And because most adults receive health insurance through an employer, lack of employment can have a profound effect on people's access to health care.

Because OMAS was not designed to scrutinize employment, the analyses in this brief focus on disabled and non-disabled adults who are not working, rather than respondents' self-reported *reasons* for not working. So while it is possible to estimate the proportion of non-working adults who are disabled, it is uncertain whether a disability is their primary reason for not working.

Chart 1: Reasons for not working: US adults (25-64) from lower income households ($<138\%$ FPL)

Source: U.S. Census Bureau, 2015 Current Population Survey



HIGHLIGHTS

- Over 77% of Ohio adults with Medicaid are working or disabled.
- Non-working adults — disabled or not — are more likely to have a history of chronic conditions like cancer.
- Non-working adults are more likely to experience worrisome patterns of health care.

OBJECTIVES

This brief aims to answer two questions:

What types of adults are not working? This will include estimating the size and proportion of Ohio's non-working adults — both disabled and not disabled — and describe their demographic characteristics

How is not working associated with access to health care and health care outcomes? Beyond group differences in demographic characteristics, analyses will describe how not working is associated with health care access and outcomes.

METHODS

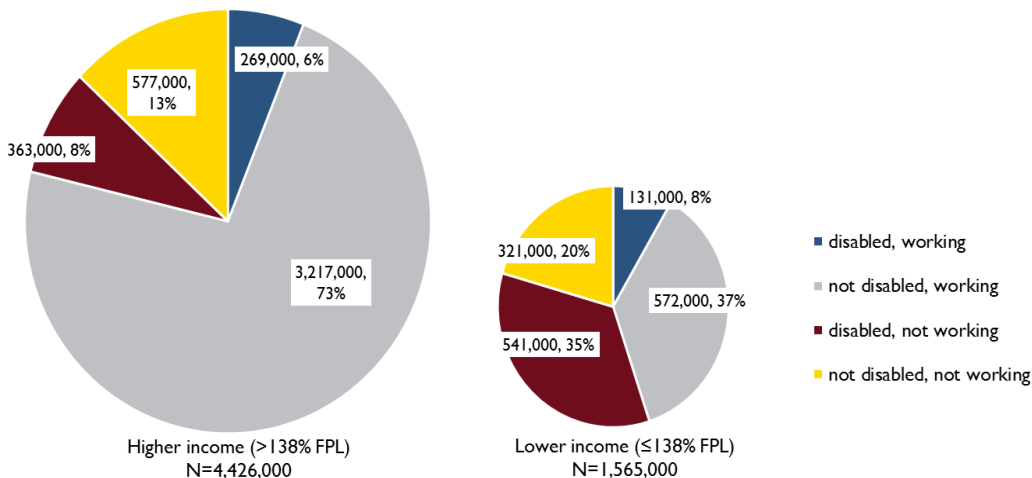
OMAS is a telephone survey that samples both landline and cell phones in Ohio. The survey examines access to the health system, health status, and other characteristics of Ohio’s Medicaid, Medicaid eligible, and non-Medicaid populations. In 2015, researchers completed 42,876 interviews with adults and 10,122 proxy interviews of children. The 2015 OMAS is the sixth iteration of the survey. The estimates in this brief adjust for survey weights and are representative of non-institutionalized adults in Ohio. For details, see the OMAS methods report.²

In the 2015 OMAS, people who answered “no” to the question, “Last week, did you have a job either full or part time?” were classified as “not working.” Disability status was classified by respondents who indicated they met at least one of the following criteria: (1) had a potential disabling mental health condition; (2) involvement in certain disability benefit programs; (3) needed long-term day-to-day assistance, (4) needed special therapies; (5) needed other assistance as an adult with special health care needs who self-rated his/her health status as “fair” or “poor.”

RESULTS

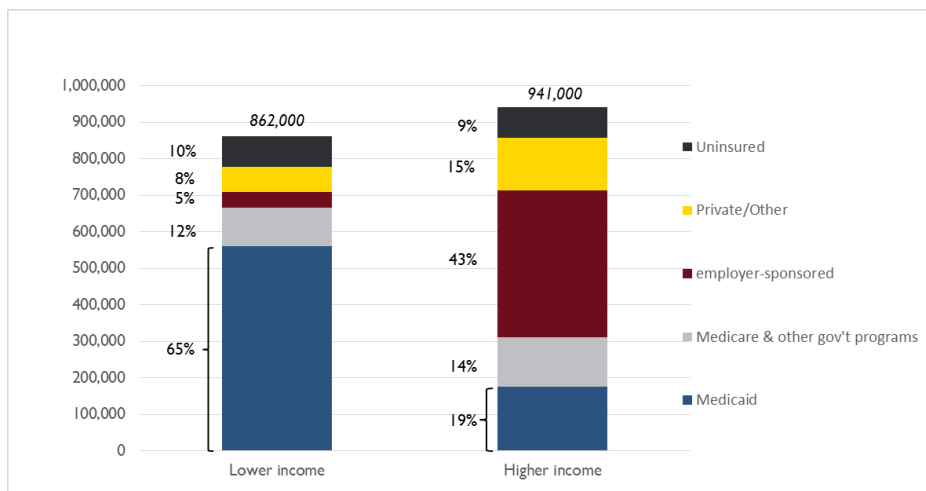
Overall, 30% of Ohio’s adults ages 25-64 (of all income levels) are not working — about 1.8 million people. Older, female and less educated adults are less likely to work, and among those with a disability, white and African-American adults are more

