



When Michigan's Caregivers Lack Coverage:

*Findings from a Survey of
Michigan's Home Help
Workforce*

Report to :

The Michigan Quality Home Care Coalition

By the:

Paraprofessional Healthcare Institute

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The telephone survey was conducted by the Feldman Group Inc. of Washington, D.C.

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The Paraprofessional Healthcare Institute

PHI works to improve the lives of people who need home or residential care—and of the workers who provide that care. Our practical workplace and policy expertise helps consumers, workers, and employers improve care by improving the quality of direct-care jobs. Our goal is to ensure caring, stable relationships between consumers and workers so both may live with dignity, respect, and independence.

PHI's program activities include developing innovative approaches to recruitment, training, and supervision; client-centered caregiving practices; and effective public policy. PHI also staffs the National Clearinghouse on the Direct Care Workforce (www.directcareclearinghouse.org), a central online library of news, research, best practices, and other information for people working to solve the direct-care staffing crisis in long-term care.

Health Care for Health Care Workers (www.coverageiscritical.org), an initiative of PHI, seeks to expand health coverage for workers who provide support and assistance to elders and people living with chronic illnesses and/or disabilities. Consumers need a skilled, reliable, and stable direct-care workforce to provide quality long-term care services. We believe that one way to ensure a quality direct-care workforce is to provide quality direct-care jobs—jobs that offer health coverage and pay a family self-sufficient wage.

Executive Summary

When Michigan's Caregivers Lack Coverage identifies a significant challenge facing Michigan's health, aging, and disability services: high rates of uninsurance among direct-care providers* employed by the Michigan Medicaid Home Help Program. As is detailed in this report, this predominately female, older, and overwhelmingly low-income workforce faces not only high rates of uninsurance but also significant financial burdens associated with accessing health care services.

Michigan's Home Help Program is the state's largest Medicaid-funded long-term care program providing personal care services to elderly and disabled adults who otherwise could not live independently. To qualify for services, Home Help clients must have very low incomes—50 percent below the federal poverty level (\$4,400/year for a single person)—or have medical bills that far outstrip their ability to pay. Despite such restrictive eligibility rules, the program serves over 55,000 people annually.

The Home Help program provides personal care services to some of Michigan's poorest residents, and the providers it employs to support these individuals live in poverty or near poverty as well. During the time of the telephone survey that provided data for this report, almost half of the 45,000-person workforce earned as little as \$5.15 hour. Accordingly, one of every six providers lived in a household with an annual income below \$10,000.†

As a workforce hired directly by consumers, Home Help providers do not receive employment-based health coverage. Many, because of their extremely low wages, rely on publicly funded health insurance and safety-net services. For those who do not qualify for public programs, however, purchasing private insurance is extremely difficult. As a result, Home Help providers are uninsured at a much higher rate than other Michigan residents.

Key Findings

- Nearly one-third (29 percent) of Home Help providers lack health insurance coverage. This rate is almost three times the level of uninsurance in Michigan statewide—11 percent of Michigan residents, ages 18 to 64, are uninsured.
- Of the Home Help providers who have insurance coverage, 33 percent are covered from a second job or pay for insurance themselves; over a third rely on public coverage through Medicaid and Medicare.
- Geographic disparities in insurance coverage exist within the state. In some areas, including counties within the greater Kalamazoo, Lansing, Allegan, and Grand Rapids regions, Home Help providers have higher rates of uninsurance than their counterparts in the rest of the state.
- Home Help providers, regardless of insurance status, pay significant out-of-pocket health care expenses. One in six Home Help providers purchases his or her own private health insurance, despite having very low incomes. Nearly half (44 percent) of uninsured providers report having unpaid medical bills. As a result of medical debt, many Home Help providers are saddled with bad credit and higher interest rates.

*Generally, PHI and others working in the field refer to people working as frontline, non-licensed caregiving staff as direct-care workers. People employed by the Michigan Medicaid Home Help program are titled "providers" by that program and "providers" is the term used in this report to describe members of this workforce.

†In October 2006, nine months after this telephone survey of Home Help providers, the state's wage rate for these jobs increased to a \$7.00 per hour floor in all counties. For those counties already paying more than \$7.00 per hour, the wage increased by \$0.50.

