

**SYNOPSIS** » Direct care workers and long-term care employers are facing greater challenges than ever before in securing affordable health coverage. In an era of soaring health insurance premiums and state fiscal crises, the prospects for expanding health coverage for more direct care workers seem daunting. But there are ways to design health insurance packages so that they are reasonably priced for direct care workers and long-term care employers. This issue brief presents the case for improving health coverage to direct care workers and offers realistic strategies for making health coverage more available and more affordable to them and their families.

## Health Insurance Coverage for Direct Care Workers: Riding Out the Storm

### INTRODUCTION

Karen Thompson is one of 13,000 home care workers in Oregon who until recently worked without health insurance protection. Earning \$900 a month caring for her disabled husband, she made too much money to qualify for the Oregon Health Plan, a state-sponsored health insurance program for low-income people. But her income was also not enough to pay for insurance.

Karen is also recovering from cancer, which was detected late due to her lack of health insurance, and has medical bills expected to surpass \$100,000. "I relied totally on charity care, throwing myself at their mercy," Thompson said. "I told them, 'I'll do what I can to pay them back later, but right now I want to live.'" Last fall, however, home care workers who are members of SEIU Local 503 in Oregon won health insurance benefits through collective bargaining. While the benefits, which begin April 1, 2004, won't help Karen pay off her medical debt, she will have insurance for her future medical care.

There are thousands like Karen across the country. One in every four direct care workers lacks health insurance coverage, a rate that is



Karen Thompson

50 percent higher than those in the general population under age 65.

The prospects for increasing health insurance coverage for direct care workers may look very discouraging right now.

Health insurance premium rates are soaring, state fiscal crises are forcing cuts

in eligibility for Medicaid and other programs to help the uninsured, employers are scaling back health benefits or requiring increased cost-sharing, and direct care workers' wages are too low for them to afford ever higher premiums and co-pays. But Oregon's home care workers show that there are viable strategies for providing health coverage to direct care workers and ways to ride out the storm.

This issue brief lays out the challenges and opportunities for improving health insurance for frontline workers in the long-term care sector. It describes the scope of the problem, why there is such a high rate of uninsurance among direct-care workers, and how employers decide to provide health benefits to them. It provides examples of innovative models of coverage tar-

CREDITS: This issue brief was written by Debra Lipson, Deputy Director of Better Jobs Better Care at the Institute for the Future of Aging Services (IFAS) and Carol Regan, an independent health policy consultant. The authors acknowledge and appreciate research assistance from Natasha Bryant, Research Associate at IFAS and Barbara Frank and Paul Saucier for their thoughtful review and comments.

geted to frontline workers. It concludes that while the winds blowing against efforts to expand coverage are high, there is still room for optimism about options for improving health coverage to direct care workers.

This brief was written for those who care about improving health coverage for direct care workers, but are not health insurance experts. Since health insurance is very complicated, the issue brief cannot cover in depth many technical issues involved in actually implementing options for expanded coverage. Those who wish to pursue particular strategies are encouraged to contact experts in health insurance policy design, Medicaid eligibility options, and other areas relevant to their particular interests. The BJBC National Program Office can provide some technical assistance and referrals to get you started.

#### SCOPE AND CAUSES OF THE PROBLEM

Today, one of every six Americans under the age of 65 – over 44 million people – lack health insurance coverage at some point during the year (US Census Bureau, 2003). During 2002, an estimated two and a half million people lost their health care coverage, the biggest one-year increase in the previous ten years. Those hardest hit are low-wage working people and their families.

The problem is worse among the estimated 2.2 million direct care workers, including nursing aides, home health aides and personal care or home care workers nationwide. About a quarter of all nursing home aides lack health insurance. And the situation is even more dreadful for home care aides with uninsurance rates ranging from 40 to 45 percent. (Yamada, 2002; Case, et.al. 2002; Cousineau, 2000).

What is it about long-term care jobs that result in this higher rate of uninsurance? The reasons are rooted in the employment conditions and demographics of the direct care worker population. Uninsurance rates are higher for all the groups that are disproportionately represented among direct care workers: low-wage workers; those in service occupations; part-time workers; minorities and foreign-born individuals; and those with a high-school education or less.

While nearly two-thirds of all Americans under age 65 obtain health coverage through an employer, only about 42 percent of nursing home aides and 26 percent of home care aides

do so (see chart on p. 3). Direct care workers often lack employer-based health coverage due to the following reasons:

- **Not all employers offer health coverage.** Nearly all long-term care organizations that participated in recent nationwide surveys reported that they have a health insurance benefit (Hospital and Healthcare Compensation Service, 2002 & 2003).<sup>1</sup> But as the cost of health insurance has soared in the past few years, some employers have decided to drop family, and sometimes even individual, coverage, or cut back on benefits and increased co-pays.
- **Self-employed workers lack access to employer health plans.** A large proportion of direct care workers are self-employed — 29 percent according to a study by Leon and Franco (1998). Independent providers of home care or personal assistance, who are self-employed or work for an individual rather than an agency, usually lack access to group health insurance. Furthermore, about one in five home health aides and one in 10 nursing aides work for temporary agencies or “registries”, which rarely provide health coverage to employees.
- **Not all employees are eligible for employer-sponsored health benefits.** Because many direct care workers only work part-time, or whose work hours fluctuate each week, they are often not eligible for employer health coverage, which usually requires that employees work at least 30 hours per week. In addition, many nursing facilities require workers to be employed two or three months before workers are eligible to join the health plan; home health agencies and hospices are more likely to offer it upon employment or after a month (HHSC, 2002 and 2003). With very high turnover rates among newly employed nursing home aides, many do not work long enough to qualify for health coverage.
- **Not all employees enroll in an employer health plan, usually due to cost barriers.** Many workers eligible for employer health benefits decide not to participate in it because they simply can't afford it. About one in 10 nursing homes and home care agencies do not pay any portion of the



