INTRODUCTION

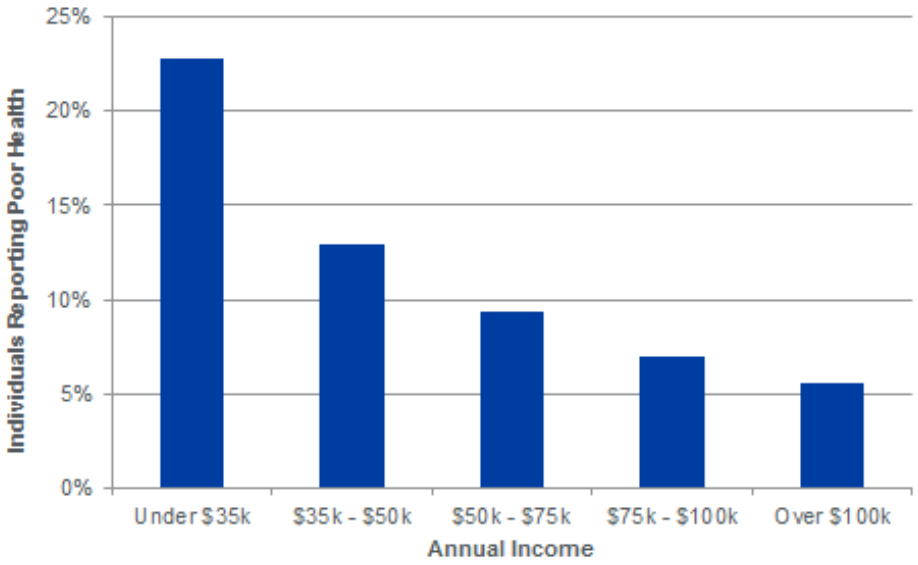
Employment and health are inextricably linked. Employment and income have a direct impact on life expectancy, quality of life, and health care costs. Relatedly, medical health has a direct impact on employability. Acute and chronic illness can prevent work entirely, cause job loss, and prevent wage gain. Despite this clear interdependence, there is little to no history of collaboration between health care (providers, payers, plans) and workforce services.

In May of 2016, the unemployment rate hit 4.7%, the lowest since November, 2007.[i] That same month, the workforce participation rate, or the percentage of Americans participating in the labor force, was 62.6% (a forty-year low).[ii] In short, that means there are more jobs and fewer people working. This represents an unprecedented opportunity to help people with barriers to employment get back into the workforce.

This paper is intended to be an educational tool for health care, work force and policy professionals to understand how the landscape and emerging trends are aligning to drive a new era of collaboration and innovation.

INCOME AND HEALTH: THE CORRELATION

The correlation between income and health manifests itself in countless ways, but all lead to the same conclusion: the poorer you are, the sicker you are, and the more likely you are to die young. As shown in the chart below, 22.8% of people with an annual income below $35,000 report being in poor health, compared to only 5.6% of individuals with annual incomes of over $100,000.[iii]



UnitedHealthcare® COMMUNITY & STATE

The following is a list of some of the most compelling statistics showing the causal relationship between income and health. It is by no means exhaustive.

- In the last four decades, life expectance of male workers retiring at age 65 has risen 5.8 years in for high earners but only 1.3 years for lower earners[iv]
- Between 1988-1998, adults at less than Federal Poverty Level could expect to live 49.2 years after the age of 25, while those at more than 400% could expect to live 55.7 years after 25[v]
- 89% of high income, 74% of mid income and 64% of low income individuals have a regular doctor[vi]
- In the U.S., where we were able to analyze a sufficient sample size, unemployed youth have a worse physical well-being compared with employed older adults — 23% vs. 31% thriving[vii]
- Unemployed youth with college degrees have the lowest physical well-being (14% thriving), followed by those with secondary education (27% thriving) and primary education (28% thriving)
- 83% of laid off workers are more likely to develop a stress-related health condition[viii]

Laid-off workers are **54%** more likely to have **fair or poor health**[1]**.**

People with **lower incomes** are **less likely** to seek preventive care[2]**.**

The correlation also extends to mental health. Those with an annual family income below $35,000 a year are four times more likely to report being nervous and five times more likely to report sadness “all or most of the time”[ix].