Chart 2: Working and disability status among Ohio adults (25-64) in higher and lower income households



likely than Hispanic adults to report not working. The non-working adult population is about evenly split between those who are disabled (50.2%, 904,000) and those who are not (49.8%, 898,000). It is also evenly split between those who live in higher income households (>138%FPL; 941,000) and those who live in lower income households (≤138%FPL; 862,000).³ The differences between these groups are striking (Chart 2). In higher income households, 21% of adults are not working, including 363,000 who are disabled and 577,000 who are not. In comparison, 55% of adults from lower income households are not working, including 541,000 who are disabled and 321,000 who are not.

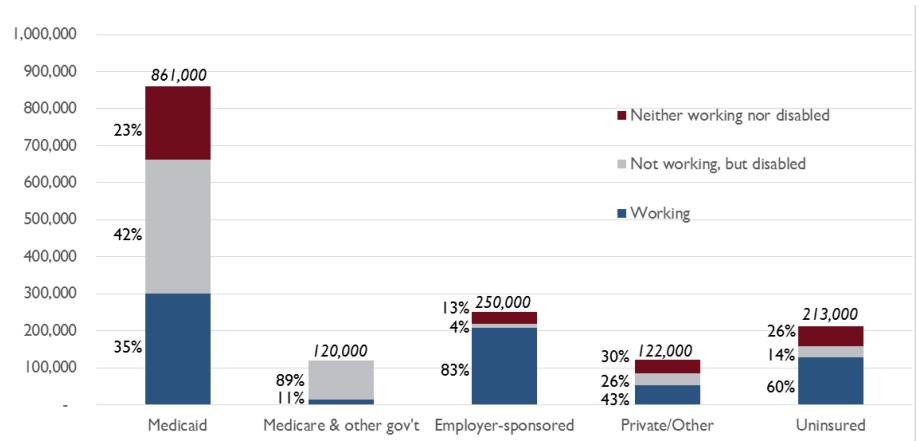
Chart 3: Health insurance type/status among non-working Ohio adults (25-64) in lower versus higher incomes households.



Health insurance coverage varies for non-working adults in higher versus lower income households (Chart 3). Of Ohio’s 862,000 non-working adults from lower income households, 65% have Medicaid, an additional 12% are covered by Medicare or another government program, and only 5% have employer-sponsored insurance. In comparison, of Ohio’s 941,000 non-working adults in higher income households, 19% have Medicaid, 14% have Medicare or another government program and 43% have employer-sponsored insurance. In both lower and higher income homes, about 1 in 10 non-working adults is uninsured.

Chart 4 presents another perspective on the data: the working and disability status of lower income adults by insurance type/status. Most of the 861,000 lower income adults with Medicaid, for instance, are either working (35%) or disabled (42%). Yet 83% of lower income adults with employer-sponsored insurance are working and only 4% are disabled. Such differences persist across insurance type/status, even after adjusting for demographic and health characteristics (not shown).

Chart 4: Percentage of lower income adults (25-64) who are either working; not working but disabled; or neither working nor disabled — differences within each insurance type/status

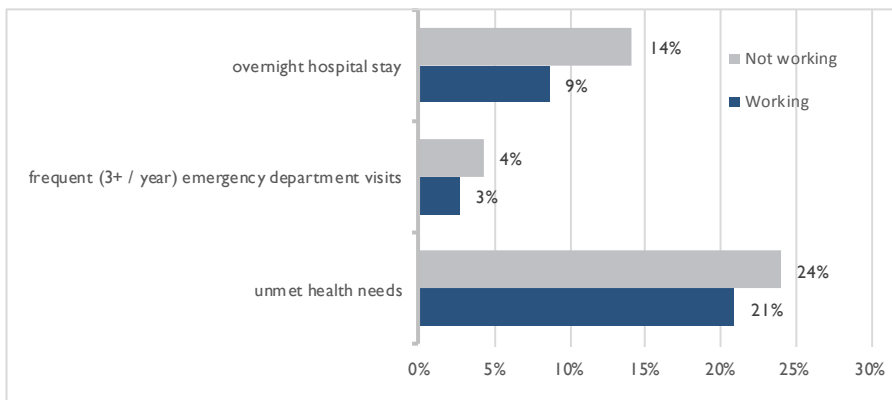


Is lack of employment associated with health status and health care utilization?