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health premium at all (Yamada, 2002). At the salaries paid to full-time nursing home aides, individual coverage that averages \$3,380 is almost 25 percent of total income, and family coverage at \$9,000 annually is over half of their income. Such sums are clearly out of reach for them. Many employers contribute a substantial portion of premium rates for individual employees, but in response to soaring rates in recent years, employers are shifting more of the share of the cost to employees. For low-income employees, these additional costs can tip the scale and force them out of the plan.

ineligible for coverage. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 prohibits insurers from denying coverage to small employers (2-50 employees) based on their industry or high risk. But insurers can still refuse to offer health coverage to employers with more than 51 workers in high-risk industries – those characterized by having a largely older workforce (over age 60), high turnover rates, and exposure to hazardous work conditions – all common in the long-term care industry.

If they can get group health insurance, small

### HEALTH INSURANCE STATUS, 1999-2000

|               | All Non-elderly Adults | Nursing Home Aides | Home Care Aides |
|---------------|------------------------|--------------------|-----------------|
| Employer plan | 68%                    | 42%                | 26%             |
| Medicaid      | 6%                     | 11%                | 16%             |
| Other*        | 8%                     | NA                 | NA              |
| No insurance  | 18%                    | 24%                | 40-45%          |

Sources: Yamada, 2002; Case, et.al., 2002; and Kaiser Commission on Medicaid and the Uninsured, 2000

\*Other includes private non-group coverage and other public insurance, mostly Medicare and military-related



### EMPLOYER CHALLENGES TO OBTAINING AFFORDABLE HEALTH COVERAGE

Long-term care employers' decisions to offer health coverage to direct care workers and their ability to afford premium rates depend on a number of considerations. One key factor affecting their decision to offer coverage is the size of their workforce. Large and mid-size employers with more than 200 employees, and national chains with thousands of employees and locations across the country, have the cost advantage. They can more easily negotiate better rates from insurance companies and tailor the benefit package to their needs. The largest firms can self-insure if they choose, i.e. assume the insurance risk and operate under somewhat looser federal laws rather than state regulations.

Small employers—those with fewer than 50 or even 100 workers — face greater problems finding affordable group health insurance. Employers in certain industries, including nursing homes, may be “redlined” or considered

employers including some long-term care employers often face higher premiums. Employers with less than 25 employees are charged 5 to 10 percent higher premiums than the largest employers (Gabel, et.al. 2003).<sup>2</sup> And because most private insurers set premium prices using “experience rating” — based on expected health care use of the group — long-term care providers are at a disadvantage because their workforce is largely women, who use health services more than men. Health insurance industry representatives in Minnesota said rates are higher for the long-term care industry because workers had higher than average costs per hospital admission, higher than average number of prescriptions per year, and a higher prevalence of depression, asthma, obesity, back problems, diabetes and high blood pressure (Minnesota Department of Health, 2002).

In addition, insurers will not cover small firms unless most employees enroll; in low

### Direct Care Workers Opinions on Employee Contributions to Benefits

*From a summary of a focus group in which participants were direct care workers in Pennsylvania. It appeared in "In Their Own Words, Pennsylvania's Frontline Workers in Long-term Care," Pennsylvania Intra-governmental Council on Long-term Care, February 2001. [www.workforce21.net/report\\_care.pdf](http://www.workforce21.net/report_care.pdf)*

- \* Participants said they are willing to make a contribution toward benefits if that contribution is realistic. Requiring a direct care worker to pay the same bi-weekly contribution, as an RN or administrative staff member is unrealistic considering pay disparity. Participants consider a percentage of salary deduction to be fairer than deducting a set dollar amount that is the same for everyone regardless of pay rates.
- \* Participants also felt that direct care workers who do not use company-provided benefits should receive remuneration. One organization pays full-time employees 15% more an hour if they don't use benefits. Part-time employees receive 8 percent more per hour. In some cases, if a direct care worker does not need benefits, he or she does not receive any reimbursement, according to participants. From the focus group participants' perspective, that individual is not being equally compensated when compared to coworkers who receive company-provided or company-subsidized benefits.
- \* Overwhelmingly, participants think part-time employees should be eligible for benefits if they work 25 hours or more a week. They also felt part-time employees should be eligible for holiday pay and paid time off. According to the participants, some organizations do offer benefits to part-time employees. However, several participants indicated that the contribution part-time employees make toward their benefits is higher than full-time employees' contributions. Participants did not understand why part-time employees, who typically make less money, are required to pay more for their benefits.

wage firms that means the employer share of the premium must be at least 75 or 80 percent to induce sufficient enrollment. A Massachusetts study of health and human services workers found that when employers paid 75% of the individual premium costs (63% for family), only about 60 percent of nursing home workers enrolled (Massachusetts Division of Health Care Finance and Policy, 2003). Higher premium costs may make small employers hesitant to offer such coverage. In a 2003 survey, three-quarters of small employers cited high premiums as the reason for not offering coverage, compared to two-thirds in 2001 (Kaiser and HRET, 2003).