- Uninsured Home Help providers lack a regular source of care. Half of the uninsured providers report not seeing a doctor when it is necessary, including many who report having chronic illnesses such as hypertension or diabetes.

Implications

Home Help providers—people who provide thousands of Michigan residents with essential health care services—ironically lack adequate and affordable health insurance coverage themselves. Even Home Help providers with health insurance coverage report inadequate coverage, exposing them to significant medical debt. The lack of health care insurance is particularly difficult for the one-third of Home Help providers who live with chronic health problems. However, the impact of high levels of uninsurance and underinsurance does not stop at the doorstep of these providers; it touches the lives of those for whom they provide care and places strain on the long-term care system and the entire health care sector.

Most importantly, inadequate health insurance coverage and care of Home Help providers results in:

- An unhealthy workforce that cannot provide consistent, high-quality care for consumers;
- A diminishing pool of providers willing and able to care for people who are old or living with disabilities at a moment when these populations are increasing exponentially; and
- Increased costs for the publicly funded health care system because providers must rely on public insurance systems, emergency rooms, and neighborhood health care clinics.

The lack of insurance for Home Help providers can leave consumers without reliable and consistent care. When Home Help providers become ill—or have to manage chronic health conditions without adequate medical care for themselves—they miss work, or end up unable to do the work at all. This is highly disruptive to consumers who rely on their Home Help providers for the support they need to live independently.

Also, the number of consumers needing long-term care is growing, yet incentives for people to become direct-care workers are few. As demand for direct-care providers continues to grow, health insurance coverage is essential to attracting and retaining a qualified and committed direct-care workforce.

I. Introduction

The Michigan Medicaid Home Help Program provides personal care services to over 55,000 elders and individuals with disabilities who need long-term care services and supports. Over 45,000 direct-care providers support eligible consumers by providing personal care services (e.g., bathing and toileting) and doing daily chores (e.g., grocery shopping, meal preparation, and laundry).

Most Home Help providers are different from other direct-care workers who provide Medicaid-funded long-term care services because they are considered “independent providers”—i.e., they are hired directly by the consumers for whom they provide care rather than by an agency. As “independent providers,” Home Help providers’ wages, benefits, and training needs are often overlooked. In 2005, the Michigan Quality Community Care Council was created to provide a centralized entity to monitor the administrative, support, and training needs of Home Help providers, as well as establish a registry where consumers can access available providers.

In an effort to better understand the needs of this workforce, the Michigan Quality Home Care Campaign commissioned a telephone survey to assess provider satisfaction, wages, and health insurance availability. The Paraprofessional Healthcare Institute (PHI) analyzed the health insurance findings from the survey as a part of its Health Care for Health Care Workers (HCHCW) initiative. The findings from this survey provide important information on the lack of adequate and affordable health insurance coverage for Home Help providers and how it impacts their lives, Michigan’s vital long-term care system, and the larger health care industry.

II. Survey Methodology and Data Sources

The *Michigan Homecare Workers’ Survey* was designed by the Feldman Group, Inc., with assistance from PHI on the health insurance portion of the survey instrument. The Feldman Group administered the survey via telephone interviews from December 11, 2005, to December 15, 2005. Participants were contacted both during the day and in the evening.

The survey sample is a random sample of Michigan Home Help providers. Respondents were screened for current or recent employment in the program from a Home Help provider list supplied by the state of Michigan. The telephone survey gathered data on the demographic and employment characteristics of the workforce; their experience in the program; health and health insurance status; access to care and use of health services. A total of 600 telephone interviews were completed.

In addition, background information on the Home Help Program and county wage rates were provided by the Michigan Department of Community Health (DCH) and the Michigan Department of Human Services (DHS). Information on the assessment process and services provided in the Home Help Program are from relevant sections of the DHS Adult Services Manual.

III. The Michigan Home Help Program

The Michigan Medicaid Home Help Program provides personal care services to elders and individuals living with disabilities. These 55,000 Medicaid recipients account for half of the beneficiaries receiving Medicaid long-term care services in Michigan but their services compromise only 12 percent of the state’s long-term care expenditures. The current annual cost of the program, \$206 million, is funded entirely with state (\$86.52 million) and federal (\$119.48 million) monies.

