Is New York Prepared to Care?

A Comprehensive Coverage Solution for Home Care Workers

A Report from:

PHI Health Care for Health Care Workers

In Collaboration with:

Manatt Health Solutions

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HEALTH CARE *for* Health Care Workers

An Initiative of PHI

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PHI and the Health Care for Health Care Workers Initiative

PHI (**www.PHInational.org**) works to improve the lives of people who need home and residential care—and the lives of the workers who provide that care. Using our workplace and policy expertise, we help consumers, workers, employers, and policymakers improve long-term care by creating quality direct-care jobs. Our goal is to ensure caring, stable relationships between consumers and workers, so that both may live with dignity, respect, and independence.

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 conditions and/or disabilities. These 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 living wage.

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Executive Summary

New York State's 215,000 home care workers—personal care attendants, home care aides, home health aides—provide essential services that allow hundreds of thousands of elders and people with disabilities to live with dignity and independence in their homes. Accordingly, the state has made a special effort to ensure that these workers have access to affordable health coverage. Notably, these progressive state public policies, combined with high rates of unionization, have made New York State a national leader in providing good health insurance coverage for its home care workforce.

Yet this coverage is now in jeopardy and, in some cases, is already deteriorating. Rising health insurance costs price many small eldercare/disability services employers out of the market for affordable coverage. Shrinking state revenues have constrained Medicaid reimbursement—funding that this sector heavily depends upon to provide services and pay for labor costs.

Admittedly, ensuring health coverage for home care workers is particularly challenging: Irregular hours, part-time work, and multiple employers often affect a worker's income and eligibility for both employer-sponsored insurance (ESI) and public insurance. Therefore, despite targeted wage and benefit enhancements available to employers throughout the state—including special initiatives aimed at increasing coverage for home care workers in New York City—and significant expansions of public insurance for low-income adults and children, nearly one in three *personal and home care aides* in the state has no coverage, and many more are inadequately insured.

Even more troubling, the quality of coverage for home care workers in many plans has actually decreased in recent years—in terms of increased co-pays and caps on benefits. In addition, workers are losing coverage due to barriers in enrollment and re-enrollment. This erosion of coverage is occurring at the very time that the home care industry is rapidly growing—as our population ages and the preference for noninstitutional care and services increases.

Coverage is eroding at the very time that the home care industry is rapidly growing.

Therefore, we recommend in this report that New York State undertake a two-fold response:

1. Immediately address the weaknesses within the current state-supported plans—particularly Family Health Plus Buy-In—in order to stem deterioration in coverage.
2. At the same time, create a more targeted "Home Care Workers Insurance Fund" as a quasi-public option that would comprehensively address the unique needs of this critical workforce.

Purpose of Report

This report offers the first statewide review and analysis of insurance coverage of home care workers in New York and, in response, provides specific recommendations to strengthen coverage for this essential workforce. It includes an analysis of data collected from the first survey of upstate and Long Island home care employers (see *Health Insurance Coverage for New York's Home Care Aides: Findings from a 2008 Survey of Home Care Agencies Outside of New York City*, **www.coverageiscritical.org**); an assessment of key state-specific health insurance initiatives targeted at home care; and background on the workforce, structure and financing of the home care industry.

Importance of the Home Care Workforce

While the plight of home care workers is shared by many other low-wage workers in New York, the reasons for policymakers to pay special attention to this workforce are compelling:

- Home care workers are a "lifeline" for elders and people with disabilities who are living in their homes. New York State has long had a policy of expanding home-based services, which within the emerging federal policy environment, will be likely to expand further.
- At 215,000, home care workers comprise the *largest group of employees in the health sector* in New York State, far surpassing registered nurses, who number 164,970.[1] Home health aide jobs increased by 20 percent in the five years between 2001 and 2006.[2]
- While already the largest health care workforce in the state, the home care workforce is expected to keep growing at a fast pace: in New York City alone, an additional 65,000 home care workers will be needed in the decade ending 2016.[3]
- Home care workers are employed by agencies that are heavily dependent on public funds to provide caregiving services and ensure adequate wages and benefits to their employees.
- When compared to other workforce sectors, these workers have high rates of workplace injuries (due to muscle strains from lifting) as well as chronic health conditions (such as asthma, diabetes, and hypertension), making access to affordable medical services all the more important for themselves and their clients.

The health coverage picture that emerges for home care aides working for agencies that operate outside of New York City is bleak.

Survey Findings

PHI's new survey data, collected from 73 home care agencies operating outside New York City, reveals that significant numbers of home care aides employed by these agencies lack access to employer-sponsored insurance (ESI). Despite an unexpectedly high percentage of participating agencies reporting that they offer health insurance to their aides, only one in four of these workers is enrolled in the ESI offered. The primary contributors to low enrollment of aides among agencies offering health insurance appear to be twofold: 1) eligibility requirements that disqualify a high percentage of the workforce, and 2) the high cost of health insurance premiums, which are not fully covered by employers.

Based on the responses of the 73 participating agencies, the health coverage picture that emerges for home care aides working for agencies that operate outside of New York City is bleak:

- 25 percent work for employers that do not offer any health coverage to their home care aides
- 29 percent work for employers that offer coverage, but they are ineligible for that coverage
- 21 percent work for employers offering coverage for which they are eligible, yet they are not enrolled
- Only 25 percent are actually enrolled in employer-sponsored insurance plans

For workers who earn on average $10/hour, premium costs are a significant barrier to participation in employer-sponsored insurance.

The data from this study also reveals that:

- If every home care agency that participated in the survey offered a health insurance plan at current rates of eligibility and enrollment, only about 33 percent of home care aides would be enrolled.
- If every agency offered health coverage at current premium costs—and every aide who worked for that agency were eligible for this coverage—only about 54 percent would choose to enroll.
- Yet, if every agency offered insurance, every aide were eligible for insurance, and *90 percent or more of the health premiums for those aides were covered by the agency*, approximately 83 percent of aides would be enrolled.[4]

For workers who earn on average $10/hour, premium costs are a significant barrier to participation in employer-sponsored insurance. Yet, many home care employers run small businesses that do not have sufficient income to cover the premium costs for their employees.

Evaluation of Health Insurance Initiatives

With the exception of expansions in eligibility for public insurance—which has reached many home care workers and their families—state public policy has generally encouraged employer-sponsored insurance through improved reimbursement rates, rate add-ons, and other enhancements to pay for coverage of home care workers. Three major efforts have been undertaken in the past 10 years to expand employer-sponsored health coverage.

State public policy has generally encouraged employer-sponsored insurance through improved reimbursement rates, rate add-ons, and other enhancements to pay for coverage of home care workers.

One has been to provide additional funding to Office of Mental Retardation and Developmental Disabilities (OMRDD)-sponsored agencies that has enabled them to enhance employer-sponsored health benefits for their direct-care and -support staff. The other two have focused primarily on coverage for the personal care aides (known as "home attendants" in New York City) employed by 67 New York City agencies contributing to the 1199/SEIU National Benefit Fund for Home Care Employees (referred to as "the Fund") for comprehensive individual and family health coverage.

This report evaluates all three initiatives, but highlights the Family Health Plus Buy-In program. The intent of the state in passing the legislation that created the program in 2007 was to eventually open it up to employers across the state. This program allows employers and union/management Taft-Hartley funds to "buy into" Family Health Plus. In 2008, the program began with the participation of the 1199/SEIU National Benefit Fund's home attendants. The Family Health Plus Buy-In replaced an earlier state-funded Home Care Workers Health Insurance Demonstration that, through a state subsidy, had enabled the Fund to continue administering its own benefit plan.

PHI's preliminary assessment of the first six months of program implementation (April–October 2008) has revealed a significant drop in enrollment. The primary reason for this appears to be enrollment complications due to a far more bureaucratic and complex process. Enrollees have also experienced some changes in benefits that have increased out-of-pocket costs. In addition, in the transition, the Fund has experienced increased costs related to higher premiums and administrative challenges, including having two groups of enrollees (subsidized, non-subsidized) with different enrollment processes, varied provider networks, and most recently, different prescription plans. While some of these challenges may be resolved through administrative adjustments, others may require policy changes at the state or federal levels to minimize enrollment complexities.

Because New York City-based 1199/SEIU National Benefit Fund enrollees were previously insured with comprehensive and affordable benefits, it is difficult to assess whether the experience of the Fund and its members with Family Health Plus Buy-In will be applicable to home care workers statewide. However, based on data from PHI's upstate employer survey—on types of plans offered and the associated premium costs—it appears that several obstacles may make participation in the Family Health Plus Buy-In option difficult for upstate and Long Island home care employers and their employees.

It appears that several obstacles may make participation in the Family Health Plus Buy-In option difficult for upstate and Long Island home care employers and their employees.

One primary obstacle is the state's requirement that the employer pay at least 70 percent of the premium (estimated at around $4,000 annually). Based on the PHI survey results, this would exclude an estimated half of all employers.[5] Yet for a small segment of home care workers—those whose current employers pay at least 70 percent of the premium and whose household income meets FHP eligibility requirements for premium subsidy—the plan offers an affordable option.

Recommendations

New York's progressive state policies, combined with high levels of unionization, have enabled many home care workers to access both employer-sponsored and public coverage. However, PHI's analysis indicates that employer-sponsored coverage is too often unavailable, unaffordable, or inadequate for thousands of home care workers. Many workers also face a rather perverse incentive: working more hours increases their income, yet in turn limits or eliminates their eligibility for public coverage.

Also, many home care employers are struggling with rising health care coverage costs while simultaneously feeling the squeeze of increasingly stringent reimbursement limits. This situation prevents them from offering their employees both family-sustaining wages and affordable benefits. For many employers that are funded primarily with Medicare and Medicaid dollars, public funding dictates the price of their services and therefore plays a large role in wage and benefits levels.

Still, New York can continue to lead the nation in creating both quality jobs and quality care in the eldercare and disability services sector. To do so, however, will require bold action and leadership.

We therefore recommend that the State of New York undertake a two-fold approach to providing sustainable coverage to those home care workers who are eligible for public health insurance programs and affordable options for those who do not qualify for public options.