UnitedHealthcare® COMMUNITY & STATE

EMPLOYMENT & HEALTH CARE COVERAGE

Employment status is frequently a factor in options for health insurance. Understanding the different ways in which employment status impacts health care coverage is a foundational step in exploring opportunities for the workforce and the health care industry to collaborate. Coverage, eligibility and benefit design fluctuate according to the health care payer.

For those who have health insurance offered through their employer, the employer makes determinations about coverage, benefits and wellness programs. Many employers also find ways to improve working environments to promote physical and mental health in an effort to keep employees productive.

Since the implementation of the Affordable Care Act, millions of Americans without employer sponsored healthcare are purchasing coverage on the exchange. Income determines the availability of subsidies to support individuals purchasing insurance on the exchange. While access to healthcare coverage supports management of health contributing to employment stabilization, plans offered on the exchange are not required to offer employment supports (i.e. assistance getting or maintaining a job).

Of particular interest to this paper are individuals who are Medicaid eligible and individuals eligible for Medicaid-funded long term supports and services (LTSS). As of April 2016, 72.39 million individuals relied on Medicaid, a joint state and federally funded program, for health insurance coverage.[x] To qualify for Medicaid, individuals must meet income guidelines. For childless adults in states that have chosen to expand Medicaid, income must be at or below 138% of the federal poverty limit ($11,880 for individuals).[xi] Many pregnant women or caregivers, who are often covered by Medicaid at higher income eligibility thresholds, are under-employed or unemployed. While their Medicaid benefits help them access care, address health needs and get support needed to stabilize their physical and mental health, they typically do not have access to Medicaid benefits that directly support employment. Furthermore, changes in employment typically result in changes to eligibility for Medicaid resulting in potential disruptions in care.

In contrast, individuals who qualify for Medicaid-funded long term supports and services (LTSS) ***may*** have access to employment supports and services. There is currently no data on the number of individuals receiving employment supports and services through Medicaid on a national level. We do know, however, that based on 2011 data, approximately 4.8 million people received Medicaid-funded LTSS benefits, and of these, 3.4 million of these beneficiaries (71 percent) received home and community-based services (HCBS).[xii]

HCBS are functional supports that allow individuals the support needed to live safely at home or in an integrated community setting. States are required by federal law to

provide access to nursing facilities and other institutional facilities for those that meet institutional level of care requirements. States have the option of providing HCBS to targeted groups of individuals through state plan amendments and waiver authorities. Most states run multiple waivers. Each waiver is specifically designed for a target population with a unique set of HCBS. Environmental adaptations, home delivered meals, personal care attendants and respite care are examples of common HCBS.

States have historically offered employment related supports for individuals with intellectual and developmental disabilities through HCBS waiver programs. In 2011, CMS issued guidance that highlighted "the opportunities available to use waiver supports to increase employment opportunities for individuals with disabilities within current policy."[xiii] This guidance continued to advance supports for competitive employment and called attention to established best practices in supporting employment.

In 2013, CMS again underscored the important role employment can play in health and wellbeing when it encouraged states "to include in their benefit packages supports to enable workforce participation such as personal assistance services, supported employment and peer support services, as appropriate and desired by the participant."[xiv]

A recent study focusing on the impacts Medicaid Expansion has on access to care and employment status for people with disabilities found that individuals in Expansion states reported having a usual source of care post-ACA at a rate of 84.5% versus 74% in non-Expansion states. The study also noted that "post-ACA, respondents in Medicaid Expansion states were significantly less likely to report having been uninsured for the year (-2.6%, $p<0.001$) and more likely to be employed (6.1%, $p<0.001$) compared to those in non-Expansion states." Authors of the report hypothesized that this impact on employment is due to the new opportunity for individuals with disabilities to work, accumulate assets and maintain coverage.