In addition to size and access to group insurance products, major sources of revenue can affect the funds available to purchase employer health coverage. For example, nursing homes and some home care/personal care agencies that are more dependent on Medicaid revenues may be at a disadvantage when it comes to covering the cost of premium increases. If they are located in a state that has frozen or cut Medicaid reimbursement rates in the last few years<sup>3</sup>, it will be harder for them to cover

the cost of health plan premium increases. On the other hand, states that have passed Medicaid "wage pass-throughs" may enable long-term care providers to cover rising health premiums with those funds, as long as there is flexibility to use the funds for wages *or* benefits (PHI and IFAS, 2003). Long-term care providers with a greater share of private pay patients have other revenues to apply towards rising insurance costs, but there may be limits to rate increases in the private market. Home health agencies, which usually have higher proportions of revenue from Medicare, are also in a better position to offer more generous health insurance benefits to workers.

### KEY DESIGN ISSUES

Developing employer-based health insurance plans that are affordable both to long-term care employers and to direct care workers involves consideration of an array of design issues. As explained below, changes in benefit design may make health insurance more affordable to employers and there are ways to increase the availability of coverage to direct care workers.

Most of the options described, however,



About one in 10 nursing homes and home care agencies do not pay any portion of the health premium at all.

involve difficult trade-offs between access, cost and the quality of coverage. Efforts to lower premium costs tend to produce health insurance benefit plans that are less generous and therefore offer less financial protection to workers. Efforts to expand coverage to more direct care workers come with a price. The trick is to find the right balance between cost and coverage and to secure a funding partner willing to subsidize the additional cost of improved coverage.

- **Eligibility/Minimum Hours.** While most nursing homes offer coverage only to aides working full time (either 37.5 or 40 hours/week), some allow part-timers to purchase insurance. For example, Cooperative Home Care Associates in New York City pays 100 percent of the premium cost for full-time employees and prorates the pay-

“With more creativity and dedication to building ports in the storm of rising health costs, workers like Karen Thompson will no longer have to face crushing debt when they or their family members get sick.”

ment for part-time employees. Some home care agencies base eligibility for health coverage on hours worked per month rather than per week. Many public authorities in California set the minimum hours per month to permit greater access (e.g. 35 hours); New York City and Oregon have an 80-hour per month eligibility rule. Some direct care workers think part-time employees should be eligible for benefits if they work 25 hours or more a week (see box on p. 4). While lowering the minimum number of hours worked per week or per month can help more workers participate in an employer health plan, the trade-off is that insurance companies may consider a part-time workforce to be riskier and more expensive to cover.

- **Health Services Covered.** Benefit packages that are minimal (some outpatient care and limited hospital admissions) are less expensive than comprehensive ones, covering the full spectrum of medical, hospital, dental, prescription drugs, prevention, and mental

health services. Many firms search for the middle ground by setting limits on the number of days or visits or tests covered, or requiring enrollees to pay higher co-payments for covered services or medications. But this raises out-of-pocket costs to low-wage workers who can ill afford it. While leaner benefit packages can help to reduce premium cost, they also increase the likelihood that many workers will be underinsured, i.e. having a policy that fails to cover needed services resulting in out-of-pocket expenses that cannot be paid. More employees may also find minimal benefit packages to be less valuable, leading to lower participation rates.

- **Premiums and other Cost-Sharing.** Unless premiums and out-of-pocket costs are minimal, low-wage workers will not

enroll. Studies show that as premiums increase above four or five percent of family income, enrollment among low-income people falls drastically (NASHP, 2003; Ku and Coughlin, 2000). When premiums rose to more than 10 percent of income, only a small proportion of the eligible group is willing to buy coverage. Another reason to keep premiums low is that only sicker individuals will buy into the plan if the cost is very high because they really need it (referred to as adverse selection), whereas healthier people will opt out. That would leave a more costly group for the employer. One multi-state continuing care retirement community with 7000 employees, Erickson Retirement Communities, implemented a two tier premium structure, with discounted premiums for ‘service level’ employees, such as nurse aides, housekeepers, dining staff, etc. For example, the discounted premium for an individual standard option medical plan is just \$6.87 bi-weekly. To keep premiums affordable, some suggest the use of sliding fee scales that set premi-



ums based on percentage of wages or family income (Neuschler and Curtis, 2003).

- **Individual versus Family Coverage.** It is important to consider the value to workers of providing individual and family/dependent coverage versus individual workers only. Most states have State Children's Health Insurance Programs (S-CHIP) that provide coverage to children in low and even middle-income families, and a few states offer coverage to their low-income parents. Thus, it may be possible to provide coverage to children of direct care workers through these programs. The downside is that such programs rarely cover the spouses of direct care workers, who often need health insurance too. Groups such as the Cooperative Home Care Association in New York City, which offers individual and spouse health coverage, screen workers to determine if their children qualify for public programs and help them enroll. As explained later, in some states Medicaid and S-CHIP programs can be tapped to subsidize employer and/or employee premiums for family coverage.
- **Type of Health Plan.** The cost of health insurance coverage can sometimes be lowered by offering an HMO that contracts with a specific set of health providers. While the difference in price between HMOs or other managed care plans and traditional fee-for-service plans is not as significant as it once was, there may still be some savings. Warm Hearth Village, a retirement community in Blacksburg, VA which has 213 employees and provides a continuum of care from independent living through nursing home, offers a choice between managed care plan or point-of-service plan that charges more for using non-network providers. Smaller employers, however, might have a hard time offering a choice of two plans and getting adequate participation in both.