The Home Help Program enables consumers to live independently at home. It is a “consumer-directed” long-term care program that allows consumers to directly supervise providers and

The 55,000 Home Help recipients account for half of the beneficiaries receiving Medicaid long-term care services.

manage delivery of authorized services. Home Help consumers have the right to recruit, select, and train their own providers. The provider and consumer jointly report delivered services to DHS. A DHS caseworker also is required to meet twice a year with both the consumer and the Home Help provider.

Consumer eligibility for Home Help is based on income; consumers must have an annual income of less than \$4,400 or spend down to that income level by incurring medical expenses. Once deemed financially eligible, consumers are then assessed by local DHS staff as to the kinds of personal care services needed and the amount of hours needed for each service.

Home Help services are delivered in consumers’ homes, with monthly hourly caps on house-cleaning (8 hours), laundry (7 hours), shopping for food and other necessities of daily living (5 hours), and meal preparation (25 hours). The average Home Help consumer receives 55 hours of service per month, encompassing assistance with both activities of daily living (ADL) and instrumental activities of daily living (IADL).¹ Approximately 24,000 Home Help consumers need levels of service that qualify them to live in nursing homes.²

IV. Survey Findings and Analysis

General Demographic Information

Based on the survey’s demographic information outlined in **Appendix 1**, the Michigan Home Help workforce is predominately female (83 percent); tends to be middle-aged or older (74 percent are over age 45 and 22 percent are over age 65); and is racially and ethnically diverse (50 percent white, 38 percent African American and 6 percent Latino). These home care providers are likely to be poor or near poor, with *over half* reporting annual household incomes of \$30,000 or less and 15 percent below \$10,000. Nearly half are married (43 percent) and one-quarter (26 percent) live in households with children under 19. Over one-third have a chronic health condition such as diabetes, asthma, or high blood pressure.

The profile of the state’s Home Help workforce differs from that of other direct-care workers employed by nursing homes and home health agencies in Michigan (**Table 1**).³ Home Help providers are more likely to be African-American (38 percent) than other direct-care workers (23 percent) in the state. Home Help providers are less likely than other direct-care workers to be married (43 percent as compared to 51 percent) or to live in a household with a minor child (26 percent live in households with a child under 19 as compared to 49 percent of other direct-care workers).

Table 1

Home Help Provider Demographics Compared to Those of Other Direct-Care Workers (Employed by Nursing Homes or Home Care Agencies)

Characteristic	Home Help Provider	Other Direct-Care Workers
African-American Workers	38%	23%
Married Workers	43%	51%
Workers with Children Under 19	26%	49%

Employment Characteristics

The data in **Appendix 2** reflects Home Help providers’ longevity, satisfaction, and commitment to their work. For 68 percent of providers, the Home Help program is their only employment. Over one-third (38 percent) work part-time and 31 percent work more than 40 hours per week. The majority (80 percent) of Home Help providers have only one client. Most of these providers are committed to their jobs and their clients, with one-third having been Home Help providers for between two and five years, and 39 percent with more than five years of service.

Even with the high level of commitment that providers have to their work, there is still considerable turnover among Home Help providers. A survey of Home Help consumers showed that about one-third (35 percent) had a provider change within the year.⁴ The most common reason reported for the change was that the provider “got a different job.”

Notably, more than half of Home Help providers care for a relative, a factor that likely contributes to longevity. Across the country, the practice of hiring a family member to provide Home Help services is relatively common in consumer-directed state Medicaid programs. A recent national study of 40 states operating 62 consumer-directed programs found that 79 percent of the programs allow family members to be paid caregivers.⁵

Because of the intimate nature of caregiving, many consumers are more comfortable with a family member providing personal care services. In addition, low wages make it difficult to attract other workers. States have used this design element in an effort to stabilize the workforce and provide long-term care services to consumers who do not want to move into nursing homes or other residential care settings.⁶

Michigan’s elderly population is expected to expand by more than 70.7 percent by 2030, and the traditional source of new caregivers, women ages 25 to 44, is projected to shrink by more than 10 percent.⁷ As the number of elderly and individuals with disabilities continues to grow, family members will be an important pool of new direct-care workers. A recent study of California’s Medicaid-funded In-Home Supports Services (IHSS) workers—that state’s Home Help providers—shows that paying family members to provide homecare services can bring more workers into the direct-care workforce.⁸ Of IHSS workers who currently provide care to a family member, 43 percent reported that they would consider continuing to provide care to strangers in the future.