1. Take immediate action to prevent further erosion of coverage:
    - Maintain the state's current commitments to subsidizing employer-sponsored insurance coverage.
    - Address weaknesses in the Family Health Plus Buy-In option.
    - Eliminate the barriers to public coverage.
    - Institute new systems of monitoring expenditures and reporting by employers on the use of state funds for health insurance.
2. Begin now to design a new *Home Care Workers Insurance Fund* as a quasi-public comprehensive health coverage initiative:
    - Create a new multi-employer benefit fund – a risk pooling mechanism and administrative structure to purchase health coverage for home care workers employed by the hundreds of home care agencies across the state that either don't provide coverage or provide coverage that does not meet a state standard (e.g., FHP or Medicaid).
    - At the same time, maintain and ensure adequate funds for the large Taft-Hartley funds now in operation in New York City that ensure coverage for home attendant and home health care workers through collective-bargaining agreements.

The goal of this two-pronged recommendation is to increase the quality of care by creating a more stable home care workforce. By creating a Home Care Workers Insurance Fund, New York can: encourage full-time work, eliminate the churning between ESI and public coverage, create larger purchasing pool(s) that can negotiate for affordable coverage, spread risk and reduce overall costs, and create greater transparency and accountability for both the state and its employers/contractors.

Direct-care workers are the backbone of the state's home- and community-based eldercare and disability services delivery system.

Introduction

Overview

Direct-care workers[6] are the backbone of the state's home- and community-based eldercare and disability services delivery system. Today this workforce is facing a serious crisis that challenges the future of quality care for millions of New York residents who depend upon these workers each day. Low wages and lack of access to affordable health coverage—and other benefits—have led to high turnover and vacancy rates throughout the state. This workforce instability comes at the same time that the state expects a sharp increase in demand for home- and community-based care. This demand is due to two factors: the aging of the "baby boomer" population and new public policies that shift eldercare and disability services from institutions to home and community-based settings.

As of 2006, over 215,000 home care workers were providing services to elders and people with disabilities throughout New York State. Moreover, over 100,000 new home care aides will be needed over the period 2006 to 2016, to meet the growing demand for eldercare/disability services, making home care one of the fastest-growing occupations in the state.[7]

Low wages and lack of access to affordable health coverage — and other benefits — have led to high turnover and vacancy rates throughout the state.

As the primary payer for these services, the state must consider how to strengthen and stabilize the direct-care workforce to meet this growing demand. A sustained investment is needed to attract new workers to these occupations and to reduce the turnover that undermines the quality of care for consumers.

Recent studies show that health insurance coverage for home care workers is strongly associated with improved retention, yet these workers are twice as likely as other workers to lack coverage.[8] In fact, in New York, one in five direct-care workers — and nearly one in three personal and home care aides—lack coverage.[9] Consequently, we believe that it is imperative that the state target resources to improve access to comprehensive, affordable, and sustainable health care coverage for this important and growing workforce.

New York's home care workers obtain health coverage through one of two main vehicles: public programs or employer-sponsored insurance. Many home care workers have income that is low enough to qualify for public health insurance programs, such as Medicaid or Family Health Plus (see Appendix A for eligibility criteria). These programs offer comprehensive coverage with little or no cost-sharing.

Though many employers offer insurance plans, enrollment rates are low. Because of high costs, employers limit eligibility and require considerable cost-sharing through premiums, deductibles, and/or co-payments. This is a significant financial burden for low-wage workers already struggling to meet the financial needs of their families. The one exception is among unionized home care workers, who are far more likely to be covered by affordable plans than their nonunionized peers.

Workforce instability comes at the same time that the state expects a sharp increase in demand for home and community-based care.

Recognizing the challenges employers face in trying to provide coverage, New York State has been a leader in implementing initiatives aimed at insuring home care workers. For example:

- The Home Care Workers Health Insurance Demonstration, begun in 2000 and funded by tobacco settlement funds, provided lump-sum annual payments to employers in the down state area. This demonstration for personal care workers (known as "home attendants" in New York City) was the first initiative in the country to subsidize employer-sponsored insurance for the home and community-based services workforce.
- Since 2002, there have been significant add-ons to the Medicaid rate for recruitment and retention of home care workers with direct-care responsibilities. These add-ons could be used for benefits, wages, or training.
- The Office of Mental Retardation and Developmental Disabilities (OMRDD), recognizing the importance of coverage in the retention of its home and community-based workforce, developed the Health Care Enhancement program, which, beginning in 2005, gave additional funding to service providers in order to purchase or supplement existing employee coverage.

Each of these initiatives has expanded coverage, but because the funding mechanisms have not been sustainable, none have offered a long-term solution. Public coverage offers an affordable solution to many low-income families, but budget pressures as well as eligibility constraints jeopardize this as a stable option for home care workers.

New York State policymakers understand that workers in certain sectors of the economy require special attention and investment when it comes to health insurance. Special programs have been designed for garment workers, dairy farmers, freelancers, and home care workers. Massachusetts created a fund for fisherman; Rhode Island for child care workers. Now, in order to grow and sustain its home care workforce and ensure services for the growing numbers of elders and people with disabilities, it is time for the state to reassess current policies, keep what works, and develop strategies for the future.

It is imperative that the state target resources to improve access to comprehensive, affordable, and sustainable health care coverage for this important and growing workforce.

Purpose of this Report

This report offers the first statewide review and analysis of the health coverage status of home care workers in New York and, in response, provides specific recommendations to strengthen coverage for this essential workforce. The report includes an analysis of data collected from the first survey of New York home care employers outside New York City, as well as an assessment of key state-specific health insurance initiatives targeted at the home care workforce.[10] In addition, the report provides background on the workforce, as well as the structure and financing of the home care industry.

While an analysis of the rate setting and structural fragmentation of the eldercare/disability services sector is beyond the scope of this report, a general overview is included to illustrate the multiple challenges to providing health coverage to home care workers through their employers. This report focuses on the coverage mechanisms—past and proposed—that will best serve this workforce; however, the very organization of this workforce—its variation in payment and payers and the characteristics of the employers—have contributed to the challenges this report outlines.

Each of these initiatives has expanded coverage, but because the funding mechanisms have not been sustainable, none have offered a long-term solution.

Methodology

This report draws heavily from interviews with—and data collected from—the following entities: New York State agencies (Department of Health, Office of Mental Retardation and Developmental Disabilities), home care agencies (Certified Home Health Agencies, Licensed Home Care Services Agencies), 1199/SEIU National Benefit Fund (which operates Taft-Hartley funds for home attendants and home health aides primarily in New York City). Interviews with state agencies, home care agencies, Fidelis Insurance Plan, and the 1199/SEIU National Benefit Fund were conducted in person and by phone during 2008. Conversations with direct-care workers also provided important information.

Data on New York City workers was provided by the 1199/SEIU National Benefit Fund. In addition, PHI contracted with the Center for Healthcare Workforce Studies (CHWS) at the School of Public Health, State University at Albany, to conduct a survey of home care agencies outside New York City to capture the penetration of employee health coverage.

CHWS analyzed the survey data collected from agencies outside New York City, and in addition, conducted two focus groups by phone with 13 home care agencies around New York State (volunteers drawn from the survey participants) to discuss agencies' opinions about and approaches to providing employer-sponsored coverage to their workers. (A separately published report, *Health Insurance Coverage for New York's Home Care Aides: Findings from a 2008 Survey of Home Care Agencies Outside of New York City*, analyzes the survey and the focus group results and is available at **www.coverageiscritical.org**.) Finally, PHI conducted focus groups with direct-care workers employed both downstate and upstate. Where applicable, published reports and articles were drawn upon to supplement the primary research conducted for this report.

Each year, there are approximately 215,000 home care workers providing services in New York to over 400,000 consumers.

Home Care Workers

Occupations

Two categories of home care workers—Home Health Aides and Personal and Home Care Aides—serve the needs of frail elderly, disabled, and chronically ill populations across the state of New York. While training standards vary across occupations, these workers assist with bathing, dressing, eating and other daily tasks, and clinical tasks such as blood pressure readings and assistance with oral medication administration. These services are delivered across a range of settings, including consumers' private homes, group homes for individuals with developmental disabilities or mental illness, assisted living residences, and other community-based settings.

Each year, there are approximately 215,000 home care workers providing services in New York to over 400,000 consumers.[11] These workers are divided between 140,000 home health aides and 75,000 personal and home care aides (also known as personal care aides, personal assistants, or home attendants).[12] At least 60 percent of these home care workers are located in New York City, where they are divided among 47,160 home attendants and 81,830 home health aides.

The differences in these two occupations are relatively minor. Home health aides typically provide more health-related services, while personal care aides provide daily assistance with basic tasks, such as dressing and feeding. The differences in services provided, training, and the type of licensed entity that employs the workers are described in Table 1 below.

Table 1: Characteristics, Home Care Workers, New York State[13]

	Home Health Aides	Personal and Home Care Aides
Services Provided	Home health tasks such as: • Monitoring health status through blood pressure, temperature, pulse • Medication assistance Personal care tasks (incidental to a home health aide visit)	Personal care tasks such as: • Dressing • Feeding • Personal hygiene • Assistance with walking • Laundry • Meal preparation
Minimum Training Requirements	• 75 hours (initial) • 12 hours of in-service (per year)	• 40 hours (initial) • 12 hours of in-service (per year)
Employer	Licensed Home Care Services Agency (LHCSA), Certified Home Health Agency (CHHA), Hospice	Licensed Home Care Services Agency (LHCSA), Consumer
Supervision	Registered Nurse	Registered Nurse, Consumer
Number[14]	138,290 in NYS (60% in NYC)	74,680 in NYS (47% in NYC)

Varying reimbursement structures and levels of unionization affect whether or not a home care worker has access to health coverage.

Understanding the distinctions between *home health aides* and *personal care aides* is important to the discussion of health care coverage. Both types of workers are employed primarily by Licensed Home Care Services Agencies (LHCSAs) but, as we discuss below, varying reimbursement structures and levels of unionization affect whether or not a home care worker has access to health coverage.

Growth in Demand

As the baby boomers reach retirement age over the next 10 to 15 years, demand for home and community-based care will rise dramatically, both as a result of consumer preference and state policy. Between 2006 and 2016, the New York State Department of Labor projects a need for 64,700 more home health aides and 38,800 more personal care aides.[15] Home health aides and personal care aides are the third and fourth fastest-growing occupations in New York State, according to the state Department of Labor projections. In New York City, one in seven low-wage workers are already employed in direct care.