Intersection of Health Care Coverage, Income and Employment

	Employer Coverage	Coverage Available on the Exchange	Medicaid	Medicaid w/ LTSSs Eligibility
Description of Coverage	Employees receive healthcare insurance benefits paid for or subsidized by employer	Individuals without employer-sponsored coverage can purchase coverage and may qualify for premium and out of pocket subsidies	State sponsored health insurance for individuals meeting eligibility criteria	State sponsored benefits that are targeted to individuals with particular functional impairments needing home and community based supports and services
Players	Employer Employee (beneficiary) Health Plan contracted and chosen by the employer	Individual Health plans	Individual State CMS Health Plans (if state has opted for Medicaid Managed Care)	Individual State CMS Health Plans (if state has opted for Medicaid Managed Care)
General Employment Status	Experience relatively stable employment	More likely to be self-employed, have lower wage jobs and/or experience fluctuations in employment status/wage	Experience fluctuations in employment status and likely experience periods of unemployment	Likely experience periods of or consistent unemployment; employment frequently challenging without supports
Income relates to eligibility	No – employment status determines eligibility	Cost assistance is based on your income – which must be between 100% and 400% FPL	Income must be less than or equal to 138% FPL (states may have higher thresholds for some populations)	Income must be less than or equal to 138% FPL (states may have higher thresholds for some populations)
Employment Supports Available through health care coverage	No	No	No, but benefits such as behavioral health access, case management may support success in the workplace	Some home and community based services “programs” offer employment services and supports
Employment & Health Intersection	• Wellness initiatives • Workplace wellness & safety • Work/Life Balance	• Securing or maintaining employment to afford coverage • Addressing changes in coverage associated with fluctuations in employment status	• Finding employment and reducing dependency on programs • Training and education	• Maintaining needed benefits while working • Training and education • Securing and maintaining competitive employment

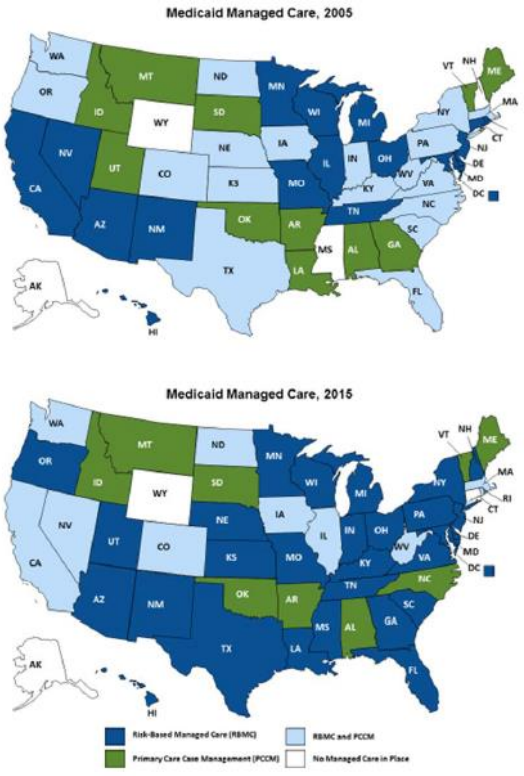
TRENDS IN HEALTHCARE

Four key trends are driving healthcare's interest in collaborations with the employment sector:

- Increasing use of managed care for Medicaid and LTSS programs
- Intensified focus on quality outcomes
- Rising costs and budget pressures
- Growing awareness that outcomes cannot be met without attention to social determinants of health

Increasing use of managed care for Medicaid and LTSS programs

In 2013, there were 62.2 million Medicaid beneficiaries nationally and 71.7% of those beneficiaries were in some form of managed care.[xv] While the term "managed care" can be used to describe a variety of arrangements, the most prevalent model is risk-based managed care. Under risk-based managed care, the state sets a per-member-per-month rate (based on historic utilization trends) for broad categories of individuals, using gender, age and eligibility categories to dictate the rate and payment. The health plan is then responsible for managing the benefits and ensuring the individual receives his/her needed services while meeting access and quality requirements. If service utilization for an individual is above the rate, the health plan must cover the cost of care. If utilization is below the rate, the health plan will retain the balance of the funds not spent for that member. Under-utilization over time can lead to poor



SOURCE: Health Management Associates (November 2015). White Paper: The Value of Medicaid Managed Care. Available at: https://www.healthmanagement.com/assets/News-Articles/HMA-Value-of-MMC-White-Paper-FINAL-111215.pdf.