Wages and Benefits

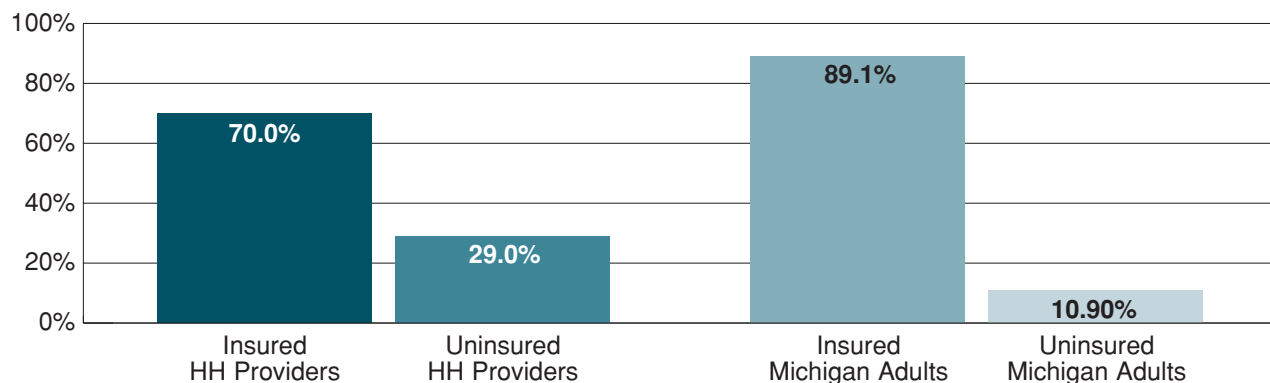
Increased appropriations allowed the wage rate for Home Help providers to increase to a floor of \$7.00 per hour in October 2006. For those county wage rates already set at more than \$7.00/hour, the wage increased by \$0.50 per hour. This is the first wage increase Home Help providers have had in about a decade.⁹

Historically, Home Help provider wage rates were set by each county’s Family Independence Agency boards, now the county DHS. As a result, wages vary from county to county. Prior to this October 2006 increase, the average wage for Home Help providers was \$6.07 per hour, but almost half of the 45,000 person workforce earned as little as \$5.15 per hour. While this increase is significant, these providers still earn wages that are significantly less than the overall average of \$19.25 per hour for all Michigan workers.¹⁰

In addition, survey results indicate that nearly one-third (29 percent) of Home Help providers lack health insurance coverage. This rate is almost three times the overall level of uninsurance in Michigan—10.9 percent of Michigan residents, ages 18 to 64, are uninsured (**Chart 1**).¹¹

Chart 1

Insurance Status of Home Help Providers Compared to Michigan Population

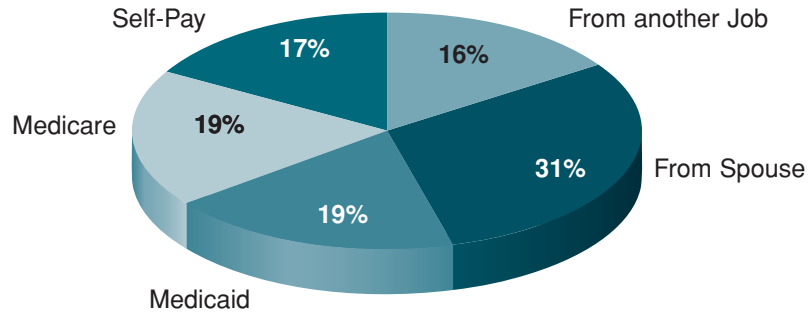


Of Home Help providers who are insured, survey results show that 31 percent receive their health care coverage from their spouse, and another 33 percent either get it from another job or

purchase private insurance themselves. Of those with insurance, 19 percent have Medicaid coverage and 19 percent are covered by Medicare (with some reporting dual eligibility).

Chart 2

Source of Coverage for Insured Home Help Providers¹²



Insurance Status: Key Findings

The high level of uninsurance among Home Help providers is directly related to their wages and family income levels.

