



An Initiative of the Paraprofessional Healthcare Institute

**Health Care for Health Care Workers www.hchcw.org
Comments before the House Health Policy Committee
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My name is Tracy Lawless and I am representing the Paraprofessional Healthcare Institute (PHI). Specifically we are interested in commenting on the impact lack of health insurance has on direct-care workers—the hands-on caregivers who work in the Commonwealth's 3,400-plus home care agencies and residential long-term care facilities. I also want to tell you about a project we are involved in that explores the feasibility of developing a Professional Employer Organization (PEO) that will allow these provider agencies who want to be able to offer affordable healthcare to their employees the ability to do so.

PHI is a not-for-profit organization that works to strengthen the direct-care workforce within Pennsylvania's long-term care system. Our work is grounded in the philosophy that **quality jobs** for direct-care workers will lead to **quality care** for long-term care consumers. Competitive wages and health insurance coverage are critical elements in attracting and sustaining a strong, qualified corps of direct-care workers, employees of the state's long-term care providers. With this in mind, PHI recently began the *Health Care for Health Care Workers Initiative*, with the specific goal of advocating for affordable health insurance coverage for direct-care workers in nursing homes, assisted living, and in-home settings. We have been actively involved in the Department of Health's Health Resources and Services Administration (HRSA) State Planning Grant for the Uninsured, by providing our input on how health insurance models being explored in that process will affect the direct-care workers and their employers. Of particular interest to this committee, we are currently conducting a feasibility study of long-term care employers to better understand the current availability of health insurance coverage for direct-care workers and identifying the barriers that long-term care employers face in providing coverage to their workers.

SCOPE OF THE PROBLEM:

There are an estimated 130,000 direct-care workers in Pennsylvania. Nursing assistants, home health aides, and personal care attendants provide 70 to 80 percent of the hands-on long-term care services to elders and individuals with disabilities. We know that nationally, one in four nursing home workers and more than two out of five home care workers lack health insurance coverage. Given the challenges that direct-care workers and long-term care

employers face in obtaining health insurance coverage we believe these national rates of non-insurance among direct-care workers are applicable in Pennsylvania. **Direct-care workers lack insurance for two primary reasons: It is too expensive for them or it is too expensive for their employers.** In Pennsylvania, home health aides and nursing home assistants earn an average of \$9.00/hour. Studies show that almost half of direct-care workers live in households that are at or below the poverty line. In the instances when health insurance is available through their employer, these workers often cannot afford the average employee premium of \$45/month for individual and \$138/month for family coverage. Long-term care employers are also challenged by the high cost of health insurance coverage. Health insurance premiums are often higher for long-term care employers because their workers are considered high-risk due to their age, gender, and high on-the-job injury rate. For many smaller long-term care employers, the high cost of health insurance makes it impossible for them to offer affordable health insurance coverage to their workers. I am sure many of you have heard these same concerns about the cost of health insurance expressed by your constituents, and are asking why direct-care workers merit particular attention.

Most of us will need a direct-care worker to care for us or a loved one at some point in our life. Direct-care workers are the backbone of the long-term care industry. Pennsylvania's elderly population is expected to expand during the next 25 years by more than 52 percent, but the traditional source of new caregivers, women ages 25 to 44 is projected to shrink by more than 10 percent. Given this crisis, decision makers in both the public and private sectors need to take necessary steps to attract and retain qualified, committed, direct-care workers.

PROFESSIONAL EMPLOYER ORGANIZATION FEASIBILITY STUDY -

PHI is interested in cost-sharing of benefit packages. We are interested in learning more about how long-term care employers can offer affordable health insurance. Low income workers are more likely to use and access health insurance when cost-sharing is below 5 percent of their income. Also, while we recognize the need to keep the cost of care at manageable levels, we find that direct care workers realistically need a **solid benefit package**, including prescription drugs, disease management/education services, and, given their high rate of on-the job injury, physical and occupational therapy services.

It is becoming increasingly difficult for health care provider agencies to provide employees in their industry with adequate health insurance and other benefits.

With this in mind, the Paraprofessional Healthcare Institute (PHI), the Tri-County Patriots for Independent Living (TRIPIL Services), the Service Employees International Union, and the ICA Group have partnered to conduct research to explore alternatives that might make affordable employee benefits more widely available within the home and community based service sector in the Washington, Fayette and Greene County area. This effort is part of a larger project TRIPIL is undertaking with the financial support of the Pennsylvania Department of Labor and Industry, to create a Regional Workforce Center in southwestern Pennsylvania.

Our efforts have been focused on a survey that will explore the feasibility to develop a Professional Employer Organization (PEO) that could offer affordable health insurance

for the long-term care sector in Southwestern Pennsylvania. The mission of the proposed PEO will be to establish a co-employer of record for agency-employed caregivers in the region for purposes of payroll, health insurance, and other benefits. The PEO offers an increasingly common solution to the escalating cost of health insurance for small and medium sized companies.