UnitedHealthcare® COMMUNITY & STATE

quality ratings, unmanaged conditions and increased use of high-cost service. There are numerous regulatory and contract requirements that are built into the managed care arrangements with the state and CMS that drive the health plans to ensure that utilization is not unnecessarily high or inappropriately low.

As of 2015, 22 states provide at least some LTSS under risk based managed care contracts for at least some of the population that is eligible for these benefits; another five states plan to implement new managed LTSS programs in 2016.

Intensified Focus on Quality Outcomes

As states and CMS have looked to reform Medicaid programs, they have focused their attention on the "Triple Aim" – improving costs, quality and experience for the individual. In so doing, states are frequently exploring avenues for paying for quality rather than quantity of services. The shift to quality-based payments motivates insurers and providers to think differently about the services they provide to support health.

All states with Medicaid managed care have external quality review boards and extensive quality monitoring protocols. These monitoring programs typically rely on tools such as Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. Many states have quality targets as part of their contracts with managed care organizations. Several states are also implementing initiatives allow individual seeking services the opporutnity to see health plan performance.

For those who qualify for LTSS programs and ID/DD programs, measuring quality is even more complex. The existing tools of HEDIS and CAHPS do not sufficiently measure overall quality of life that is so critically important to determining successful implementation of HCBS programs. Quality for these programs must relate to individuals' ability to access services and live in the most integrated setting. In 2016, UnitedHealthcare Community & State's National Advisory Board developed a recommended quality framework for MLTSS and ID/DD programs. Within this framework are measures to assess the ability to gain competitive employment.

Rising Costs and Budget Pressures

Program expenditures for each Medicaid enrollee were estimated to be ~$6,900 in 2013.[xvi] It is estimated that enrollment will increase to 78.8 million individuals and expenditures will increase to $835 billion by 2023.[xvii]

Many states continue to struggle to regain general fund revenues on par with pre-recession levels (2008). According to the National State Budget Officers Spring 2016 Fiscal Survey of States, 23 states fiscal 2016 general fund revenues remain below 2008 figures and 29 states report general fund expenditures lower than 2008.[xviii] Medicaid

spending represents 27.4% of total state spending. [xix] Medicaid spending increased by 16.3% in fiscal year 2015 – 6% increase in funding from state funds. This significant increase was driven largely by the growth of Medicaid in states that have chosen to participate in Medicaid Expansion. State spending is expected to grow by 8.3% in 2016. [xx]

While much of this current growth in spending relates to enrollment growth, spending continues to be concentrated with a small number of highest-need enrollees. It is widely noted that 5 percent of Medicaid beneficiaries account for 54 percent of total Medicaid expenditures and 1 percent of Medicaid beneficiaries account for 25 percent of total Medicaid expenditures.[xxi] For the 1 percent, multiple chronic conditions are often a difficult reality. Within that 1 percent, 83 percent have at least three chronic conditions and more than 60 percent have five or more chronic conditions.[xxii]

The occurrence of behavioral health conditions among those with multiple chronic conditions is also high. In 2011, one in five Medicaid beneficiaries had behavioral health diagnoses; however, those with behavioral health diagnoses accounted for almost half of total Medicaid expenditures. This population accounted for more than $131 billion in health care spending across physical, behavioral, and other Medicaid-covered services. [xxiii]

Growing Awareness of Social Determinants of Health

A growing body of research consistently points to factors outside of genetics and behavior that contribute or detract from our health. Researchers point to the United States relatively high spending on health services and relatively low spending on social services compared to similar western countries that experience better health outcomes.[xxiv]

Increasingly, there is a realization that to improve health and control costs, states and insurers cannot focus soley on what happens in the doctor's office. There is a broader need to address the underlying social issues that many Medicaid beneficiaries face. Housing stability, food security, access to transportation and meaningful employment are all contributors to overall health and wellbeing. In many respects, the issue of employment is the primary determinant that could, if stabilized, bring about significant improvements in many other social determinants and health.