State policy is to shift eldercare and disability services from institutional to home and community-based settings.

New York State policy is to shift eldercare and disability services from institutional to home and community-based settings. Already, the state has begun to close skilled nursing facilities and promote home and community-based service programs. New York's Commission on Healthcare Facilities in the 21st Century is charged with reducing excess inpatient capacity statewide.[16] Existing home and community-based Medicaid waiver programs such as the Long Term Home Health Care Program, Care at Home, and the newest, the Nursing Home Transition and Diversion Waiver, also facilitate the delivery of care in consumers' homes and communities. New York has also made significant progress over the years in shifting from institutional to community-based settings for the care of people with developmental disabilities.

As a result of these policies, as well as the preference of consumers for home care services, by 2016, home care workers are expected to outnumber facility-based direct-care workers by 2 to 1.[17] Together, these demographic trends and policy changes reinforce the need for a stable workforce that is able to grow and meet the rising demand of New York State residents who require and/or choose home and community-based care.

The Home Care Industry

Structured by a myriad of state licensure requirements, programmatic criteria, and contractual relationships, New York State's home care industry is complex. Agencies are public and private, non-profit and for-profit, and contract directly and indirectly with state and city government. Revenue is derived primarily from Medicaid, though Medicare is a significant payer as well. Both Medicaid and Medicare are moving aggressively towards managed care in which commercial insurance companies will play an increasingly large role. As discussed below, the way in which the industry is organized and reimbursed has a direct impact on the ability of individual agencies to provide health insurance coverage for their workers.

Home Care Employment

Home health aides and personal care aides are usually employed by Licensed Home Care Services Agencies (LHCSAs). When a Medicaid eligible individual needs personal care, a county social or aging services agency contracts for a personal care aide and Medicaid pays the employer (i.e., LHCSA) directly for the care. However, when an individual needs skilled care, there is an additional organizational layer through which payment flows. New York, like other states, provides home health services through a Certified Home Health Agency (CHHA) or through a variety of waiver programs, most of which contract for aide services from the LHCSA rather than providing that service directly. In this case, the CHHA[18] receives the payment and then pays a lesser amount to the LHCSA for the contracted service. These contracting arrangements create an extra layer of costs, diluting the amount of money available for wages and benefits for home health aides.

The way in which the industry is organized and reimbursed has a direct impact on the ability of individual agencies to provide health insurance coverage for their workers.

Along with the rest of the country, New York is also experiencing a growth in consumer-directed care. Sometimes consumers hire their workers directly; other times they hire workers with the assistance of an agency (often called "agency with choice" model). These consumer-directed personal assistance agencies perform administrative functions for consumers (handling timesheets, payroll, taxes, etc.). Their primary role is to serve as a fiscal intermediary. They receive reimbursement for services rendered by the workers and issue the paychecks.

Reimbursement and Its Impact on Wages and Benefits

Home care agencies are primarily dependent on the state and federal government for their revenue. While this report does not purport to review and analyze the state's reimbursement system, it is important to understand that given the dominance of public funding, these employers do not set their own price for services rendered. Moreover, the two dominant payers, Medicare and Medicaid, use different methodologies to determine reimbursement rates.

Medicare pays home health agencies a prospective payment, or a price for a 60-day episode of care with numerous adjustments for the health condition and care needs of each beneficiary served (case-mix adjustment), time served (Low Utilization Payment Adjustments), extraordinary costs (outlier adjustments), and geographic differences associated with wages. Outside of Medicare managed care, individual employers have no ability to negotiate these rates with state and federal governments.

In contrast, Medicaid home care is largely fee-for-service (again, with the exception of managed-care programs), reimbursed on a per visit or hourly basis.[19] The base rates are calculated on costs from two years past, adjusted for inflation. The rates for home health aide and personal and home care aide services also vary greatly depending on the payment the LHCSA agrees to accept from the agency contracting for services.

In both cases, there is an assumption that the reimbursement rates are sufficient to cover the costs. However, there are several dynamics at work. First, a shortage of nurses and therapists has led to higher-than-expected labor costs that are not recognized in the payment rate until two years later. In addition, the number of LHCSAs creates a competitive situation that enables contractors to negotiate the lowest cost for aide services, leaving the LHCSA with a rate that is insufficient to cover family-sustaining wages and benefits.

Home care agencies are primarily dependent on the state and federal government for their revenue.

A belief that labor costs will be kept low by relying on low-skilled, easily replaceable direct-care workers has also contributed to compensation decisions. However, in the face of increasing demand for services in the community, even for nursing home eligible clients, these assumptions need to be re-evaluated. Quality care depends on a caring, skilled, and dependable workforce. Family-sustaining wages and health coverage are fundamental to recruiting a stable workforce capable of delivering quality care.

In summary, home care providers, whose major source of revenue is from public payers, face a number of challenges that constrain wages and benefits:

- First, since the state sets the rate, employers cannot adjust service fees to cover the cost of wages, benefits, and other overhead expenses.
- Second, LHCSAs negotiate their rates and the competition for business, volume and timely payment cause the LHCSA to accept rates that are often less than is needed to cover their costs, including those associated with health coverage.

- Third, LHCSAs are predominantly for-profit agencies with a portion of the rate providing profit to the owners.
- Fourth, geography affects the size of agencies and volume of business. Upstate agencies have fewer clients and thus even fewer dollars with which to manage administrative and other overhead costs.
- Fifth, state and federal budget constraints have resulted in cuts to provider reimbursement that further constrain the amount of money available for wages and benefits.

As a result of these constraints, home care has long been characterized by low wages and poor benefits. One counter balance to this situation has been unionization.

Unionized Workers

Unionization has been essential to improving and sustaining health coverage rates for home care workers, particularly in New York City where nearly all home attendants and a large number of home health aides are affiliated with unions. Despite a national decline in unionization, the level of unionization of home care workers has risen in recent years.[20]

Unionized home care workers are more likely than non-unionized workers to have health coverage. Nearly half of unionized home care aides nationwide have employer-sponsored insurance, compared with 22 percent of non-unionized aides.[21] In addition, agencies that employ unionized workers tend to contribute a larger share of the total cost of individual and family coverage, compared with agencies whose employers are not unionized.[22]

Unionization has been essential to improving and sustaining health coverage rates for home care workers.

Unionization rates in New York State differ both between occupations (personal care aide and home health aide) and between upstate and downstate workers. Statewide, personal care aides are more likely than home health aides to be unionized. Further, personal care aides in New York City began unionizing in the 1980s, while home health aides began joining unions in the 1990s. As a result, the personal care aides tend to have better wage and benefit packages. Unionization rates are much lower in upstate New York than in New York City.

Of personal care aides in New York City, 43,000 out of a total of 47,160, or approximately 90 percent, are unionized. These workers participate in either the 1199/SEIU National Benefit Fund for Home Care Employees or AFSCME's Local 389 Fund.[23] The 1199/SEIU National Benefit Fund receives contributions from 67 home care agencies; 11 agencies contribute to AFSCME's Fund. Contributions are based on a cents-per-hour-worked basis to provide health care and other benefits for enrollees eligible for coverage.

Of home health aides in New York City, approximately 35,000 out of a total of 81,830, or about 43 percent, are unionized. Their coverage is provided through the 1199/SEIU Home Health Aide Fund. Contributions, also paid on a cents-per-hour-worked basis, are made by 12 home care agencies in New York City under the collective-bargaining agreements with 1199/SEIU to provide health care and other benefits to union members eligible for coverage. Employers contribute to both the home care and home health aide funds for every hour worked by employees, regardless of how many employees enroll in health coverage.[24]

The most recent data confirms that New York home care workers are underinsured.

Obstacles to Providing Health Coverage for Home Care Workers

Evidence Shows High Numbers of Home Care Workers Lack Insurance

As detailed above, the unique structure of the home care industry limits the ability of employers to provide their employees with decent wages and health care benefits. The most recent data confirms that New York home care workers are, in fact, underinsured. New York's personal and home care aides are twice as likely as other New Yorkers to lack health coverage: 30.1 percent of personal and home care aides lack coverage as compared to 14 percent of all New Yorkers.[25]

Table 2: Health Insurance Coverage of Direct-Care Workers in New York

Occupation	Employer-provided, Private	Other Private Insurance	Public Insurance	Uninsured	Total
Nursing, psychiatric, and home health aides[26]	60.4%	2.8%	17.7%	19.0%	100.0%
Personal and home care aides	42.8%	1.8%	25.3%	30.1%	100.0%
Total Percent	57.6%	2.7%	18.9%	20.8%	100.0%

Source: Pooled data from 2006–2008 CPS March Supplement, PHI

This data on health coverage identifies the source of coverage but does not assess the quality of coverage. Many low-wage workers with employer-sponsored insurance are underinsured.[27]

Nature of Home Care Work Presents Unique Challenges

As the discussion above points out, the home care industry is highly constrained by the public reimbursement system that provides the bulk of the industry's revenue. This—and the nature of home care work—has lead to an industry that is characterized by three factors that affect insurance coverage for the workers: a) low wages, b) irregular work schedules, and c) workers considered high risk for insurance coverage.

The home care industry is highly constrained by the public reimbursement system that provides the bulk of the industry's revenue.

Low Wages: In 2008, the statewide median hourly wage for a New York home care worker was $9.74 per hour. This compared to a median hourly wage of $16.91 for all workers in New York State. In New York City, starting wages for home health aides were between $7.50 and $8.00 per hour, while unionized home attendants started at $9.60 per hour.

Low wages make it difficult for home care workers to afford either employer-sponsored insurance or private insurance plans.

Low wages make it difficult for home care workers to afford either employer-sponsored insurance, which usually comes with high cost-sharing requirements, or private insurance plans. Yet many of these workers earn just over the income limit to qualify for public insurance programs. Table 3 below shows the income of typical New York City workers, and how those wages compare to the Federal Poverty Level (FPL) used to determine eligibility for public benefits.