Some of these options may be more appropriate or feasible with certain groups of direct care workers. It is also essential to consider possible interactions among the design features. For example, home health aides and personal care assistants often work fluctuating hours and may work for multiple employers. This makes it hard both to meet the minimum work hours per week or month to qualify for

an employer-sponsored plan, and to budget for the workers' premium share because monthly earnings vary. Reducing a waiting period for coverage from 90 to 30 days might increase access, but even if this helps to reduce turnover, insurers may not reduce premiums. Low-wage workers whose children qualify for Medicaid or SCHIP can face disincentives to add hours or accept overtime assignments if that means their earnings rise above the state income eligibility requirements causing them to lose health coverage for their kids. These examples illustrate the importance of careful planning when designing or before making changes to existing employer-sponsored health insurance policies.

### COVERAGE MODELS AND APPROACHES

Despite the complexity, it is possible to design health insurance programs for low-income direct care workers and put them into practice. This section describes strategies to improve health insurance plans for front-line workers that have been applied in a variety of long-term care settings.

The common thread to these approaches is adequate financing to help subsidize the cost for those who cannot afford it. Most direct care workers are willing and able to pay something, but given their low family incomes, the amount is relatively low. Thus, employers and unions, state and local governments, insurers and health care providers must work together to make the cost affordable. As the approaches below illustrate, public funding from some source is almost always needed to subsidize direct care workers' premium share.

**Medicaid and other public insurance program coverage expansions.** Frontline long-term care workers often have incomes so low that they qualify for publicly-financed health coverage. For those who do not have access to an employer-based health plan, because they are self-employed or do not work enough hours to qualify or their health condition excludes them, public insurance coverage is an important option.

If direct care workers live in families with incomes at or near the poverty line (\$15,260 for a family of three), they or their children could be eligible for Medicaid, the state children's health insurance program (SCHIP) or another state health program. In the late



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1990s, about one in ten nursing home aides and nearly one in seven home care aides were covered by Medicaid (Yamada, 2002). Each state has different income limits that determine eligibility for these programs so low-income workers may be eligible in one state but not another.

**Example 1:** Mary, a single mother of two children living in Iowa who works 30 hours per week at \$7.50 per hour as a home health aide, earns \$11,700 per year. Her employer offers benefits and her share of the premium would cost her \$25.50 per week (\$1,325 per year). In Iowa, working parents with incomes up to 84 percent of poverty (equal to annual earnings of \$12,818 for a family of three) are eligible for Medicaid, so Mary and her children can get Medicaid coverage.

**Example 2:** Rosa, a single mother of two living in Georgia works as a full-time nurse aide. Her employer offers individual health insurance coverage and her share of the premium would be \$115 per month. Working 35 hours a week at \$6.50 per hour, she would have to pay nearly 15 percent of her income for the premiums, before taking into account copays and deductibles. Her children qualify for state Medicaid coverage since she earns less than \$14,480 annually. But in Georgia, adults cannot earn more than \$6,371 to qualify for Medicaid.

As income eligibility thresholds and enrollment requirements vary across states, and can change frequently, it is important to keep up-to-date with the situation in your state. States have broad authority to extend Medicaid eligibility beyond the federal minimum standards. Persuading state governments to take advantage of these options requires intensive advocacy. Those interested in exploring these options, which are multiple and complex, should consult with Medicaid and state health program experts or contact the BJBC National Program Office.

**State premium subsidies for workers or employers.** Rather than enrolling low-income workers into public insurance programs, states may choose to subsidize employees' or employers' premiums for private employer-sponsored health plans. There is strong rationale for doing

so: 1) it builds on the employer-based insurance system, through which the majority of working Americans get covered; 2) it gives workers access to mainstream health providers, rather than just those who accept Medicaid; 3) it can reduce public costs if workers would otherwise enroll in Medicaid; and 4) it offers the potential for covering all family members of the worker. There are administrative challenges, however, to the design and implementation of such programs that need to be taken into account (Kaiser Commission on Medicaid and the Uninsured, 2003).

States can provide premium subsidies through their Medicaid program (with or without a waiver of some federal requirements) or via state-only programs that do not get federal funds. About 14 states had such programs as of April 2003. To obtain federal matching funds, states generally must show that it is cost-effective to pay beneficiaries' premium, deductibles, and other cost-sharing obligations of an employer plan.<sup>4</sup> Funds for health insurance premium subsidies for direct care workers might be earmarked in long-term care providers' Medicaid payment rates. Some states, like Massachusetts and Maryland, also have employer buy-in options under separate SCHIP programs, which qualify for higher federal matching rates.