There is growing interest and debate as states and CMS consider opportunities to draw attention to services and funding for addressing these social determinants of health. Many of the early efforts to address social determinants of health have been focused on caring for individuals with complex medical, behavioral and social needs. These individuals are often part of the 1-5% of the Medicaid population that drives a disproportionally high spend. Housing and supportive housing services have gained traction as a potential intervention worth investing in to improve outcomes and reduce

overall costs. This conversation has been advanced by a growing number of examples that have been able to detail those cost savings.

THE NEED FOR COLLABORATION

As discussed above, employment and income are key social determinants of health. Not only does unemployment lead to poor health, that poor health makes it more difficult to reenter the workforce, resulting in a perpetuation of the cycle of poverty. For example, as the duration of unemployment increases, the likelihood of becoming employed in the following month declines. In 2014, about 35 percent of people who had been out of work less than 5 weeks found work in the next month; about 11 percent of people who had been out of work for 1 year or longer became employed in the following month. [xxv]

Long-term unemployment also has physical and behavioral health impacts that lead to disability.[xxvi] Job loss decreases life expectancy and increases mortality rates (up to 100% in the year following displacement).[xxvii] Roughly 14.7 million Medicaid beneficiaries are non-aged and non-disabled adults, and about 27.9 million are children.[xxviii] Aged and disabled beneficiaries constituted 27 percent of all enrollees, yet those populations accounted for 64 percent of Medicaid benefit expenditures.

The evidence therefore indicates that short-term unemployment leads to long-term unemployment, which leads to long-term dependence on medical and social supports, disability, and/or poor health. Better collaboration between Medicaid and workforce can help to address this slide into dependence and should serve as a principle to establish necessary collaborations.

Considerations

- Short-term unemployment leads to long-term unemployment, which can lead to long-term dependence on the health care and social services systems, disability, and/or poor health.
- Better collaboration between Medicaid and workforce can help to address this slide into dependence.

BUILDING BLOCKS FOR COLLABORATION

Both workforce and Medicaid serve people who have recently lost their jobs. However, the two industries rarely, if ever, interact.

Assistance is available to people who lose their jobs. Both the Workforce Innovation and Opportunity Act (WIOA) and Temporary Assistance for Needy Families (TANF) allocate money for local workforce authorities to provide assistance to people who are seeking a job (or a better job). That assistance comes primarily in three forms; local "One-Stop" Employment Centers, TANF career centers, and philanthropic, community based organizations. However, the help can be confusing and hard to access.

There are many opportunities for collaboration between workforce and Medicaid that could drive better overall health results. Some key initiatives are described below:

- *Increase Awareness:* Limited interaction between workforce and Medicaid means we rarely speak the same language and frequently fail to understand the opportunities and barriers in place for our respective sectors to work together. MCOs and workforce agencies should begin having conversations about the strengths and challenges in serving their respective populations and identifying where shared priorities may facilitate collaborations.

- *Share to Target Interventions*: MCOs gather and process large amounts of demographic and health information. They have easy access to data regarding concentration of their membership and the relative health of that membership. That data could be used to identify candidates for workforce interventions and match them with job opportunities. It can also be used to coordinate transportation.

- *Measure How Employment Affects Health Care Costs*: MCOs have claims and enrollment information for all of its members. It can track the impact of various types of interventions on long term costs. Once candidates have been identified for workforce interventions, MCOs can track whether employment resulted in improved health and/or disenrollment from Medicaid do to exceeding income thresholds.

  By tracking this information, MCOs and workforce providers will have the necessary information to inform conversations around benefit inclusion and collaborative interventions. This data is critical to advancing advocacy that supports state and federal policy makers in reforming the system.

