



**CMS Direct Service Workforce Demonstration Grants:  
Overview and Discussion of Health Coverage Interventions**

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In 2003, the Center for Medicare and Medicaid Services (CMS) launched the *Demonstration to Improve the Direct Service Community Workforce (DSW)* by awarding five grants. Five more were made in 2004.<sup>1</sup> Of the ten grantees in this demonstration, six grantees are using all or a portion of their funds to make health care coverage more affordable and/or accessible for direct-service workers.<sup>2</sup> These interventions vary greatly in their strategy, design and scope. While every intervention is unique, each takes one of the following three general approaches to the problem:

- Subsidizing employer-based coverage,
- Offering arrangements that combine basic insurance and personal accounts, or
- Outreach to enroll direct-service workers in plans offered through public-private partnerships

This report provides an overview of how grantees are pursuing these approaches, discusses the key advantages and disadvantages of each, and highlights some of the lessons learned so far about expanding health coverage to this workforce. In addition, the attached spreadsheet provides a description of each intervention, identifying key components, including: number of participants, total premiums, costs to employers and employees, and potential sustainability of coverage. The purpose of these materials is to provide information that will assist grantees as they assess and refine their interventions and more broadly to aide advocates for the direct-service workforce nationwide.

#### OVERVIEW AND DESCRIPTION OF THE GENERAL APPROACHES

Of the many interventions that grantees are testing to improve retention and recruitment of the direct-service workforce, expanding health coverage, because of its cost, is among the most challenging. Grantees in four states—**Indiana, North Carolina, Virginia,** and **New Mexico**—are spending demonstration funds directly on benefits for a small target group of direct-service workers. While the first three states in this category are approaching this by subsidizing employer-based coverage, **New Mexico** is offering an arrangement that combines basic insurance and personal accounts. Grantees in two states, **Maine** and **Washington**, are spreading grant funds more broadly to benefit larger groups of workers: Both states are using outreach campaigns to increase the number of direct-service workers enrolled in already established plans.

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<sup>1</sup> Grantees demonstrating health care interventions received approximately \$1.4 million over a three-year cycle and are scheduled to expire in 2006 and 2007.

<sup>2</sup> The term “direct-service workers” refers to frontline caregivers who assist long-term care consumers in their homes or in various residential settings. These workers are sometimes referred to as direct-care workers, or by specific titles such as: home health aide, certified nursing assistant, direct support professional, personal assistant, or personal care attendant.

**Approach #1: Subsidize employer-based coverage:  
Indiana, North Carolina, and Virginia**

Grantees in **Indiana**, **North Carolina** and **Virginia** are using demonstration funds to subsidize the employee share of health premiums for employer-based health plans. In **Indiana**, 249 direct-service workers employed by Arc-BRIDGES are being offered a \$50 per month cash benefit that they can apply to a cafeteria-plan of employee benefits. More than a third of these workers are choosing to apply this benefit toward the employee share of their employer-based health plan. In **North Carolina**, 300 direct-service workers employed by four partner agencies are being offered a subsidy of \$108 dollars per month to apply toward the employee share of their health care premiums. Finally, in **Virginia**, the original proposal to insure 75 workers across four agencies has been suspended and the state is examining alternative interventions.

*Advantages*

Subsidizing employer-based coverage has the potential for making health coverage affordable by spreading costs between multiple parties: the employee, their employer, and a third party payer (which is typically the state but in this case is CMS.) In both **Indiana** and **North Carolina**, this approach is providing a limited number of direct-service workers with comprehensive benefits offered through an employer-based plan.

The design of the subsidy in **Indiana** gives workers considerable flexibility by allowing them to apply the \$50 per month payment toward benefits of their own choosing—either their health care premium, vision or dental benefits, or non-health related benefits such as child care. In North Carolina, the money must go toward the health care premium, though employees do have a choice of plans.

*Disadvantages*

In both **Indiana** and **North Carolina** the level of the per-person subsidy is too modest to significantly reduce costs for either direct-service workers or their employers. In both cases, employees still face significant costs even after the \$108 or the \$50 subsidies are subtracted from their share of the premium. For example, direct-service workers in Indiana who choose to apply the \$50 payment toward their share of the health insurance premium still face monthly premium costs of \$133 to \$222 and must also pay co-pays and cover a deductible.

While the subsidies enable employers to offer their workers a slightly more affordable insurance option, they do little to reduce employers' overall costs—the employer share of premium is not subsidized and employers are still shopping for plans at regular market rates. Finally, grantees in both states are uncertain whether the participating agencies will be able to continue subsidizing the employee share of premiums because the political environment makes it unlikely that the state will pick up this cost after the grant ends.