Maine's new Dirigo Health Plan, when it begins later this year, will provide subsidies for low-income workers including direct care workers, to buy into employer-based private health insurance if they work for small businesses (less than 50 employees). Employees are eligible if they work a minimum of 20 hours per week and there is no waiting period to receive coverage. Employer contributions will be no greater than 60 percent of the premium cost. Funding for the premium subsidies will come in part from federal matching funds. While programs like this hold promise, they do not help direct care workers employed by firms with more than 50 employees.

States may also subsidize private coverage without federal funds, to avoid complicated or restrictive federal rules. For example, Rhode Island uses state-only funds to cover qualified home-based child care providers and dependents through its RItCare program and also subsidizes the cost of employer-sponsored coverage provided by licensed childcare centers. Pennsylvania's adultBasic premium subsidy pro-



gram for adults aged 19 to 64 with incomes up to 200% FPL is funded with \$76 million from the tobacco settlement. However it has a waiting list of 72,000 to join the program and many now enrolled may be dropped next year due to funding shortfalls.

**Employer purchasing pools.** To help small employers increase their bargaining power with insurance companies for more competitive rates, group purchasing arrangements (GPAs) have been established around the country (Kofman, 2003). These include employer purchasing alliances, health and welfare funds, multiple employer welfare arrangements, and association health plans which differ in their structure and operation. For example, 66 home care agencies under contract with New York City's Human Resources Agency have partnered with the 1199 SEIU Health and Human Service Employees Union. The 45,000 workers employed under a collective bargaining agreement make a cents/hour contribution to the 1199 National Benefit Fund for Home Care Workers, which purchases coverage for 39,000 eligible workers and their families. While GPAs have helped to increase plan choice for employees in small firms, they have not achieved significant cost savings (US GAO, 2000).

A variation on employer purchasing pools is a model tailored to the needs of independent home care workers directly employed by clients. To overcome the barrier to group insurance faced by these workers, some states have formed organizations that pool workers to purchase group health coverage, among other services. Counties in California and the state of Oregon, for example, have organized "public authorities", which serve as an employer-of-record for self-employed home care workers. The authorities serve as purchasing agents, making it possible to enroll individuals in a health insurance plan. Because the workers in some California counties and in Oregon are now unionized, they bargain for low premium contributions and better benefits; for example, San Francisco IHSS workers pay only \$3 per month for health coverage. Maine's home care aides, who recently organized a union, aim to secure health insurance through an independent living center, which serves as their employer-of-record.

**Use of other public insurance plans.** To get around barriers created by private insurers,

some direct care workers are obtaining health coverage through various types of publicly-sponsored insurance programs. Since the programs are already operational, there is no need to set up new administrative and purchasing functions. For example, in California, six counties cover In-Home Supportive Services workers through county-sponsored health insurance plans, which use county facilities as providers. Connecticut passed a law in 2003 allowing personal care assistants who belong to the professional association of such workers to purchase health coverage through a municipal health insurance plan. Massachusetts is studying how they might cover direct care workers under the state employee's group insurance program. And some states operate their own health plans for low-income workers or small employers that may be a resource for direct care worker groups. For example, Washington's Basic Health Plan provides subsidies to help uninsured individuals afford the cost of coverage, although caseload caps and premium increases will make this program less accessible in 2004.

**Other Strategies.** Two other approaches – tax incentives and medical savings accounts — are important to discuss since they are attracting greater interest among federal and state policymakers as ways to expand coverage of the uninsured. At least 15 states currently offer tax incentives to employers who offer, or employees who purchase, health insurance. These may be tax credits (subtracted from income tax liability) or tax deductions (which reduce taxable income). However, the amounts are usually limited to about \$1,000, which is much less than the cost of insurance for an individual. And to be used by low-income people who owe little tax, credits would likely have to be refundable. Medical savings accounts, on the other hand, are not insurance products per se. Rather, they set aside funds for each person to pay for the cost of health insurance or health care expenses. Proponents say that MSAs give employees more incentive to shop around for the best rates and allow employers to define their contribution based on what they can afford. Research indicates that the funds work best for healthy workers since those with greater health needs incur high out-of-pocket costs for uncovered services. A CMS-funded project in New Mexico plans to combine the



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## Do Better Health Benefits Boost Recruitment and Retention of Direct Care Workers?

The link between wages, health insurance, and the recruitment and retention of workers has been studied for years, yet the relationship remains unclear. It is often assumed that employers provide health coverage as a job benefit because employees want it and are willing to “pay” for it through reduced wages. Whether or not wages are actually lower is doubtful; data show that most workers with health insurance plans earn more, not less, than do workers without health benefits. Nonetheless, high and low-income workers alike value employer-based coverage because group health insurance is priced lower than individual policies, insurers cannot exclude individuals perceived to be high medical risks, and employer provided health coverage is treated as “pre-tax” income. Two-thirds of workers say health insurance is the most important employee benefit (Salisbury and Ostuw, 2000).

At the same time, much of the value to providing health insurance accrues to employers (O’Brien, 2003). They too have significant tax incentives to offer coverage.\* In addition, health benefits can help to attract and keep high-quality workers – at least among workers who value protection against the high cost of medical care. In a recent survey, three in four small employers believed that offering health benefits helped retain employees. But empirical evidence on the relationship between health insurance and turnover rates is mixed; some studies have found that it contributes to lower turnover, while others found no or very little impact on turnover (O’Brien, 2003, p. 16-17). Providing health coverage may also boost productivity by contributing to better health, shorter or fewer absences, and lower worker compensation or disability insurance costs.