Home Help providers earn wages that are significantly lower than those of other direct-care workers in the state’s long-term care system and Michigan residents overall. According to the U.S. Bureau of Labor Statistics,¹³ organizational-based direct-care workers (nursing aides and home health aides) in Michigan earn a median hourly wage of \$10.13; overall the average wage for all Michigan workers is \$19.25/hour.

As a result of their low wages, Home Help providers’ households are generally poorer than those of other direct-care worker households and households in Michigan overall. Of Home Help providers, 56 percent report living in households with incomes under \$30,000. Of all households in Michigan, 38.9 percent have incomes below \$30,000.¹⁴ Another indication of the relative poverty experienced by Home Help providers is high rates of public assistance: one-third of survey respondents receive some type of public assistance.¹⁵

As national studies show, the working poor—i.e., those with low paying jobs like Home Help providers—are least likely among all Americans to have health insurance coverage.

Nationally, poor people (defined as those with incomes below 100 percent of the federal poverty level [FPL]) are twice as likely to be uninsured as the population overall. Two-thirds of the uninsured nationally are families with incomes less than 200 percent of FPL. Findings from a recent telephone survey of Michigan households showed that households with incomes between \$10,000 and \$20,000 had the highest levels of uninsurance (26 percent) across all income categories.¹⁶

Given these figures, it is not surprising that Home Help providers have an uninsurance rate that is almost three times higher than the state average. The working poor have the greatest difficulty accessing health insurance because their employers don’t cover them, many are ineligible for public programs, and they cannot afford to buy coverage. Of Home Help providers with annual household incomes between \$10,000 and \$20,000, 42 percent lack health insurance.

Table 2

Health Insurance Status of Home Help Providers by Household Income

Household Income	Insured	Uninsured
Under \$10K	61%	29%
\$10K–\$20K	58%	42%
\$20K–\$30K	67%	33%
Over \$30K	85%	15%

The rate of insurance coverage for the poorest Home Help providers (those with household incomes below \$10,000) is slightly higher than those in the \$10-\$20,000 category because these poorest providers are more likely to be covered by public insurance programs.

All Home Help providers, regardless of insurance status, have significant out-of-pocket health care expenses and medical debt.

Despite low Home Help wage rates and poverty-level household income, nearly one in six Home Help providers (17 percent) pays out-of-pocket for his or her own private health insurance, indicating the high value providers place on health insurance despite having little disposable income. Not surprisingly, these providers report both high premium levels and out-of-pocket costs. Of Home Help providers buying private health coverage, 69 percent report paying the full cost of their plan, with almost half (45 percent) paying \$50 to \$200 per month in premiums and 37 percent paying more than \$200 per month. Yet 36 percent of Home Help providers with private health insurance also report having over \$1,000 in out-of-pocket medical expenses not covered by health insurance.

These costs add up. Of Home Help providers with private insurance, 25 percent report unpaid medical bills, as do 23 percent of those covered by Medicare. Home Help providers without health insurance are even more likely to have medical debt. Nearly half (40 percent) of uninsured Home Help providers report unpaid medical bills as a current financial burden.

Uninsured Home Help providers are less likely to see a doctor for needed care.

More than half of uninsured Home Help providers (52 percent) report not seeing a doctor for necessary care. This inability to access health services is higher among Home Help providers than other uninsured adults in Michigan: 43 percent of all uninsured adults in Michigan report not seeing a doctor for necessary care.¹⁷ This lack of access to health services is particularly disturbing considering that one-third of Home Help providers report having a chronic illness—e.g., hypertension or diabetes. These types of diseases are best managed with regular health care. Study after study shows that people without health insurance delay care, experience greater declines in health status, and die sooner than adults with continuous coverage.¹⁸

Home Help providers rely heavily on publicly funded health care sources.

Over one-third of insured Home Help providers receive their coverage through public insurance programs—either Medicaid (19 percent) or Medicare (19 percent). In addition to public funds used to cover Home Help providers through Medicaid or Medicare, as shown in **Table 3**, nearly half of uninsured providers report using hospital emergency rooms and community clinics, which rely heavily on public funding, to access health services.