## **Approach #2: Combining Basic Insurance and Tax-Free Accounts: New Mexico**

The grantee in **New Mexico** is testing a variation of the Healthcare Reimbursement Arrangement (HRA), often called a “consumer-driven” approach to health care coverage. They are offering a package that includes three components—a basic health insurance plan that offers limited reimbursement, a prescription drug card, and a monthly cash contribution of \$60 per month to a HRA account—to several hundred direct-support workers employed by seven agencies. Workers use their accounts to pay for allowable medical expenses not covered by the health insurance plan or prescription benefit.

### *Advantages*

HRAs are a low cost approach for employers and an affordable option for employees who do not have expensive health care needs. The overall cost of the three components in the **New Mexico** arrangement is \$111 per month per person. And because employers pay 100 percent of this cost, there are no premium costs for employees.

The **New Mexico** arrangement is more effective than most HRAs on the market in protecting most workers from immediate out-of-pocket medical costs. Most HRAs couple accounts with a high deductible or catastrophic health insurance plan, leaving the employees responsible for paying down this deductible before they can take advantage of the money in their accounts. In contrast, the basic health insurance plan included in the **New Mexico** arrangement has no deductible. Workers can use the limited coverage available through their basic health insurance right away. This creates an incentive to seek medical care early on in an illness rather than waiting to see if a condition worsens, potentially increasing the overall cost of care. However, as will be discussed under disadvantages, workers are at risk for very high out-of-pocket costs if they exhaust the money accrued in their accounts.

The grantee reports that so far, all of the direct-service workers participating in the **New Mexico** demonstration have had enough funds in their accounts to cover their out-of-pocket health care costs. And some workers say they like the flexibility of choosing their own providers and managing their own accounts.

### *Disadvantages*

While this approach successfully controls costs for employers, it shifts the financial risk to employees. Individuals with medical needs that exceed the amount accrued to their accounts (\$720 per year) will have full responsibility for their remaining medical costs. This puts direct-service workers with diabetes, hypertension, asthma, and other chronic or potentially expensive conditions (which many direct-service workers have) in danger of very high out-of-pocket medical costs.

The other key disadvantage of the **New Mexico** arrangement is its complexity. Understanding the three different components, what they cover and how they work

together is difficult for all lay people and a particular challenge for direct-service workers who speak limited English or who have low literacy. This complexity is compounded by the administrative challenge of managing their own accounts and the requirement that employees pay up front for health services and then submit for reimbursement, a financial hardship for most direct-service workers.

Sustainability is another challenge. The grant is funding the entire cost of the health care arrangement for agencies that previously did not provide any kind of health coverage to their employees. It is unclear whether agencies will be willing to continue offering the arrangement by either fully or partially covering the cost themselves.

### **Approach #3: Outreach for public-private partnerships:**

#### **Maine and Washington**

Grantees in both **Maine** and **Washington** are using demonstration funds for outreach programs, rather than directly funding coverage for direct service workers. In **Maine**, the grantee is reaching out to 26 home care agencies to promote DirigoChoice, Maine's new state subsidized health insurance program, as well as other options for providing health coverage to the direct-service workers.

In **Washington**, the grant is funding Referral Workforce Resource Centers to assist state-contracted Independent Providers to understand and enroll in one of the two health insurance programs that they are eligible for. Eligible workers have a guaranteed right to health benefits through their union contract and a choice of either a multi-employer health benefits trust plan (also known as a Taft-Hartley Plan) or Washington's Basic Health Plan (a state-administered plan). While the essence of the **Maine** intervention is convincing employers to offer coverage, the **Washington** program is focused on improving the take-up rate of already eligible individuals.

#### *Advantages*

Direct-service workers in **Maine** and **Washington** have the advantage of living in states where there is broad political support for universal health care coverage and publicly subsidized health insurance programs designed specifically for the working poor. Both the DirigoChoice health plan in **Maine** and the plans in **Washington** pool together individuals into large purchasing groups, giving them the ability to bargain with insurance carriers for lower rates. In both states, outreach efforts are made easier because grantees are offering plans that feature comprehensive benefits, choice of provider, and low out-of-pocket costs.

In **Washington**, the grantee is in an even better position to run a successful outreach effort because they have direct access to workers who are all potentially eligible for coverage through their union contract. Furthermore, because these workers are represented by their

union in the political sphere and are covered under a collective bargaining agreement, the funding for their health plans is more secure and the intervention more sustainable.