Table 3: Income for a Typical Home Care Worker, New York City (2007)[28]

	Sample Wage	Estimated Annual Income	% FPL for a family of three	% FPL for a household of one
Home Health Aides	$7.50/hour	$13,125	75%	126%
Home Attendants	$9.60/hour	$17,325	98%	167%

The income eligibility level to qualify for public coverage through New York's Family Health Plus for families with minor children is 150 percent of the federal poverty level (FPL). For childless adults, it is 100 percent FPL.[29] Thus, a single adult working as a home attendant in New York, with an annual income of $17,325, does not qualify for public coverage. Many home care workers are falling through the hole in the public safety net, while also earning far too little to afford today's high premium costs for health insurance.

Irregular and Part-time Work Schedules: For many home care clients, only a few hours of support and assistance are needed each day. As a result, many home care workers have part-time hours. If workers manage to get full-time hours, it is often by working for multiple agencies who assign them to multiple clients.

A variety of other factors can also affect home care workers' schedules: a client may be hospitalized or switch providers, a family member may replace the aide in caring for the client, or the client may no longer need the service. The result: home care workers—and their employers—constantly struggle with fluctuating work schedules.

Many home care workers are falling through the hole in the public safety net, while also earning far too little to afford today's high premium costs for health insurance.

Changes in hours lead to changes in income and, sometimes, fluctuations in eligibility for health care coverage. Most employer-based health care plans require workers to work a certain number of hours every week or over the course of several weeks in order to maintain eligibility. When their hours drop, they lose their coverage.

For workers who qualify for public coverage, extra hours may raise their income above eligibility limits, yet they cannot afford other insurance options. Some workers manage this problem by refusing to take extra hours, but this dynamic can put consumers at risk by constraining the labor pool at a time of high demand.

Finally, this churning in and out of various insurance programs not only leaves workers vulnerable to being without insurance, but also increases overall administrative costs. Each time a worker moves from employer-based to public insurance and back again, more paperwork is required to process his or her dropped coverage and re-enrollment.

Poor Health Status: Low wages, irregular hours, and minimal training requirements lead to another dynamic unique to the home care industry: many home care workers come from demographic groups that suffer from high rates of chronic health conditions such as asthma, diabetes and hypertension. Such conditions require medical attention and management.[30] In addition, direct-care workers experience astonishingly high rates of on-the-job back injuries, muscle strains, and tears.[31] The health status of the workforce, along with the risk of on-the-job injury, increases the cost of insurance for home care employers, limiting their ability to offer affordable employer-sponsored insurance.

Many home care workers suffer from chronic health conditions such as asthma, diabetes, and hypertension.

As a result of this dynamic, we see an industry with a workforce at greater risk than the overall population for serious health problems, yet because of their low wages and irregular work schedules, these workers have less access to health coverage. In the end, this has a direct impact on the ability of New York to provide consistent quality care for consumers. *Without insurance, workers face high out-of-pocket costs that cause them to delay or forego care, leading to missed days of work and disruptions in care for the clients they serve.*

Limits of Employer-Sponsored Coverage

For all the reasons cited above, home care employers struggle to provide insurance to their employees. Today, as we all know, insurance premiums are pricing many employers out of the market. For New York's home care workers, accessible employer-sponsored coverage is more often available to unionized workers, the majority of whom live and work in New York City.

To understand more fully the coverage dynamics for home care employers and their employees outside New York City, where a much smaller percentage of the workforce belongs to unions, PHI contracted with the Center for Healthcare Workforce Studies to conduct a health insurance survey of upstate home care agencies. The results of this study—*Health Insurance Coverage of New York State's Home Care Aides: Findings from a 2008 Survey of Home Care Agencies Outside of New York City*—confirm that employer-sponsored insurance (ESI) is not working for the home care industry. (A description of the survey methodology can be found in the full report at **www.coverageiscritical.org**.)

The evidence shows that employers use two mechanisms to reduce the financial burden of insurance coverage on their agencies: eligibility requirements and cost-sharing.

The first of its kind, the survey provides a wealth of new information and indicates several reasons why ESI has not been a successful source of coverage for home care workers. Despite an unexpectedly high percentage of surveyed agencies reporting that they offer health insurance to their home care aides (possibly reflecting a response bias), only one in four home care aides at the 73 agencies that participated in the survey is actually enrolled in an ESI plan.

The evidence shows that employers use two mechanisms to reduce the financial burden of insurance coverage on their agencies:

1. Eligibility requirements limit the number of employees who can actually enroll. Often workers must work at least 30 hours per week to qualify for insurance. The part-time nature of home care work—and the irregular hours described above—make this a high threshold. High turnover of new employees also affects eligibility, since workers often cannot access plans until they have worked for an agency for 90 days.
2. Employers require individual workers to pay a large share of the premium cost. The average health insurance premium for all workers in New York State is $4,605 annually.[32] On average, workers are asked to pay 21 percent of this premium, along with deductibles and co-pays. This is the *average* contribution for all workers in the state; the home care employer survey shows that home care workers are often asked to pay a much higher percentage. This is simply unaffordable for workers whose wages average around $10 per hour.

For workers employed by the 73 home care agencies participating in the study, the health insurance picture that emerges is indeed bleak:

- 25 percent work for agencies that do not offer health insurance to their home care aides
- 29 percent work for employers that offer coverage but are ineligible for that coverage
- 21 percent work for employers offering coverage for which they are eligible but are not enrolled
- Only 25 percent of the aides are enrolled[33]

The data from this study reveals that, among the participating agencies, if every employer offered a health insurance plan, only about 33 percent of home care workers would be enrolled given current rates of eligibility and enrollment.[34] If every agency offered insurance and every worker who worked for that agency were eligible for insurance, only about 54 percent would choose to enroll given current premium costs. Yet, if every agency offered insurance and every worker were eligible for insurance and ***90 percent or more of the health premiums for those aides were covered by the agency***, as many as 83 percent of aides would be enrolled.

Of the employers surveyed, 90 percent indicated that they believed health coverage was either essential or important to the retention of workers.

But home care employers, for the most part, cannot afford these costs. Of the employers surveyed, 90 percent indicated that they believed health coverage was either essential or important to the retention of workers. Nonetheless, they expected costs to continue rising, putting comprehensive, affordable policies further out of reach.

Targeted Coverage Vehicles for Home Care Workers in New York State

Recognizing the critical connection between health insurance coverage and stability of the state's home care workforce, New York State has proactively developed and implemented regional and statewide approaches to improve access to health coverage for home care workers.

These initiatives, however, have resulted in a patchwork of approaches: some have been regional in nature, others have been specific to a type of employer, and all have been time-limited in their funding.

These initiatives have resulted in a patchwork of approaches… and all have been time-limited in their funding.

The initiatives described in this section include:

- **Home Care Workers Health Insurance Demonstration**

  The Home Care Workers Health Insurance Demonstration program, which provided state subsidies to home care agencies in New York City providing home attendant services, supplemented the reimbursement rate to allow the continued provision of comprehensive and affordable coverage. The funding for the demonstration was time limited and the program was applicable to only one segment of the workforce—New York City's home attendants (i.e., personal care aides).

- **Family Health Plus Buy-In**

  The Family Health Plus Buy-In is a public-private partnership, which, through state subsidies, is intended to make health coverage more affordable for employers and their employees. The program began in April 1, 2008, as a replacement for the Home Care Workers Health Insurance Demonstration. Currently, the only participants are the home attendants insured through the 1199/SEIU National Benefit Fund for Home Care Employees. The program's sustainability and affordability for home care employers and their workers remains to be seen.

- **Health Care Enhancement**

  The Health Care Enhancement program, administered by the Office of Mental Retardation and Developmental Disabilities (OMRDD), provides funding to help OMRDD-funded agencies improve access to health insurance for their direct-care workforce. The goal of the program is to help stabilize the workforce. The funds are paid through the Medicaid program and, therefore, the program's sustainability remains to be seen. Further, because a standard benefit is not defined for participating agencies, coverage levels and cost-sharing varies across employers.

Home Care Workers Health Insurance Demonstration

Description

To respond to the high rates of uninsurance and high turnover rates among home care workers statewide, in 1999, the New York State Legislature authorized up to $203 million from Health Care Reform Act funds for a demonstration to support employer provision of health coverage for personal care aides in cities and counties with populations greater than one million (at the time, this included New York City, Nassau and Suffolk counties). The demonstration project was initially funded for three years, but was extended through legislation in 2003 until it was supplanted by the Family Health Plus Buy-In program in April 2008.

The demonstration commenced in April 2000 through a Request for Proposals. Funds were awarded to 60 home care agencies that contribute to the 1199/SEIU National Benefit Fund for Home Care Employees (the Fund), which is a multi-employer Taft-Hartley Fund[35] that provides health coverage and other benefits to home attendants. In addition, select agencies that do not contribute to the Fund participated in the demonstration. These agencies received a rate enhancement to provide coverage directly to their employees.[36]

Funding for the program was time-limited, thereby threatening sustainability…

Eligibility and Enrollment

To qualify for coverage, enrollees were required to meet eligibility criteria set by the Fund's trustees. For individual and family coverage, eligibility required 80 hours of work per month over two consecutive months. Employees who met this threshold applied for coverage by completing an enrollment form and mailing or faxing it in to the Fund. Enrollees eligible for family coverage were required to provide copies of marriage certificates and birth certificates of children, as applicable. In November 2007, six months prior to the end of the program, eligibility requirements for spousal coverage increased to 170 hours worked each month over two consecutive months. As a result, 8,000 spouses were dropped from coverage.[37]

Benefits

The program initially involved the delivery of primary, vision, and dental care to personal care aides through HealthFirst's managed-care plan. After enrollment, Fund members received an insurance card and were able to access care through the designated provider network. To reduce administrative costs, the Fund became the insurer and administrator in 2002. To the Fund enrollee, no change was apparent; all changes took place on the "back end," within the administrative structure.

Cost-Sharing

The Fund, using employer contributions, covered the full cost of premiums. Enrollees were not subject to co-premiums. Faced with rising health care costs but stable funding, the Fund instituted modest co-payments for enrollees for select services toward the end of the program: prescription drugs ($3 for generic and $6 for preferred brand), office visits ($10), emergency room visits ($3), and inpatient stays ($25).