Non-working adults tend to have more health problems compared to their peers who work. For instance, they are more likely to have a history of a chronic condition like cancer, hypertension or diabetes (54% vs. 33%). Such findings persist regardless of disability status or income level. For example, among non-disabled adults from lower income households, 28% of workers have a history of chronic conditions compared to 42% of non-workers. Thus, to understand the association of (not) working with health care utilization, analyses should adjust for the fact that non-working adults tend to have greater health needs.

Chart 5 illustrates the association of working status with health care outcomes. Each model presents estimated probabilities⁴ of the outcome for working and non-working adults, after adjusting for group differences in demographic characteristics, insurance type/status and health status.

Chart 5: Estimated probabilities⁴ of health care outcomes among working and non-working Ohio adults (25-64)



Non-working adults are more likely than working adults to report worrisome patterns of health care outcomes, such as having an overnight hospital stay (estimated probability⁴ 14% vs. 9%), frequent emergency department visits (4% vs. 3%) or unmet health needs (24% vs. 21%). This pattern of findings persists whether adults have Medicaid, employer-sponsored insurance or are uninsured.

Other models (not shown) indicate that employment has no association with misusing prescription painkillers or experiencing care consistent with a patient-centered medical home.⁵

POLICY CONSIDERATIONS

In the context of Medicaid expansion, other states (e.g., Arizona) have considered requiring Medicaid recipients to work. Yet analyses of the 2015 OMAS suggest that such policies may be ineffective in Ohio, as over three quarters of Medicaid adults in the state are either already working or are disabled. While the OMAS data are unable to determine their reasons why some adults without disabilities are not working, other research suggests that they have significant caregiving responsibilities for children or other family members that limit their employability.⁶ As such, work requirements for Medicaid recipients may do little to reduce the program's rolls and any reductions may come largely from disenrolling low income caregivers rather than spurning job-seeking.

The cross-sectional (i.e., single point-in-time) design of the OMAS make it impossible to estimate how much (not) working influences health status, versus how much health status influences (not) working. What is clear, however, is that there is a strong relationship between the two. Each possible causal direction has distinct and complimentary implications for policy.

To the extent that employment improves health status and reduces worrisome patterns of health care utilization, Ohio's myriad efforts to promote job growth, may also improve population health and reduce health care costs. While this study was unable to measure any cost savings, even modest improvements in efficiency can yield impressive savings in large systems like Medicaid. Efforts to promote job growth should therefore consider evaluating how they might produce important effects on health status and health care utilization, especially for lower income adults potentially eligible for Medicaid.

It is also likely that health outcomes limit Ohioans' ability to work. Because disabled individuals represent such a large proportion of the non-working population, policymakers should consider how well current job promotion efforts are appropriate for disabled adults who are able and willing to work. State agencies like Opportunities for Ohioans with Disabilities may be vital for improving the Ohio's economy and its residents' health.

Given the associations among income, employment and health status, future iterations of OMAS can be a useful tool for documenting how Ohio's employment trends are associated with the health of its residents. Such research, however, would require measures of employment that are more robust than the single item used in this study. In addition, policymakers may leverage OMAS's large size and complex design to combine its findings with other data sources. Ohio Labor Market Information, for example, provides extensive data at the county level on employment.⁷ Future local, regional or statewide efforts to promote job growth could evaluate their impact though an innovative combination of OMAS and other data sources.

REFERENCES

1. Robert Wood Johnson Foundation. [How Does Employment — or Unemployment — Affect Health?](#) Issue Brief; March, 2013.
2. Ohio Colleges of Medicine Government Resource Center and RTI International. *2015 Ohio Medicaid Assessment Survey: Methodology Report*. Research Triangle Park, NC: RTI International; 2015.
3. Hereafter, "adults" refers to adults ages 25-64 unless otherwise specified, and "lower income households" refers to those with incomes ≤138% of the Federal Poverty Level. ("Higher income" households refer to >138% FPL.)
4. Estimated probabilities are values from a multivariable logistic regression models and represent the estimated percentage of a hypothetical subpopulation predicted to have the outcome, assuming they have otherwise average characteristics. For this brief, statistical models adjusted for age, gender, income, education, race/ethnicity, marital status, household composition, county type (e.g., suburban), insurance type/status, history of chronic conditions, and self-rating health status as "fair" or "poor." (It was not possible to adjust for disability status, as the variable was used to help impute values for insurance type. All estimates adjust for survey weights.
5. For more information on this type of care, see: Wickizer T, Steinman K, Shoben A, Chisolm D, Biehl J, Phelps L.. *Patient-Centered Medical Homes and the Health of Ohio's Adults and Children*. Columbus, OH: Ohio Colleges of Medicine Government Resource Center; 2016.
6. Rupp K, Ressler S. Family caregiving and employment among parents of children with disabilities on SSI. *Journal of Vocational Rehabilitation*; 2009; 30:153-175.
7. Ohio Department of Job and Family Services. [Ohio Labor Market Information](#). Columbus, OH: Ohio Department of Job and Family Services; 2016.

FOR MORE INFORMATION

To view more information about OMAS and the findings in this policy brief, please visit the OMAS website at the Ohio Colleges of Medicine Government Resource Center www.grc.osu.edu/OMAS.