### *Disadvantages*

Even with a “good deal” to offer, enrollment rates have been lower than expected in both **Maine** and **Washington**. In **Maine**, employers are reluctant to participate due to the costs associated with the program, and because DirigoChoice is a new program that has had numerous start-up problems, which have generated negative publicity.<sup>3</sup> In both states, the complexity of the plans offered creates hurdles. Employees have difficulty understanding the different plan options, how much they will have to pay, and how to navigate complicated enrollment forms.

## **LESSONS LEARNED & CHALLENGES FOR THE FUTURE**

Grantees in all five states are engaged in creative and innovative strategies to ensure that caregivers have the support they need to take care of their own health care needs. For the most part, the interventions funded by the DSW grants address the necessary first step in this process—coverage for workers who work enough hours to be deemed full time. In the future it will be necessary to go further in order to identify models for the significant portion of direct-service workers who work less than full time or whose hours that fluctuate as the needs of their clients change. This is an issue that will need to be addressed both through an eligibility lens as well as with strategies to stabilize hours for workers who desire full-time employment.

Family coverage is another challenge for future demonstrations. While in most cases the employers participating in these demonstrations offer the option of purchasing family coverage, none of the interventions significantly reduce the high costs that make accepting this coverage prohibitive for many direct-service workers. Without full family coverage, workers with dependents carry the burden of significant financial risk and stress levels that contribute to high rates of turnover and jeopardize quality of care.

While there are always more challenges to address in the future, it is important to acknowledge the cutting edge work of the grantees involved in these demonstrations. These grants have reduced the number of uninsured workers and lessened their out-of-pocket health care costs. And more importantly, they will inform efforts for broader reform in the future. Each intervention will be formally evaluated to assess their impact and overall effectiveness in strengthening the direct-service community workforce. In the meanwhile, grantees have this to share about some of the lessons they have learned so far:

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<sup>3</sup> For more information on the Maine’s effort thus far, see *Health Insurance Coverage for the Home Care Sector: Experience from Early DirigoChoice Enrollment in Maine* (2006), [www.paraprofessional.org](http://www.paraprofessional.org).

## **Indiana**

The cafeteria plan is very popular. Workers like the flexibility of using it for whatever they choose—to reduce their health premium, for dental or vision coverage, for child care or extra vacation days. Because it is so flexible everyone uses it.

- Janice Roshanmanesh, Arc-BRIDGES, Inc.

## **Maine**

We learned that to successfully reach direct-service workers and their employers we needed to offer information and support [multiple] options for accessing health insurance rather than only promoting DirigoChoice. In the beginning, our outreach efforts were hindered by focusing on DirigoChoice, a new program that has been clouded by negative publicity and that is still in a design and development phase.

- Elise Scala, Muskie School of Public Service, University of South Maine

## **New Mexico**

Due to the complexity of the health care arrangement we are offering, we have learned that outreach materials and procedures must be very, very clear. It is working well to have agency staff promote the arrangement directly with their employees rather than having outsiders such as representatives from the companies that manage the products speak to employees.

- Barbara Ibanez, University of New Mexico

## **North Carolina**

The “state terrain”—variables such as the political climate, the extent to which the direct-care workers have an organized advocacy voice, and the rules and regulations governing the insurance industry—greatly impact what grantees can accomplish with limited funds. Our health insurance intervention is modest because it does not appear that much else is politically feasible in North Carolina until the state terrain changes. It is also very important to communicate with relevant state associations in order to coordinate efforts and make sure they are aware of the needs and interests of the direct-care workforce.

- Linda Kendall Fields, Project Director,  
North Carolina’s CAPT (Caregivers are Professional Too!)  
Direct Service Workforce Grant

## **Washington**

The enrollment rates are much lower than we originally projected. Through our outreach we are finding that workers are confused about their options, resistant to make changes, and skeptical. We are learning more about our audience and what they pay attention to and what they don’t. They will open mail that is about their paycheck or hours while they are more likely to ignore pieces that look like junk mail or marketing. To reach them we need materials that are clear and easy to understand but not too “slick” looking.

- Mindy Schaffner, Executive Director, Home Care Quality Authority

**Virginia**

Virginia will be conducting a follow-up survey during the last year of the grant to delve further into the reasons why our initial insurance intervention was not successful. We hope this will not only provide valuable information for the DSW grant, but will reveal data that can be used to drive policy in the Commonwealth.

—*Teja Stokes, Virginia Department of Medical Assistance*