Assessment

Though the Fund was able to continue offering accessible, comprehensive and affordable coverage to Fund enrollees through the demonstration program, funding for the program was time-limited, thereby threatening the sustainability of the program as premium costs continued to rise. Further, the program primarily served personal care aides in New York City, and did not include thousands of home health aides within the same region.

Publicly available evaluative information on this program is limited. As of June 2003, nearly 78,000 individuals—home attendants, their spouses and dependents—received benefits through the Fund and other agencies that participated in the demonstration project. The program has shown to contribute to reductions in "churning" or involuntary disenrollment from coverage. Whereas prior to the program, an average of 1,550 home care workers in the Fund lost coverage each month, that figure was reduced to 1,034 workers each month after the third year of the program.[38] Anecdotal feedback revealed low absenteeism and high satisfaction rates. More than 70 percent of Fund enrollees indicated that they planned to remain in the home care industry as a result of the demonstration project. The demonstration program concluded on April 1, 2008, with implementation of the Family Health Plus Buy-In program, described below.

Health coverage provided through 1199/SEIU returned to being self-administered, allowing the Fund and its Trustees to design its own benefit package tailored to the unique characteristics of home care workers. This involved adjusting cost-sharing levels, eligibility criteria, enrollment processes, and the provider network. Eligibility criteria for individual and family coverage was not based on income, residency, or citizenship. Enrollment was streamlined: eligible members were required to complete an enrollment form, include copies of a marriage certificate and/or a birth certificates for spousal or child coverage, as applicable, and mail or fax in the form. Attendants were not required to appear in person to apply, which drastically improved accessibility of enrollment.

The demonstration program provided affordable, comprehensive coverage, including family coverage options, for those who worked sufficient hours.

The demonstration program provided affordable, comprehensive coverage, including family coverage options, for those who worked sufficent hours. State funding eliminated the need for cost-sharing throughout most of the demonstration. In the final six months of the program, due to rising costs, the Fund modified eligibility and instituted modest co-payments for prescription drugs, office visits, inpatient stays, and emergency room visits. Given the low wages of home care workers, the ability to limit cost-sharing significantly reduced barriers to enrollment.

Financial sustainability proved to be the most challenging aspect of the program. The demonstration offered time-limited state funding derived from the Health Care Reform Act allocations. Initially, the demonstration was able to cover the cost of health care for Fund enrollees. However, rising health care costs resulted in coverage expenditures exceeding available demonstration funds.

State funding was not approved to continue the program after 2008. However, recognizing that a subsidy would be necessary to avoid significant increases in the uninsured, the state—working with 1199/SEIU—proposed replacing the Home Care Worker Health Insurance Demonstration program with the Family Health Plus Buy-In. This program transition, is described below.

Family Health Plus Buy-In

Description

Statutory Overview. In July 2007, New York State enacted into law a program that allows certain employers and Taft-Hartley funds to provide health insurance coverage to low-wage employees through the Family Health Plus program (effective April 2008). Family Health Plus (FHP), an extension of New York State Medicaid, was established in 2000 to provide comprehensive health coverage to the state's low-income adults who meet specific eligibility requirements and do not already have health insurance.

This "Employer Partnerships for Family Health Plus" program (known as "FHP Buy-In") offers coverage through a combination of employer, state, and employee contributions. The employer must cover at least 70 percent of the annual premium. For employees who qualify for Family Health Plus (or Medicaid) under current eligibility guidelines,[39] the state covers the share of the premium not covered by the employer (generally 30 percent). Employees who do not meet current eligibility guidelines for Family Health Plus are required to pay the portion of the premium not covered by their employer.

There is one exception to this cost-sharing. If the state determines that an employer cannot afford the 70 percent cost-sharing for employees who qualify for Family Health Plus, the state will pay the full premium. For this population, federal funds are available to match the state's costs. In addition to employees and their spouses, the Family Health Plus Buy-In offers coverage options for dependent children through the Child Health Plus B program (hereafter referred to as Child Health Plus).

At the time of its enactment, the "FHP Buy-In" was hailed as ensuring "that more New Yorkers have access to affordable health insurance, while simultaneously controlling state health care costs."[40] If successful, the program would allow employers and Taft-Hartley funds to offer a comprehensive benefit package while offsetting some of the cost through a state contribution for an employer's lowest-income employees. Additionally, this program offers the state assistance in covering eligible low-income adults through the contribution from employers for a large portion of the annual premium.

Current Implementation Overview. The first and only participant in the FHP Buy-In program is the Taft-Hartley 1199/SEIU National Benefit Fund for Home Care Employees (the Fund), which administers benefits for home attendants in New York City who work for 67 agencies under contract with New York City's Human Resources Administration. Faced with the expiration of the Home Care Workers Health Insurance Demonstration on March 31, 2008, the FHP Buy-In was instituted as an alternative means of coverage for this population. Under the demonstration, the Fund was self-insured. For the FHP Buy-In, Fidelis was selected as the insurer. Under this program, the new name of the plan for home attendants became the 1199/SEIU Fidelis FHP Plan.

The 1199/SEIU National Benefit Fund for Home Care Employees—through the Home Care Workers Health Insurance Demonstration—covered just over 67,400 individuals in March 2008, including home attendants and their spouses and dependents. Six months after transitioning to FHP Buy-In, a total of 55,273 individuals, including home attendants, their spouses and dependents, were covered (see Table 4). Of those who lost coverage, two-thirds were terminated due to failure to comply with the application process.[41] Another third lost coverage due to reduction in hours. According to the Fund, anywhere between 1,000 and 3,000 members lose coverage every month due to changes in hours.

The "FHP Buy-In" was hailed as ensuring that more New Yorkers have access to affordable health insurance, while simultaneously controlling state health care costs.

Eligibility Criteria

To qualify for health coverage through the Fund, all participants must meet the eligibility threshold set by Fund trustees (which include representatives of labor and management). As with the Home Care Workers Health Insurance Demonstration, participants must have worked 80 hours per month for two consecutive months for individual and child coverage. For spousal coverage, the work requirement remained 170 hours per month for two consecutive months.[42] In addition, applicants must meet new state requirements for proof of income, residency, and citizenship, in order for the Fund to access state subsidies. This has made the enrollment process considerably more complex for both the Fund and their members.

Table 4: Family Health Plus Buy-In Enrollment Numbers (October 2008)

Enrollment	Number
Total Non-Subsidized	41,834
FHP Subsidized	6,217
Child Health Plus Subsidized	6,514
Total Enrollment	**55,273**

Note: Additionally, at this point in time, another 700-plus members of 1199/SEIU Fund were covered by Medicaid.

Source: 1199/SEIU National Benefit Fund, November 2008

Financing Mechanism/Cost-Sharing

For the home attendants, New York State elected to exercise the option under the statute of covering 100 percent of the premium for Fund enrollees who qualify for Family Health Plus under current eligibility requirements. While the FHP Buy-In permits cost-sharing for nonsubsidized participants, the Fund elected to continue to cover the entire premium—as had been the practice prior to the FHP Buy-In. Thus, neither the subsidized nor nonsubsidized groups are subject to premium cost-sharing. Spouses and dependent children are similarly covered, without premium cost-sharing.

Definitions of Family Health Plus Buy-In Groups	
Subsidized Group:	Fund enrollees enrolled in Family Health Plus through FHP Buy-In who qualify for the program through current eligibility requirements set by the state. These individuals can enroll in Family Health Plus and the state covers 100 percent of the cost of coverage.
Non-Subsidized Group:	Fund enrollees who do not meet current eligibility requirements for the Family Health Plus program. For these enrollees, the Fund covers 100 percent of the cost of coverage.

For non-subsidized enrollees, the Department of Health reviewed existing insurance encounter data from Fund members and developed a risk-adjusted methodology to determine the premium cost. Since home care workers, including those in New York City, are disproportionately women older than 40 with an estimated higher average utilization than younger women, the risk-adjusted premium is approximately 40 percent higher than for those currently enrolled in Family Health Plus. Total premium cost is estimated to be $3,800 annually.[43]

According to the Fund, anywhere between 1000 and 3000 members lose coverage every month due to changes in hours.

All adult enrollees, regardless of enrollment group, are responsible for modest co-payments for select services. Co-payments are the same for those in the subsidized and non-subsidized group[44] and mirror requirements under the FHP program.

Fund enrollees who have dependent children under 21 may enroll their children in subsidized coverage through Child Health Plus, New York State's children's health plan offering comprehensive benefits to children under 19 with family income levels above Medicaid eligibility but below 400 percent of the federal poverty level. Children enrolled in Child Health Plus, regardless of income, are not subject to any co-payments.

Benefits

All enrollees in FHP Buy-In, whether or not they receive subsidies, are eligible for the same benefit packages offered through the Family Health Plus and Child Health Plus programs (see Appendix B for a list of benefits). Coverage is comprehensive, though limits on some services apply for both Family Health Plus and Child Health Plus.

Plan Participation and Care Delivery

FidelisCare (Fidelis), a New York State-based managed-care plan that serves Medicaid, Family Health Plus, and Child Health Plus recipients, was selected by the Fund as the exclusive plan to serve Fund participants through FHP Buy-In. Fidelis was selected because a large number of its providers overlapped with that of the Fund's own provider network and because it has experience in delivering the Family Health Plus and Child Health Plus benefit package.[45] As part of the transition, Fidelis has expanded its network of primary care physicians and specialists to ensure continuity of care and meet the needs of enrollees. Once enrolled, workers can receive care from any provider in Fidelis' provider network.

Enrollment Process/Recertification

Adding an income-based subsidy introduced a new level of complexity and administrative overhead to the Fund's enrollment process. To initiate and inform members of the FHP Buy-In program, the Fund sent several letters (available in multiple languages) to the home attendant members in early 2008.[46] Through these letters, their outreach coordinators, member service representatives and numerous other communication vehicles—such as posters/flyers on-site at the Fund offices and articles in the members' magazine—the Fund and the union introduced the program to its members and conveyed the dates, time, eligibility, and documentation requirements for enrollment. Fidelis was the primary facilitated enroller and organized special enrollment sessions for Fund members at multiple union office sites around New York City.