Only a few empirical studies have explored the connection between compensation, including health insurance, and recruitment and retention of direct care workers. Howes (2002) studied the impact of wage and benefit increases on supply and turnover rates among in-home supportive service providers in San Francisco. Over a four-year period of wage and benefit upgrades, there were greater spikes in the

number of family members who applied to become care providers than non-family members after health insurance was added as a benefit. Howes found that the turnover rate for providers fell by 17 percent; when adjusted for turnover due to consumers leaving the service, the turnover rate actually fell by 30 percent. But because the introduction of health coverage coincided with hourly wage raises, the study could not measure the effect of health insurance alone.

When direct care workers’ pay is so close to the poverty level, it would not be fair to ask them to make a choice between higher wages and better health benefits. Nonetheless, it would be helpful to know under which conditions health benefits serve as a key factor in the recruitment and retention of direct care workers and the effect of health status or other personal characteristics. Last October the federal Centers for Medicare and Medicaid Services awarded three grants to conduct demonstration projects that will test whether improving health benefits can be an effective tool for recruitment and retention of home health and personal care aides working in community-based settings.

Maine, for example, plans to offer its new Dirigo Health plan to 5,000 direct service community workers employed by 150 Medicaid and state-funded home care and personal assistance services, employers with less than 50 employees. The program will determine whether: 1) employers offering affordable health benefits to workers have better recruitment and retention rates for direct service workers than those that do not; and 2) employers offering health coverage and “employer-of-choice” workplace services such as orientation and training, peer support and mentoring, and employee career development, show even better recruitment and retention rates than those offering just health coverage.

Assuming these projects are implemented and that health benefits turn out to be important to direct care workers, they are still unlikely to be a “magic bullet” to the long-term care workforce crisis. As the Maine proposal to CMS says, health insurance is likely to be a “necessary, but not sufficient component to solving the shortage and turnover of direct service community workers.”



\*According to O’Brien, “Payments for health insurance are deducted from gross revenues in calculating the employer’s taxable income, and they also are excluded from the base payroll in determining the employer’s share of the payroll tax for Medicare and Social Security.” (2003, p. 11)

two approaches by establishing tax-exempt employer-funded “health reimbursement accounts” for certain direct service workers.

### FUTURE PROSPECTS

Public opinion polls and the debates leading up to November’s national elections show that concerns about health care and health insurance – especially cost — are once again at the top of the public agenda. But the fiscal crisis facing most states, soaring health care costs, and the political impasse over who will pay for coverage are making it hard to expand access to health insurance. In this situation, is progress possible for those who wish to improve health coverage for direct care workers?

**Challenges.** With regard to public subsidies and especially Medicaid, the prospects for coverage expansions appear bleak. Even holding on to the status quo is a struggle in light of reimbursement cuts and continuing state budget deficits. In 2002 and 2003, 34 states made cuts or changes in Medicaid and SCHIP programs that led to between 1.2 and 1.6 million low-income people losing publicly-funded health coverage (Center on Budget and Policy Priorities, 2003). In addition, 35 states reduced benefits, 32 increased co-pays, and every state either froze or reduced rates to many provider groups. With labor costs consuming the lion’s share of long-term care expenses, and long-term care services accounting for 35% of Medicaid spending, the squeeze will inevitably affect wages and benefits in the long-term care sector.

Oregon increased Medicaid premiums for people in the Oregon Health Plan Standard plan, causing 40,000 to disenroll. Oregon also rescinded earlier plans to extend coverage to adults with incomes over the poverty line. Pennsylvania and Washington stopped enrolling parents in state-only funded programs that had higher-income thresholds. Some states were able to avoid drastic cuts due to \$20 billion in federal fiscal relief funds, half of which was earmarked for state Medicaid budgets, but the federal relief funds expire in July 2004.

Improvements to employer-sponsored plans also seem unlikely. Both large and small employers alike are finding it harder to afford the cost of rising health insurance costs. Between 2002 and 2003, monthly premiums for employer-sponsored health plans rose

almost 14 percent (Kaiser-HRET, 2003) for all employers, compared to 2.2 percent inflation and 3.1 percent in wage gains for non-supervisory workers. Some providers and advocates report that insurers add a surcharge over and above these rate increases for long-term care employers. Providers report that in response to soaring costs, they have raised employee premium contributions, lengthened the waiting period from 30 to 90 days, or stopped contributing to family insurance coverage. Employers heavily dependent on Medicaid and other public revenue have been hard hit by state fiscal crises that have held the line on rate increases.

Then there is the debate about whether health benefits constitute an effective mechanism to improve recruitment and retention of direct care workers. The evidence on the importance of health benefits to direct care workers is mixed (see box on p. 9). Some employers believe that offering health benefits is a critical component in their efforts to be “employers-of-choice” and retain workers. Others remain unconvinced that they need to offer health benefits to recruit and retain workers or that wage increases or other workforce investments are more effective.