- *Build an Integrated Solution*: Obstacles to better employment are often medical in nature. Acute and chronic medical conditions can make it difficult to maintain a job or move up the workforce. Both MCOs and workforce utilize case managers to address the many factors preventing better health or better employment. However, few, if any, are cross trained in the other discipline. Furthermore, existing funding structures do not allow for the coordination of resources across disciplines. Opportunities to facilitate cross-sector training could be an initial step toward a more integrated solution.

CONSIDERATIONS FOR POLICY MAKERS

To make these collaborations more effective, policymakers should reshape funding structures and program policies to reward work that integrates employment and healthcare interventions. Currently, there are significant barriers for health plans to integrate with workforce entities.

State policy makers can also work to foster an environment of collaboration. For states with established managed care programs – especially managed long term supports and services programs – vocational rehab and workforce entities should be engaged and aware of changes in the Medicaid program and encouraged to work collectively to provide seamless service.

State policy makers can also support this collaboration by encouraging innovation and tolerating that potential for both success and learning.

When possible, policy makers should explore opportunities to extend Medicaid employment supports and services benefits to targeted individuals who would benefit.

---

[i] Bureau of Labor Statistics, http://data.bls.gov/timeseries/LNS14000000
[ii] Bureau of Labor Statistics, http://data.bls.gov/timeseries/LNS11300000
[iii] Source: Schiller, J. S., J. W. Lucas, and J. A. Peregoy. 2012. "Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2011." Vital and Health Statistics 10 (256): Table 21. http://www.cdc.gov/nchs/data/series/sr_10/sr10_256.pdf
[iv] RWJF, How Does Employment-Or Unemployment-Affect Health? http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf424902
[v] Paula Braveman, Susan Egerter, and Colleen Barclay, "Income, Wealth and Health," Exploring the Social Determinants of Health, (Princeton, NJ: Robert Wood Johnson Foundation): 2011.
[vi] http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2004/oct/wages--health-benefits--and-workers-health/788_collins_wageshltbenefits_workershlt_ib-pdf.pdf
[vii] https://hbr.org/2016/10/the-health-effects-of-youth-unemployment
[viii] RWJF, How Does Employment-Or Unemployment-Affect Health?
[ix] http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000178-How-are-Income-and-Wealth-Linked-to-Health-and-Longevity.pdf
[x] https://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/april-2016-enrollment-report.pdf
[xi] https://www.healthcare.gov/glossary/federal-poverty-level-FPL/
[xii] https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/ltss-beneficiaries-report-2011.pdf
[xiii] https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-09-16-2011.pdf
[xiv] https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/1115-and-1915b-mltss-guidance.pdf
[xv] Health Management Associates (November 2015). White Paper: The Value of Medicaid Managed Care. Available at: https://www.healthmanagement.com/assets/News-Articles/HMA-Value-of-MMC-White-Paper-FINAL-111215.pdf.
[xvi] Id
[xvii] Id
[xviii] https://www.nasbo.org/sites/default/files/Spring%202016%20Fiscal%20Survey%20of%20States-S.pdf
[xix] Id

[xx] Id
[xxi] Mann C.Medicaid and CHIP: On the Road to Reform. Presentation to the Alliance for Health Reform/Kaiser Family Foundation. March 2011. Based on FY 2008 MSIS claims data.
[xxii] Kronick R, Bella M, Gilmer T, and Somers S. The Faces of Medicaid II: Recognizing the Care Needs of People with Multiple Chronic Conditions. Center for Health Care Strategies, Inc. October 2007. Available from: http://www.chcs.org/usr_doc/Full_Report_Faces_II.PDF
[xxiii] https://www.macpac.gov/wp-content/uploads/2015/06/Behavioral-Health-in-the-Medicaid-Program%E2%80%94People-Use-and-Expenditures.pdf
[xxiv] http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf415185; *The American Healthcare Paradox*
[xxv] http://www.bls.gov/spotlight/2015/long-term-unemployment
[xxvi] http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412887-Consequences-of-Long-Term-Unemployment.PDF
[xxvii] Id
[xxviii] Id