STATE-SPONSORED PURCHASING COALITIONS

A recent report shows that focus groups conducted with small businesses concluded that interest in developing coalitions of small employers to negotiate jointly with insurers has spawned authorizing legislation in a number of states. However, enrollment in purchasing coalitions is characteristically low—both a cause and a consequence of their failure to reduce premiums. California launched the nation’s first statewide purchasing alliance for small employers in 1994, now known as PacAdvantage— it has relatively low enrollment and no discernable impact on either premiums or the general rate of uninsured in the state. An alliance recently formed in Minnesota may overcome the problems associated with small size. Unlike conventional coalitions, employers and labor groups that participate in Minnesota’s Smart Buy Alliance continue to buy coverage separately and collectively do not focus on negotiating lower premiums. Instead, they focus collectively on coordinating value purchasing; setting uniform performance standards, and cost and quality reporting requirements; and coordinating the technology demands on health plans and providers. The Minnesota Alliance hopes to reduce direct health care outlays (and premiums) by an estimated 30 percent by eliminating inappropriate and poor-quality care, and another 10 percent by adopting coordinated health information technologies.

POTENTIAL DIRECTIONS FOR PENNSYLVANIA

A number of states have taken a more aggressive approach than Pennsylvania to improving small-group coverage, and some may offer models for taking a more activist approach to promoting coverage in Pennsylvania. Although the ultimate impact of any one of these initiatives is uncertain, collectively they could improve coverage at least marginally—and if it were possible also to offer subsidies, they might improve coverage significantly. For example:

- Pennsylvania’s statutory and regulatory preference for commercial carriers has had significant unintended consequences, without any apparent benefit. Pennsylvania might do better with rate regulation that is uniform for all carriers (as in nearly all of the comparison states). At minimum, it is important that Pennsylvania begin to obtain information from all carriers in the market, and to obtain information about small-group health insurance premiums and losses (by size of group) distinct from larger groups and other health products such as disability insurance. Such information would help Pennsylvania understand its small group market more clearly, and to understand the impact of its regulatory preferences on premiums and competition.
- Pennsylvania might consider the impact of rating factors on coverage in the small group market—including demographic rating and rating by group size. To pool risk more broadly and reduce premium instability, Pennsylvania might consider options to force uniform insurer practice, broader risk pooling, and less premium volatility. For example:

- (a) require pure community rating (like New York) and also investigate the need to develop risk adjustment to support pure community rating;
- (b) prohibit all carriers from using demographic rating—in effect, require for all carriers the rating practices that BCBS plans and HMOs used prior to 2000); and/or
- (c) Identify a common set of rating factors allowed for all carriers and set rate bands that may be tighter than have been proposed.
- Other states such as, Maine, Maryland and New Jersey require carriers to meet a minimum loss ratio for small groups, and raise the minimum relative to those currently in place. This strategy would be consistent with expectations about better health insurance value returned to consumers.
 - In New Jersey and Maryland, the implementation of standard benefits has made the operation of the small group market in these states much clearer to employers and presumably more price competitive, while still offering employers choice among health plans. As a result, both states have established a basis for a market-wide subsidy to support small group coverage, although neither has yet developed a subsidy program. If Pennsylvania wishes to develop a statewide strategy to support small-group coverage (as opposed to a program operating within the market, as in New York or Maine) it might look to these regulatory models to simplify the market, maximize price competition, and lay the groundwork for a subsidy program.
 - Pennsylvania might consider whether the problems that affect coverage in the smallgroup market also carry into the mid-size market. Conventionally, some insurers rate mid-size groups in the same way that they rate small groups; others rate them differently. In either case, many mid-sized groups (with 50-100 employees) may also have problems related to how premiums are set in the market.
 - The potential for employer purchasing coalitions to improve value by coordinating quality measures and standards and technology demands across all or most purchasers is significant. In Minnesota the Smart Buy Alliance is based on the belief that coordination of purchasers' expectations of insurers and providers offers the best hope for improving value, reducing health care costs, and reducing premiums for all purchasers, including small groups. Such coalitions are unlikely to succeed unless the state—one of the largest purchasers of health care—participates. Pennsylvania has been a leader of quality improvement initiatives, but has not coordinated these efforts across all insurers, employers, and providers in the state. The Minnesota model is a good example for reducing the cost and improving the value of coverage to all Pennsylvanians.

Finally, just as uninsured direct-care workers can be found in every county in Pennsylvania we would hope that the providers and health plans would be available statewide. Thank you again for the opportunity to provide comments this morning. We are available to answer any questions you may have.