**Opportunities.** Despite these challenges, there are reasons for optimism. Despite many state cutbacks in Medicaid or other state-subsidized insurance programs for low-income people, there were some notable successes in 2003. The law authorizing Maine’s Dirigo Health program also expanded the eligibility for Medicaid; childless adults with incomes at or below 125 percent of the federal poverty level and parents with kids earning up to 200 percent of FPL will be eligible for Medicaid. Illinois continued to expand coverage for low-income parents under its Medicaid/SCHIP waiver program and expanded eligibility for children in SCHIP.

After several years of state fiscal crises, there are signs that state revenues are beginning to rise and the worst of the economic downturn may be over. In 2004, state tax revenues are projected to rise. State budget shortfalls that reached almost \$80 billion in fiscal year 2003 are expected to be significantly smaller in 2004. While states’ fiscal condition is not strong yet, it is improving (NGA/NASBO, 2003). As it does, an argument can be made that those who suf-



As states’ fiscal conditions improve, those who lost Medicaid or other public health coverage over the past several years should be among the first whose benefits are restored.

ferred most during the recession should be among the first to regain health coverage that was lost. Because coverage for low-income working parents was deeply reduced in several states during 2001-2003, these are the people that state governments should target for restoration of benefits. Policies that imposed stricter enrollment requirements should be reversed.

Labor unions have also scored some important victories in gaining funding from counties and states to pay for health coverage. In 2003, SEIU won health insurance for 24,000 home care workers in nine more California counties (10 counties already provide health coverage) and 9,000 in Oregon. Union negotiations also led to more liberal eligibility criteria, insuring thousands more workers in Los Angeles County despite tight budgets. Under a grant from The Robert Wood Johnson Foundation, the Service Employees International Union in conjunction with George Washington University and Mathematica Policy Research will publish a study this spring examining various models of coverage for home care workers.

State and local governments are also playing a role in expanding health coverage. Massachusetts state officials, under another grant from The Robert Wood Johnson Foundation, are working closely with the Direct Care Workers Initiative's Health Insurance Working Group to identify options for providing health benefits to health and human service workers. Employment standards for government contractors in 29 of 43 states and 37 of 46 localities require these contractors to provide healthcare benefits or allow such benefits to count towards minimum wage requirements (Purinton, et.al.2003). Local living wage campaigns, which push for mandates on city contractors to pay employee wages that raise them

above the poverty line, have won ordinances in 116 jurisdictions; in several of them, home care employers under contract with counties are included. Many living wage coalitions are proposing other community standards in addition to a wage requirement, such as health benefits.

Lastly, many long-term care employers continue to search for innovative ways to maintain or expand health insurance to their workers. Not only is it a valued job benefit to employees, but also in some labor markets, employers find that it can be a useful tool to recruit or retain workers, thereby improving quality and their standing in the marketplace.

The growing chorus demanding basic health protection for the uninsured, together with the labor crisis in the long-term care sector, set the stage for collaboration among diverse stakeholders. From California to Massachusetts, grassroots coalitions have helped draw attention to the plight of direct care workers who lack health coverage, even as they care for those who generally have such coverage. In response, states and counties, employers, labor unions and other worker associations are joining together to make the cost of health coverage more affordable to direct care workers. While they share the same goal, the strategies they devise reflect differences in economic, political and social circumstances.

Policymakers, employers, and consumers are all recognizing that those who care for the most vulnerable people in society have earned the right to obtain health care without fear of financial ruin. With more creativity and dedication to building ports in the storm of rising health costs, workers like Karen Thompson will no longer have to face crushing debt when they or their family members get sick.



## References

- Case, B., Himmelstein, D., and Woolhandler, S., 2002. "No Care for the Caregivers: Declining Health Insurance Coverage for Health Care Personnel and their Children, 1988-1998," *American Journal of Public Health*, 92(3): 404-408, March.
- Center on Budget and Policy Priorities, 2003. "Losing Out: States are Cutting 1.2 to 1.6 Million Low-Income People from Medicaid, SCHIP, and Other State Health Insurance Programs," by L. Ku and S. Nimalendran, CBPP, December 22, 2003. <http://www.cbpp.org/12-22-03health-pr.htm>
- Cousineau, M., 2000. *Providing Health Insurance to IHSS Providers (Home Care Workers) in Los Angeles County*, Report to the California HealthCare Foundation, June.
- Gabel, J. et.al. 2003. "Health Benefits in 2003: Premiums Reach Thirteen-Year High as Employers Adopt New Forms of Cost Sharing," *Health Affairs*, September-October, 22(5):117-126.
- Hospital and Healthcare Compensation Service, 2002 and 2003. "Homecare Salary and Benefits Report" (2002-2003 and 2003-2004) and "AAHSA Nursing Home Salary and Benefits Report" (2002-2003 and 2003-2004), HHCS, Oakland, NJ. [www.hhcsinc.com](http://www.hhcsinc.com)

Howes, C., 2002. "The Impact of a large wage increase on the workforce stability of IHSS Home Care Workers in San Francisco County," Working Paper, University of California Berkeley, Center for Labor Education and Research. <http://laborcenter.berkeley.edu/homecare/Howes.pdf>

Kaiser Commission on Medicaid and the Uninsured, 2003. "Serving Low-Income Families Through Premium Assistance: A Look at Recent State Activity," Issue Paper, Kaiser Family Foundation, October. <http://www.kff.org/medicaid/kcmu4143brief.cfm>

Kaiser Family Foundation and Health Research and Educational Trust (HRET), 2003. "Employer Health Benefits: 2003 Summary of Findings," KFF Report #3369, <http://www.kff.org/insurance/ehbs2003-abstract.cfm>

Kofman, M., 2003. "Group Purchasing Arrangements: Issues for States," State Coverage Initiatives Issue Brief, Vol. IV, No. 3, Academy Health. <http://www.statecoverage.net/pdf/issuebrief403.pdf>

Ku, L, and Coughlin, T. 2000 "Sliding Scale Premium Health Insurance Program: Four States' Experiences," *Inquiry*. Vol. 36: 471-480, Winter.