Table 3

Source of Care for Home Help Providers

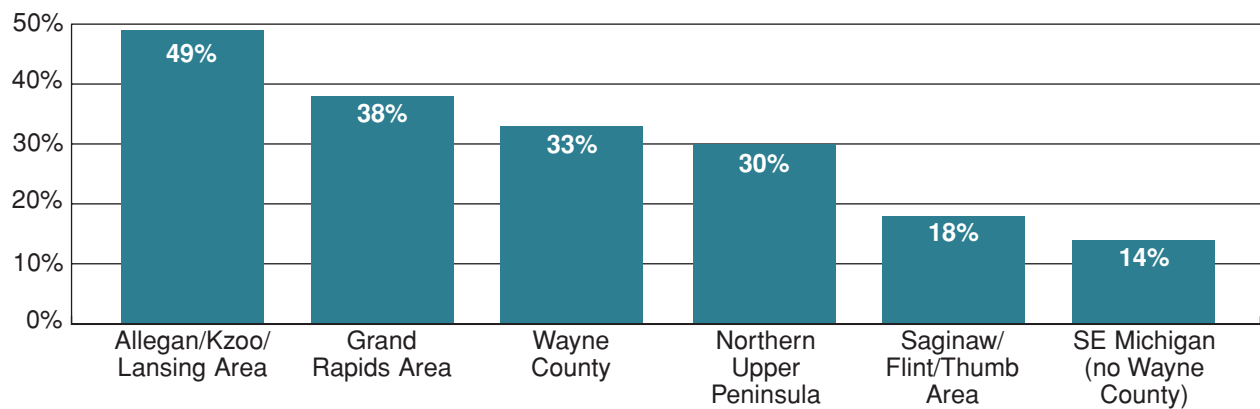
Source	Overall	Insured	Uninsured
Hospital Emergency Room	11%	7%	22%
Doctor's Office	68%	77%	48%
Local Community Clinic	17%	14%	25%

Geographic disparities exist in health insurance coverage in Michigan

Home Help providers in the Grand Rapids area and the Allegan/Kalamazoo/Lansing area are more likely to be uninsured—38 percent and 49 percent, respectively—than those living in other regions of the state. The high rates of uninsurance reflect higher percentages of households in these regions with annual incomes under \$20,000.¹⁹

Chart 3

Rates of Home Help Provider Uninsurance by Michigan's Geographic Regions



Single Home Help providers are more likely to be uninsured than married providers.

Over one third (37 percent) of single providers lack health insurance coverage compared to providers who are married (20 percent), reflecting the extent to which many providers rely on their spouse for health insurance coverage. This is consistent with national data showing that individuals who have never been married comprise 45 percent of the uninsured.²⁰

African-American Home Help providers are more likely to be uninsured than other racial groups.

One-third of African American providers are uninsured compared to one-quarter of white Home Help providers. Disparities exist between low-income households as well, with African-American Home Help providers in households with incomes of less than \$20,000 annually more likely to be uninsured (43 percent) than white providers (35 percent) with the same household incomes.

V. Implications

Implications for Providers

Findings in this report show that Home Help providers' lack of adequate and affordable health insurance coverage affects their health and their economic security. Nearly one-third are uninsured and cannot afford the cost of medical care. In addition, many of those who are insured report being burdened with high out-of-pocket expenses. Uninsured and underinsured Home Help providers report delaying needed medical care because they cannot afford to pay for it.

When they can no longer delay medical care, uninsured and underinsured Home Help providers often seek care through safety-net providers rather than a family doctor. This means they are less likely to receive quality health care services in a consistent manner, and may not be screened for treatable conditions such as diabetes, cancer, and cardiovascular diseases. The result is later diagnoses at more costly stages of the disease and shorter lengths of survival.²¹ A recent study confirms these conclusions: of uninsured individuals with a chronic illness such as diabetes, 59 percent did not fill a prescription or missed a dose of medication because they could not afford it.²² Taking medication as prescribed and seeing a physician for necessary care are positive health behaviors that can save lives and money.

This same study found that:

- More than one-third of uninsured individuals with a chronic illness recently went to an emergency room or had an overnight hospital stay, a level of hospitalization two times higher than that of insured individuals with a chronic disease.
- Uninsured individuals are less likely to get pap or colon cancer screenings or mammograms.
- Uninsured individuals are twice as likely to have duplicative tests ordered.

Although uninsured individuals are likely to access care through safety-net providers—community clinics, community health centers, and hospital emergency rooms—these services are not free. The average emergency room visit costs \$560.²³ For low-income individuals without health insurance, this type of medical expense may take months, if not years, to pay off.