To enroll, workers are required to bring in documentation of the following: total household income, dependents living in the worker's household, proof of residency in New York State, citizenship/immigration status (original birth certificate for citizens, naturalization certificate for naturalized citizens and immigration documents for Persons Residing Under the Color of Law [PRUCOLS]). Through enrollment sessions, home care workers are screened for eligibility in Family Health Plus (subsidized and nonsubsidized) as well as Medicaid.

For workers subsidized by the state, Fidelis sends the enrollment applications to the local department of social services for processing, in this case New York City's Human Resources Administration (HRA). HRA reviews the application, communicates with Fidelis regarding any additional information needed, and enrolls the individual. Fidelis subsequently receives from the Department of Health a monthly roster of the newly enrolled, subsidized individuals. For enrollees that fall into the nonsubsidized group, Fidelis processes the applications using eligibility files provided by the Fund, without involvement of HRA.[47]

Subsidized Family Health Plus enrollees are required to notify the local department of social services if they experience a change in eligibility (e.g., increase in income).[48] Subsidized participants also must recertify eligibility under the program annually. HRA sends mailings and other communication to subsidized workers in time for each recertification. Fidelis receives a roster of enrollees due for annual renewal, and follows up these mailings with direct phone calls to members to remind them of the need to renew their coverage. The non-subsidized population is not subject to annual recertification but must remain eligible with the Fund. For all Child Health Plus enrollees, regardless of subsidization level, Fidelis administers annual recertification through advance reminders and renewal packages mailed to recipients' homes.[49]

Assessment

Assessment of the Family Health Plus Buy-In program involves two questions: First, what has been learned from the six months of implementation with the 1199/SEIU National Benefit Fund? Second, how do these findings apply to a possible expansion of the program for this workforce?

It is important to flag several critical problems that the 1199/SEIU National Benefit Fund and its enrollees have encountered.

The initial pilot for FHP Buy-In targeted only home attendants in New York City who are insured through the National Benefit Fund. Since these workers had access to comprehensive health coverage, their experience may not be entirely applicable to populations without any insurance coverage. Nonetheless, it is important to flag several critical problems that the 1199/SEIU National Benefit Fund and its enrollees have encountered in the early implementation phase. These include a complex enrollment process, changes in coverage that have increased out-of-pocket costs for enrollees, and increased premium and administrative costs for the Fund.

A preliminary assessment of the first six months of FHP Buy-In implementation (April – October 2008) for the program's first participant, 1199/SEIU National Benefit Fund, has revealed significant obstacles to enrollment. Notably, several thousand of the Fund's members have dropped their coverage through the Fund. This appears to be the result of a more bureaucratic and complex enrollment process related to means testing. In addition, for the Fund, administrative requirements related to FHP Buy-In have been numerous and costly. While some of these requirements may be resolved through administrative adjustments, others may require policy changes at the state or federal level to minimize enrollment difficulties for applicants moving forward.

The experience of the Fund and its enrollees, combined with the data from the PHI survey of upstate and Long Island home care employers, provides important information on the viability of expanding this program to other employers and their low-wage workers. In addition to enrollment barriers experienced by the Fund's members, the employer survey suggests that cost will be a significant issue going forward. Thus far, the state has paid 100 percent of the premium cost for enrollees who meet income-eligibility requirements for FHP and the Fund has picked up 100 percent of the premium costs for all nonsubsidized enrollees. Evidence from the upstate employer survey strongly suggests that many home care employers could not afford to contribute 70 percent to premium costs, nor could many of their employees afford the 30 percent contribution.

Benefits and Cost-Sharing. The FHP Buy-In program provides a comprehensive benefit plan at low cost for New York home attendants. Nonetheless, the coverage is not as expansive as what was available to these workers under the Home Care Workers Health Insurance Demonstration. Moreover, co-pays for certain benefits such as prescription drugs have increased.

Most importantly, though FHP Buy-In requires a 70/30 premium split between employer and employee, in this case, the enrollee portion of the premium is being subsidized by either the state or by the Fund. The union subsidy has made coverage affordable to enrollees, even if they do not qualify for the state subsidy.

Expanding the FHP Buy-In, with its comprehensive package of benefits, to uninsured and underinsured home care workers would likely provide some expansion of health coverage. For

very low-income households that would qualify for the state subsidy (under $14,570 per year for a worker and spouse), the program would likely be an affordable option. However, for the large number of workers who would not qualify for the state subsidy, paying 30 percent of the nearly $4,000 annual premium is likely to be a significant barrier to enrollment. Data from the 1199/SEIU and Fidelis buy-in indicates that only 25 percent of the current participants receive the state subsidy (11 percent excluding children), suggesting that as the program expands, large numbers of home care workers would not qualify for subsidies.

Additionally, evidence from the PHI employer survey indicates that the majority of home care employers could not match the cost-sharing levels that the Fund has committed to. Data from the employer survey on premium costs show that, if employers are required to pay 70 percent of the nearly $4,000 annual per-employee premium, an estimated half of all employers would not be able to afford to participate.[50] When broken down geographically, employers in only one region — North Country — pay on average 70 percent or more of annual insurance premiums. And when looked at by type of agency, only public agencies pay, on average, over 70 percent of the premium.[51] While the survey did not cover home health aide agencies in New York City, these agencies share similar characteristics that would make the 70 percent premium contribution prohibitive.

For the large number of workers who would not qualify for the state subsidy, paying 30 percent of the nearly $4,000 annual premium is likely to be a significant barrier to enrollment.

In the end, providing employer-based insurance coverage for this workforce will require an adequate reimbursement rate that reflects premium costs. In addition, more generous subsidies will be required for low-income workers to participate. This will require a greater commitment of state and federal funds.

Enrollment Complexities and Administrative Challenges. Prior to the FHP Buy-In Program, the Fund set the eligibility and enrollment requirements for its enrollees. The process was relatively simple: Workers with no dependents were required to fill out and mail (or fax) in an enrollment form. No supplemental documentation was required. Workers with dependents were required to provide a copy of their child's birth certificate and/or marriage certificate, as applicable, and mail or fax these—with the enrollment form—to the Fund. FHP Buy-In, by contrast, requires in-person presentation of several legal documents.

Currently, under the FHP Buy-In, workers must appear in person to enroll and provide proof of income, state residency, and citizenship/immigration status (with an original birth certificate, naturalization certificate, or other original identity documents) as required under Family Health Plus. Further, for children, applicants must provide proof of dependency as required by Child Health Plus. The requirement to appear in person with requested documents has placed a significant burden on workers. Home care workers report to their clients' homes during their work day, making travel to a central office during the week challenging.

The New York State legislature addressed this issue in April 2009, and beginning next April, the in-person appearance will no longer be required. This will definitely reduce one significant enrollment barrier. (See Appendix C for details on changes in the Medicaid and FHP programs for fiscal year 2010.)

However, anecdotal evidence has revealed that the federal requirement to present an original birth certificate or other original official documentation of identity, citizenship/immigration status (rather than a copy or verbal attestation) has been another serious barrier to obtaining coverage through Family Health Plus Buy-In.[52] This finding is congruent with the experience of low-income citizens around the country applying for Medicaid.[53] Many individuals only have copies of their birth certificate; ordering a new certificate may be cost-prohibitive and can take weeks to process, thereby delaying enrollment in the program.

To support the new enrollment and eligibility requirements, the Fund has had to hire two additional administrative staff to support their enrollees. These staff provide ongoing information and education about the FHP Buy-In, provide enrollment assistance for employees, manage enrollment and renewal, and handle enrollee coverage problems.

Anecdotal evidence has revealed that the federal requirement to present an original birth certificate — or other original official documentation of identity — has been a serious barrier to obtaining coverage.

The fact that home care workers do not appear regularly at a central office makes the benefit managers' role more challenging. Lack of regular interaction and two-way communication with benefits managers can lead to misunderstandings about enrollment processes, covered benefits, and cost-sharing.

Using FHP Buy-In to expand coverage for these workers will require additional effort on the part of employers in order to ensure that employees understand the program and enrollment costs. Agencies may need to hire or expand the role of benefit managers, which will raise costs. In addition, eligibility and continuity of coverage depend upon the aide having sufficient hours of work which accentuates the role of schedulers. For small employers, these tasks may simply exceed their abilities.

Health Care Enhancement Program

Description

In 2004, a Health Insurance Task Force, consisting of representatives from the New York State Association of Community and Residential Agencies (NYSACRA), the Office of Mental Retardation and Developmental Disabilities (OMRDD), and the John F. Kennedy, Jr. Institute, collaborated on a foundation-funded study to provide relevant data about the developmental disabilities workforce in New York. The purpose of the study was to inform policymakers about the importance of health insurance coverage for the direct-care workforce that served people with developmental disabilities. As a result, the 2005-06 New York State budget authorized a voluntary program, known as the Health Care Enhancement (HCE) program, to offer a rate enhancement to offset the cost of employer-based health insurance coverage for workers who service clients in the OMRDD system. The HCE program, which just completed its third year, has enabled the purchase of new health coverage as well as the maintenance and expansion of existing coverage for thousands of workers who serve clients in this system.

The HCE program was intended to help stabilize the OMRDD workforce, particularly direct-care and support staff. OMRDD began by surveying their 700 community-based providers in 2005 regarding health insurance benefits. From the survey data, which included a description of

employee coverage as well as wages and benefits, OMRDD arrived at a "benchmark" for coverage. Providers identified as historically offering comprehensive health insurance coverage, at or above a benchmark level, received initiative funding without application. Thus, the health benefit packages of the benchmark agencies were identified as both examples and targets toward which all other agencies should strive.

The HCE program was intended to help stabilize the OMRDD workforce, particularly direct-care and -support staff.

HCE I (2006) and II (2007) participants were required to either provide new coverage or enhance existing programs. Enhancements could include additional coverage—for example, a vision or dental plan—or reduced cost-sharing for employees. OMRDD had to approve provider coverage plans and a board resolution approving use of the funds for coverage had to be submitted with the applications. However, OMRDD did not mandate that participating employers meet any specific enrollment targets, nor did they limit the amount of cost-sharing that could be imposed on employees.

The HCE provides a rate enhancement to participating agencies through its Medicaid reimbursement rate. In HCE I and HCE II, participating agencies that used the rate enhancement to offer new coverage were given $2,500 per eligible employee per year to cover the cost of health insurance. For HCE I, agencies were required to use the rate enhancement to provide coverage for the lowest paid staff as well as others. For HCE II, agencies were allowed more flexibility.