Leon, J and Franco, S., 1998. *Home and Community-based Workforce*, Project HOPE Center for Health Affairs, Bethesda, MD.

Massachusetts Division of Health Care Finance and Policy, 2003. "Massachusetts Health and Human Service Employers, Health Insurance Survey Results," Spring. <http://www.statecoverage.net/statereports/ma43.pdf>

Minnesota Department of Health, 2002. "Employer-Sponsored Health Insurance in the Minnesota Long-Term Care Industry: Status of Coverage and Policy Options, Report to the Minnesota Legislature, January. <http://www.statecoverage.net/statereports/mn15.pdf>

National Academy for State Health Policy, 2003. *Using Medicaid to Cover the Uninsured: Medicaid Participant Buy-in Programs*, by N. Kaye and K. Wysen, NASHP, [http://www.nashp.org/Files/Medicaid\\_buy\\_in\\_paper\\_5.03.pdf](http://www.nashp.org/Files/Medicaid_buy_in_paper_5.03.pdf)

National Governors Association/National Association of State Budget Officers, 2003. *Fiscal Survey of States*, December, <http://www.nasbo.org/Publications/fiscsurv/fsfall2003.pdf>

Neuschler, E. and Curtis, R., 2003. "Use of Subsidies to Low-Income People for Coverage through Small Employers", *Health Affairs*, Web Exclusive, May. <http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.227v1.pdf>

O'Brien, E., 2003. "Employers' Benefits from Workers' Health Insurance", *Milbank Quarterly*, 81(1): pp 5-43. <http://www.milbank.org/quarterly/8101feat.html>

Paraprofessional Healthcare Institute (PHI) and the Institute for the Future of Aging Services (IFAS), April 2003. "State Wage Pass-Through Legislation: An Analysis," Workforce Strategies No. 1, <http://www.paraprofessional.org/publications/WorkforceStrategies1.pdf>

Purinton, et. al., 2003. "The Policy Shift to Good Jobs: Cities, States and Counties Attaching Job Quality Standards to Development Subsidies," Good Jobs First, November. <http://www.goodjobsfirst.org/pdf/jobquality.pdf>

Salisbury and Ostuw, 2000. "Value of Benefits Constant in a Changing Job Environment: The 1999 /World at Work/EBRI Value of Benefits Survey," Employee Benefits Research Institute, EBRI Notes, 21:5-6.

US Census Bureau, 2003. *Health Insurance Coverage in the United States: 2002*, Current Population Reports, US Census Bureau, U.S. Department of Commerce, P60-223. [www.census.gov/prod/2003pubs/p60-223.pdf](http://www.census.gov/prod/2003pubs/p60-223.pdf)

US General Accounting Office, 2000. "Private Health Insurance: Cooperatives Offer Small Employers Plan Choice and Market Prices," GAO/HHES-00-49, March.

Yamada, Y., 2002. "Profile of Home Care Aides, Nursing Home Aides and Hospital Aides: Historical Changes and Data Recommendations," *The Gerontologist* 42(2): 199-206. <http://gerontologist.gerontologyjournals.org/cgi/reprint/42/2/199.pdf>

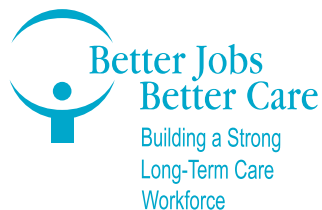
## Endnotes

<sup>1</sup> Survey response rates in 2002 and 2003 were only 7% to 8.5% for home care agencies/hospices and 16.6 to 17 percent for nursing homes; such low participation rates raise questions about how well the respondents represent all such employers.

<sup>2</sup> As study by the US General Accounting Office found that, "Although the premiums [between small and large employers] were similar, the health plans offered by small employers were slightly less generous on average—they had slightly higher average cost-sharing requirements for their employees and were somewhat less likely to offer some benefits." (US GAO, "Private Health Insurance: Small Employers Continue To Face Challenges In Providing Coverage," 2001, GAO-02-8).

<sup>3</sup> The US General Accounting Office recently found six states in 19 surveyed cut or froze per diem rates to all nursing homes at some point between 1998 and 2004. (US GAO, "Medicaid Nursing Home Payments: States' Payment Rates Largely Unaffected by Recent Fiscal Pressures," 2003, GAO-04-143)

<sup>4</sup> An exception to the cost-effectiveness test exists for states requesting federal assistance through the Health Insurance Flexibility and Accountability (HIFA) option, which allows states to pay aggregate costs for those enrolled in premium assistance programs as long as they are not significantly higher than costs would be under direct [Medicaid] coverage (Kaiser Commission on the Future of Medicaid, October 2003).



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