Thus, many Home Help providers must cope with the financial strain of medical debt. These costs can compromise their ability to afford basic necessities, or in the worst case scenario, place them in jeopardy of medical bankruptcy. A 2000 study found that almost half of the 7,000 uninsured individuals surveyed had medical debt from a safety-net provider.²⁴ This same survey found that, particularly in rural areas, the stigma and shame associated with having an unpaid medical bill deters individuals from returning to the same health care provider.

The financial consequences for underinsured individuals are equally dire. One out of six of those surveyed in a study released last year indicated that their credit scores had been harmed by medical debt of less than \$500.²⁵ The stigma of medical debt also affects underinsured individuals, leading to delays in care for themselves or their families, and as a result, poor health outcomes.²⁶

Implications for Long-Term Care Consumers

Michigan is facing a shortage of direct-care workers. Michigan’s elderly population will more than double over the next 25 years, but the state’s traditional source of caregivers—women ages 25 to 44—is projected to shrink by more than 10 percent. Given this crisis, it is important to begin identifying and implementing measures to attract and retain qualified and committed direct-care workers. Employment in the long-term care sector that does not offer adequate and affordable health insurance coverage diminishes the sector’s ability to attract people to this field. In several Michigan and national studies, direct-care workers say that lack of health insurance coverage is one of the factors that contributes to their dissatisfaction with their jobs and their decision to seek other employment.^{27, 28, 29} High vacancy and turnover rates directly impact the quality of care available to consumers, who need skilled, consistent, and compassionate caregivers to support them.^{30, 31, 32}

Not enough providers is only one issue affecting consumers. The quality of long-term care also depends on healthy providers; yet as has been documented in this report, many Home Help providers—who make up more than one-third of the state’s approximately 120,000 direct-care workers—lack a key ingredient in living healthy lives: adequate and accessible health insurance coverage.

When Home Help providers lack health insurance coverage, long-term care consumers and their families are the first to feel the effects. Because caregiving is intimate by nature, it is done best through high-quality, consistent relationships that have been established over time. When providers miss work due to injury or illnesses, the stability of these relationships is compromised and so is the quality of care delivered. A temporary replacement provider does not know the consumer’s preferences for how care is delivered, nor is the consumer necessarily as comfortable receiving care from the replacement caregiver. But the consumer’s care is also placed at risk when providers come to work sick.

This type of instability directly impacts the lives of long-term care consumers—it means they may not be bathed for the day, may not receive assistance with important exercises, or may miss work themselves because their caregiver could not make it to work. Family members also suffer the consequences, often taking time from their own jobs to provide services when a Home Help provider is absent.

Implications for the Health Care Industry

As a segment of the working poor, Michigan’s uninsured and underinsured Home Help providers are contributing to increased health care costs within the state. As the survey shows, large numbers of these providers access health care through safety-net providers and the Medicaid system because no other options are available.

As these and other low-income workers turn to the health care safety net—i.e., hospitals, community health centers, and community clinics—to access care, that safety net is facing unprecedented financial strain. In 2002, the Citizens Research Council of Michigan reported that Michigan hospitals collectively reported \$1.1 billion in charges for uninsured and uncompensated care in 2000.³³ Although the majority of these charges were in southeast Michigan, west Michigan had the third highest level of uncompensated medical care in the state at approximately \$119 million.

More recent reports across the state show that medical systems are facing record levels of uncompensated care. In 2005, Spectrum Health System, the largest provider of care to uninsured and underinsured in west Michigan, reported a 10 percent increase in what it refers to as its “community benefit contribution.”³⁴ In March 2006, the *Detroit News* reported that hospitals in Metro Detroit had approximately \$740 million in unpaid medical bills in 2005, an increase of \$163 million from 2004. Though low Medicaid reimbursements contributed to this gap in payment, by far the largest portion was the result of poor uninsured and underinsured individuals using emergency rooms as their primary source of care.

Safety-net providers cannot continue to offer adequate care as the number of people without insurance grows and funding shrinks. Federal spending on the safety net increased by 1.3 percent in 2004, while the total number of uninsured Americans grew by 11.2 percent between 2001 and 2004.³⁵ This pattern inevitably will result in fewer Michiganders having access to adequate health care services. Ironically, among those at risk for losing access to even health care safety-net services are low-income, uninsured, and underinsured Home Help providers who serve the health care system.