Agencies that already offered coverage were given $325 (HCE I) and $425 (HCE II) per eligible employee to enhance the benefits they offered and/or reduce employee cost-sharing. For the HCE III program, OMRDD devised a new method to determine the rate enhancement. Employers received between 1 percent and 3 percent of their operating costs, which they were required to use to cover eligible employees' insurance. The percentage of operating costs is allocated according to the type of participating agency and the level of coverage provided at the time of participation.

A considerable number of the 700 eligible facilities and agencies have enrolled and remain in the HCE program, providing over 70,000 workers with improved coverage and/or reduced cost-sharing. Table 5 below describes the number of agencies participating in the HCE program in each phase.

Table 5: Participation in Health Care Enhancement

	Phase I (2006)	Phase II (2007)	Phase III (2008)
Number of Participating Agencies	300	278	333
Proportion in NYC	24%	21%	27%
Proportion in Rest of State	76%	79%	73%
Proportion Participated in Previous Phase(s)	N/A	90%	71%*

* Percentage reflects proportion of agencies that participated in HCE I, II and III.

Source:OMRDD February 2009

OMRDD data shows that most employees whose employers participated in HCE had some type of health coverage prior to the program. In HCE I, 53 agencies used the funding to offer health coverage to employees for the first time. Less than 10—in each phase—used the funds to offer new dental or vision coverage. Nearly one-third of participants used funding to establish new health reimbursement arrangements. The impact of the program on employee out-of-pocket costs is hard to measure without baseline data. However an average of 10 to 20 percent of participating agencies in HCE I and II used the funds to reduce co-premium and out-of-pocket payments for employees. Recent anecdotal data from the provider associations suggests this approach was very popular with providers and their employees.[54]

Table 6 below depicts the variation by employer on uses of the rate enhancement for coverage purposes. Agencies used the funding for part-time as well as full-time workers. Residential agencies that use part-time workers on the weekends offered coverage through this initiative as a means to recruit workers to fill needed coverage hours. There was diversity in the types of agencies that used the HCE—rural and urban, small and large. The total universe of eligible agencies was approximately 700.

Table 6: Benefits Offered by Participating Agencies under Health Care Enhancement

	Phase I (2006)	Phase II (2007)	Phase III (2008)
Number of Participating Agencies	300	278	333
Number Establishing New Coverage[55]	11 (3%)	5 (2%)	N/A
Number Offering New Dental or Vision Coverage	6 (2%)	7 (3%)	N/A
Number Offering New Health Reimbursement Arrangements (HRAs)	86 (29%)	90 (32%)	N/A
Number Offering New Flexible Spending Accounts	26 (9%)	15 (5%)	N/A
Number Reducing Employee Share of Premium	61 (20%)	27 (10%)	N/A
Number Reducing Employee Out-of-Pocket Payments	29 (10%)	30 (11%)	N/A
Number Offsetting Premium Increases in Excess of Trend Factor	N/A	N/A	165 (50%)
Participating Employees			
Number of Employees Enrolled in Coverage through HCE**	66,631	70,592	N/A

* Similar data for HCE III is currently not available.

** Either receiving new coverage or enhanced benefits

Source: OMRDD February 2009

Application requirements for eligible agencies became less stringent with each phase of HCE. In the first phase, OMRDD required agencies to submit a plan for coverage enhancement, which OMRDD then approved. In addition, agencies were required to submit a board resolution authorizing the agency's participation in this program. However, administrative requirements for participating agencies were streamlined in the third phase.

For Phase III, agencies were not required to submit plans showing how they would use the rate enhancement. Instead, they were required to affirm that their plan met the criteria outlined in an OMRDD checklist. Also, board resolutions did not need to be submitted to OMRDD in order to participate in Phase III, but agencies were required to have these resolutions on file. Further, Phase III participating agencies are not required to regularly report on implementation of the program or show how the funds are being used. Instead, they are now subject to an audit by OMRDD once every three years, during which the auditors will verify documentation on how funds are used. Similarly, OMRDD is not required to report on the program overall within or outside of its agency.

Assessment

The Health Care Enhancement program provides subsidies to improve accessible coverage to direct-care workers employed by OMRDD-sponsored agencies. The program has expanded coverage and reduced employee cost-sharing. However, since the program does not set forth any specific standards of coverage for employers to attain, there remains unevenness in employee benefits across this workforce. Further, the financial sustainability of the program is jeopardized due to the unavailability of funds for the fourth phase.

The lack of ongoing targeted evaluation of this program has also made it impossible to assess how different types of employers are providing coverage. The Health Care Enhancement Program did not put forth solid guidelines on how providers could use the funding received. Funding could be used in a variety of ways—to offer new or enhance existing coverage and/or to reduce employee out-of-pocket spending. Further, OMRDD did not mandate that all employers meet a specific level of coverage, nor did OMRDD limit the amount of cost-sharing that could be imposed on employees. As a result, there are differences among OMRDD employees in type of benefits, access, and level of cost-sharing.

Moreover, less than half of OMRDD agencies participated in the HCE program. One significant impediment to using the benefit was that agencies sometimes provided non-OMRDD reimbursed services alongside OMRDD services. For those services that were not reimbursed by OMRDD, a similar rate enhancement was not available. Taking the enhancement would have created disparities among the workers unless the provider could supplement their other rates in order to create a uniform benefit across all workers.

HCE financing has been provided through Medicaid funding. Following approval at the federal level, OMRDD obtained a state allocation of $17 million per year, with a federal match for each of the three years of the program (or $34 million per year). The state budget for 2009-10 does not include any additional money for HCE. Thus, as of April 2009, there are no funds to cover the increased cost of insurance or to expand coverage to new workers. As insurance premiums continue to rise, the lack of funding for a fourth phase may also challenge employers' ability to maintain coverage for their current employees.

While the HCE program has improved access to coverage — and reduced cost-sharing for thousands of OMRDD-funded workers—it has not provided a uniform mechanism to ensure that all workers have access to comprehensive benefits. Moreover, fiscal pressures and funding cuts threaten the sustainability of this strategy to ensure access to employer-sponsored health coverage.

New York cannot rely on a "patchwork" approach to coverage for the state's fastest-growing workforce.

Conclusion and Recommendations

State policies have enabled home care workers to access both employer and public coverage over the years. However, this analysis reveals a system of employer-sponsored coverage that is unavailable, unaffordable, or inadequate for thousands of home care workers. Many workers face perverse incentives when they attempt to balance health care and income. For some this may mean intentionally limiting their work hours in order to maintain Medicaid coverage. For others, loss of hours due to fluctuating client needs results in their becoming ineligible for employer-sponsored coverage.

At the same time, many employers are struggling with rising health care costs and feeling the squeeze of reimbursement limits — preventing them from offering their workers both decent wages and affordable benefits. Public funding—i.e., Medicare and Medicaid reimbursement—dictates the price of their services and, therefore, essentially sets wage and benefits levels.

To date, none of the state's initiatives has offered a comprehensive, sustainable approach to health coverage for all home care workers. The FHP Buy-In has some positive features, including a comprehensive benefit plan, subsidies for low-income workers, and coverage that would reach many who are currently uninsured. However, numerous obstacles limit its viability for the growing home care sector:

This analysis reveals a system of employer-sponsored coverage that is unavailable, unaffordable, or inadequate for thousands of home care workers.

- Burdensome eligibility requirements under FHP Buy-In (e.g., documentation of income, residency, and citizenship/immigration status) that mirror enrollment in means-tested public programs pose major obstacles to enrollment. Already, there has been a significant drop in health coverage enrollment among members of the 1199/SEIU National Benefits Fund.
- Since home care workers do not appear regularly at a central office—often going directly from their home to their clients, and then home again—communication between workers and their benefits manager are hampered, which in turn can lead to misunderstandings about enrollment processes, covered benefits, and cost-sharing information.
- The administrative requirements that accompany this program may result in increased employer costs related to an enhanced benefits manager position (a position that some agencies do not have). Benefit managers will need to provide enrollment assistance, manage enrollment and renewal, and handle enrollee complaints.
- Cost-sharing levels for home care workers without subsidies are likely to impose serious barriers to enrolling. The Fund does not require participants to contribute to premium costs, but PHI's employer survey data indicates that cost is a major barrier to enrollment for other home care workers.
- Many publicly-funded and smaller employers will be unable to participate if they are required to pay 70 percent of the premium for their employees.

Recommendations

Based upon the findings of the PHI employer survey and this evaluation of the New York's targeted efforts to provide health coverage for home care workers, we recommend a two-fold approach to New York's policymakers:

- Immediately address (a) some of the weaknesses of the current state-funded initiatives that reimburse employment-based coverage for home care workers, and (b) barriers to eligibility for other public health insurance programs.
- Create a new, targeted, statewide *Home Care Workers Insurance Fund* to establish affordable options for those home care workers who are currently unable to access employer-sponsored or public insurance.

Both steps are necessary.

In the current fiscal environment, simply building on the current system will continue to erode the quality of coverage available to this essential workforce.

In the current fiscal environment, simply building on the current system will continue to erode the quality of coverage available to this essential workforce. With health coverage vital to job retention, this will affect the quality and continuity of care provided to elders and those living with disabilities or chronic conditions. In the long term, New York cannot rely on a "patchwork" approach to coverage for the state's fastest-growing workforce.

To meet the growing demand for quality eldercare and disability services, accessible health coverage for home care workers must remain a priority.