VI. Conclusion

Findings in this report reveal powerful yet all-too-common themes for direct-care workers caring for elderly and disabled consumers. For the majority of providers, the Home Help Program is their only source of employment and with low-wages, they live paycheck to paycheck. Moreover, they are providers in a Medicaid-funded health care program that does not include health insurance coverage for those who care for others.

As a result, many of these providers pay out-of-pocket health care costs that are disproportionate to their income or they delay receiving necessary medical care. They face high levels of medical debt, putting their families further at-risk financially. In addition, they may not receive adequate treatment for chronic conditions, which may leave them unable to continue providing care in the future.

The Michigan Home Help Program is an important part of Michigan’s long-term care system. Services delivered by over 45,000 providers through this program allow tens of thousands of elderly and individuals with disabilities to remain in their homes. Yet, having an uninsured workforce puts these consumers at increased risk. An unhealthy workforce cannot provide the consistent, high-quality services consumers need to remain independent and at home.

Consumers are also put at risk when not enough people are willing to take jobs as caregivers. Michigan’s population is aging and the demand for these services is increasing. Health insurance coverage is critical to attracting and retaining a qualified and committed caregiving workforce that can support our elders in their homes. All Michigan families—those who need care and those who provide care—deserve the security of affordable and adequate health care services.

Endnotes

1. ADL services include assistance with eating, toileting, bathing, and mobility. IADL services include assistance with taking medication, shopping, housework, and meal preparation.
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Appendix 1

Demographic Information: Michigan's Home Help Providers

Characteristics	Percentage of Respondents
Gender	
Female	83%
Male	17%
Age	
Under 45	22%
45 – 54	28%
55 – 64	24%
65 and over	22%
Race & Ethnicity	
White	53%
African American	38%
Latino	6%
Marital Status	
Married	43%
Single	27%
Widowed	14%
Divorced	11%
Separated	2%
Household Size	
One member	19%
Two members	34%
Three or more members	52%
Children under 19	
One	14%
Two	12%
None	71%
Household Income	
Under \$10,000	15%
\$10,000 – \$20,000	22%
\$20,000 – \$30,000	19%
Over \$30,000	21%

Appendix 2

Employment Characteristics: Michigan's Home Help Providers

Characteristics	Percentage of Respondents
Hours Worked per Month	
Less than 20 hours	38%
Between 20 – 40 hours	31%
Over 40 hours	31%
Relationship to Consumer	
Immediate Family Member	57%
Distant Family Member	10%
Non-Family Member	16%
Unknown	16%
Mean Hours Worked	30.32/week
Additional Employment	
Yes	32%
No	68%
Length of Employment	
0 – 2 years	28%
2 – 5 years	32%
Over 5 years	39%

Appendix 3

Geographic Designations: Michigan

Geographic Designation	Counties
SE Michigan	Lenawee, Livingston, Macomb, Monroe, Oakland, St. Clair, Washtenaw, Wayne
Grand Rapids Area	Clinton, Ionia, Kent, Mescota, Muskegon, Montcalm, Newaygo, Oceana, Ottawa
Allegan/Kalamazoo/Lansing Area	Allegan, Barry, Berrien, Branch, Cass, Calhoun, Ingham, Hillsdale, Jackson, Kalamazoo, St. Joseph, Van Buren, Eaton
Northern Michigan/Upper Peninsula	Alcona, Alger, Alpena, Antrim, Arenac, Baraga, Benzie, Charlevoix, Cheboygan, Chippewa, Clare, Crawford, Delta, Dickinson, Emmet, Gladwin, Gogebic, Grand Traverse, Houghton, Iosco, Iron, Kalkaska, Keweenaw, Lake, Leelanau, Luce, Mackinac, Manistee, Marquette, Mason, Menominee, Missaukee, Montmorency, Ogemaw, Ontonagon, Osceola, Oscoda, Otsego, Presque Isle, Roscommon, Schoolcraft, Wexford
Saginaw/Flint/Thumb Area	Bay, Gratiot, Genesee, Huron, Isabella, Lapeer, Midland, Saginaw, Shiawassee, Sanilac, Tuscola



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