Immediate reforms

New York State can take several immediate actions to prevent further erosion of health coverage for direct-care workers, while at the same time creating building blocks to a new system. These actions include:

- **Ensure adequate and sustainable financing of employer-sponsored insurance:** A sustained funding commitment is imperative to expand access to affordable and comprehensive coverage. Without adequate funding, targeted coverage initiatives become time-limited pilot programs, creating piecemeal and temporary solutions that only lead to further coverage erosion. The state must increase its commitment to subsidizing employer coverage by ensuring adequate reimbursement rates that are earmarked for health insurance coverage. In addition, it is essential to maintain a strong safety net of public coverage for the thousands of home care workers and their families that rely on Medicaid for their health coverage.
- **Reduce barriers to enrollment in FHP Buy-In:** The enrollment complexities associated with FHP Buy-In create numerous barriers for home care workers and should be streamlined for this sector of the workforce. Despite several proposals for eligibility expansion, simplification and streamlining of Medicaid and Family Health Plus enacted in the New York State budget for 2009–2010 (see Appendix C), significant challenges remain for easing the burden for this workforce. Examples of changes that would alleviate barriers include:
  - *Eliminate the income and residency documentation requirement altogether or rely on self-attestation of applicants and prospective/retrospective auditing of such documents to facilitate enrollment. Unlike other public programs, FHP Buy-In involves employers who already have this information as their workers are subject to a criminal history background check.*

- *Use data matches with state vital records systems to confirm citizenship. This change would require a change in federal statute.*
- *Require outreach beginning with employer-based education through multiple methods (oral, written) to ensure that workers are aware of and able to benefit from the program.*

Without adequate funding, targeted coverage initiatives become time-limited pilot programs, creating piecemeal and temporary solutions that only lead to further coverage erosion.

- **Eliminate disruption in public coverage:** While Medicaid and other public programs remain major sources of health coverage for home care workers in New York, numerous barriers prevent eligible workers from getting enrolled and *staying* enrolled.

One of the key barriers to coverage in the current system involves the constant fluctuation of work hours for home care workers. In the current system, this can lead to "churning" between ESI and Medicaid. This situation not only presents a problem for a direct-care worker who is seeking health coverage, but is also potentially disruptive to her eldercare and disability services clients.

A solution to this churning is *guaranteed continuous eligibility*: i.e., regardless of work hour fluctuations, once enrolled, workers should maintain their coverage for 12 months. Continuous eligibility would not only improve overall coverage, but would significantly reduce the administrative work necessitated by workers transitioning in and out of coverage. To maintain coverage beyond 12 months, efforts should be made to minimize churning at the point of annual recertification.

- **Collect Data and Monitor Expenditures:** Despite the significant amount of public funding for home care services in New York, there is little state oversight in the use of those funds as it applies to the provision of health insurance coverage for home care workers. For agencies that receive rate enhancements for workforce recruitment and retention, annual reports are required. However, agencies are permitted to report the use of funds for wages and benefits in the aggregate. No information is requested by the state on what type of health coverage is provided, eligibility criteria for participation, take up rates, or employee cost-sharing. This absence of data prevents a thorough analysis and evaluation of employer efforts to provide health insurance coverage. As a result, the only available information must be derived from voluntary surveys and anecdotal evidence. The state has several mechanisms from which to collect data (e.g., the LHCSA Statistical Report Supplement and LHCSA cost reports) not only on health insurance but also on wage rates, turnover and vacancy rates, number of full- and part-time workers, and non-service expenditures. Having data on basic workforce indicator variables is an essential ingredient of sound long-term care policymaking.

Continuous eligibility would not only improve overall coverage, but would significantly reduce administrative work.

Home Care Workers Insurance Fund

At the same time, New York State should begin immediately to design a new, comprehensive *Home Care Workers Insurance Fund*. This Fund would be a public/private partnership that ensures access to health coverage across the state for all home care employers and their workers. Details of how the Fund would be implemented—as well as other issues such as governance, employer contributions and other cost assessments—are beyond the purview of this paper. However, the essential design elements of this system should include the following:

a) The Fund would be available to all employers and be financed with a combination of existing federal, state, and employer funds.

b) The existing labor/management Taft-Hartley plans in New York City, which have proved to be excellent models for establishing and sustaining coverage, would be encouraged to continue offering coverage. However, even in these cases, coverage may not meet the benchmark standard of the new Fund, and the state would therefore need to work with employers and unions to improve the coverage, including adjusting the reimbursement rate.

c) Employers could either offer coverage that meets a benchmark plan or buy into the new Fund. Employer payments to the Fund would be determined by the state after reviewing current levels of public (federal and state) funding to employers. This would require the state to conduct an analysis of reimbursement methods and rates for publicly financed home care agencies—including the add-on payments. Employer contributions would need to be determined, as some are currently not making any contribution to employee health coverage, others are providing generous benefits, and many are somewhere in the middle.

d) This Fund would work with interested insurers to offer a product (or products) that meet a set of criteria (see Appendix D) that includes a full range of benefits and services. These benefits and services would include: preventive services, prescription drugs, mental health and dental services, as well as disease management for chronic diseases and physical therapy. Out-of-pocket costs for workers would be minimal.

e) The plan would have low eligibility requirements in order to include part-time workers, and would provide a simple, accessible enrollment process. The plan would also conduct outreach to workers.

***New York State should begin immediately to design a new, comprehensive* Home Care Workers Insurance Fund.**

f) Workers eligible and/or enrolled in Medicaid could remain in that pool or be transitioned over to the new Fund. Since state (and federal/state) funds would be the highest portion of revenues paying for health coverage, there is likely to be an incentive to bring this population under one Fund, simplifying the funding streams and decreasing administrative costs.

The benefits of this approach are numerous:

- Creating large pools of workers would spread risk and reduce overall costs by enabling large group purchasing and eliminating significant administrative costs for both the state and for employers.
- For workers who are employed by more than one agency (and are not eligible because of part-time status), the Fund would ensure they have access to coverage. In addition, home care workers whose hours fluctuate would be guaranteed continuity of coverage.

- The Fund would eliminate the administrative costs that result from the churning between ESI and public coverage, consolidate multiple funding streams, and create transparency and accountability for both the state and its employers/contractors.
- Health coverage would stabilize the workforce, reducing turnover and thus making state workforce investments far more efficient, saving money over time.
- Disparities in coverage rates among home health aides and personal care aides and among home care workers upstate and downstate would be eliminated. With the increase in consumer-directed care, this Fund could also provide access to coverage for workers employed directly by their clients.
- Workers would not have to be concerned that fluctuating hours that characterize home care employment will compromise their access to continuous, affordable coverage.

The goal of these recommendations is to create stable, affordable health coverage for a workforce that the state and its residents are increasingly dependent upon for quality care. The state has a major economic stake in this sector of its economy and the purchasing clout that the over 870 individual licensed and certified agencies too often lack. It is a strategy adopted by other states and local governments when they have determined that a particular workforce is critical to its economic development. Rhode Island has its own program for child care workers. The state of Massachusetts developed a program for fisherman. And the city/county of San Francisco operates *Healthy Workers* program for its In-Home Supportive Services (home care) workers.

The goal of these recommendations is to create stable, affordable health coverage for a workforce that the state and its residents are increasingly dependent upon for quality care.

By enacting a Home Care Workers Insurance Fund, New York policymakers can finally address what has been an intractable problem—offering reliable health coverage to the growing home care workforce. With nearly a quarter million of New York's low-wage workers providing home care, a comprehensive insurance program would be an enormous benefit to low-income families as well as elders and people with disabilities who rely on these workers every day.

Endnotes

1 PHI analysis of the U.S. Census Bureau, Current Population Survey, Annual Social & Economic (ASEC) Supplement, pooled data from 2006, 2007, and 2008 for New York State.

2. Center for Health Workforce Studies, School of Public Health, State University at Albany. *The Health Care Workforce in NY*, 2006.

3. NYS Department of Labor. Available at: **http://tinyurl.com/cck5j7**

4. Calculations by the Center for Health Workforce Studies: The total number of enrolled aides across all agencies that offer coverage was divided by the number of all aides employed by agencies that offer coverage.

5. Of survey respondents, 17 percent said they did not cover any of the aides' premiums. For those offering coverage, 14 percent covered some but less than half of their employees' premiums, and 28 percent covered at least half but less than ¾s of their employees' premiums.

6. Direct care workers in the home and community-based services sector are personal care aides, home attendants, home health aides, and direct support professionals.

7. NYS Department of Labor. Available at: **http://tinyurl.com/cck5j7**

8. PHI/HCHCW Fact Sheet, *Health Insurance Vital to Job Retention*, October 2007. Available at: **http://tinyurl.com/d75k6a**

9. PHI analysis of the U.S. Census Bureau, Current Population Survey, Annual Social & Economic (ASEC) Supplement, pooled data from 2006–2008 for New York State.

10. PHI. *Health Insurance Coverage of New York State's Home Care Aides: Findings from a 2008 Survey of Home Care Agencies Outside of New York City*, April 2009. Available at: **www.coverageiscritical.org**

11. PHI estimates using Medicare data from Kaiser state health facts, 2006; Medicaid data from MARS, September 2007, for FFY 2007. Estimates reflect a 10 percent reduction for dually eligible.

12. We have included another sector of home and community-based workers in this report—direct support workers caring for those clients served by providers under contract with the New York State Office of Mental Retardation and Developmental Disabilities.

13. 18 NYCRR 505.14 (Personal Care, Supervision); 18 NYCRR 505.23 (Home Health Services, Supervision); U.S. Department of Labor, Bureau of Labor Statistics (Training); NYS Bureau of Labor Statistics (Income).

14. NYS Department of Labor. Available at: **http://www.labor.state.ny.us/**. These numbers should be read with caution as many personal care aides are also trained as home health aides, and vice versa. Further, the data obtained by the NYS Department of Labor is self-reported by employers who are permitted to ascribe a particular title to its employees. This data does not include personal care aides who work for consumer-directed personal care agencies, but does include direct-care workers employed at facilities such as those which serve individuals with developmental disabilities.

15. PHI calculations from the NYS Department of Labor Long-Term Occupational Projections 2006–2016, New York State and New York City at: **http://tinyurl.com/cck5j7**

16. Commission on the Healthcare Facilities in the 21st Century. *A Plan to Stabilize and Strengthen New York's Health Care System*, December 2006. This final report of the Commission on Healthcare Facilities in the 21st Century recommended the downsizing of approximately 3,000 nursing home beds and expanding the capacity of adult day health care, long-term home health care, and assisted-living programs.
17. PHI. *Occupational Projections for Direct-Care Workers* 2006–2016, June 2008.
18. Certified Home Health Agencies (CHHAs) are one of several home care programs (e.g., hospices, Medicaid Managed Long Term Care Programs, Long Term Home Health Care Programs) that subcontract with LHCSAs. For purposes of this report, references to CHHA subcontracting include the full array of programs and payers that subcontract for aide services.
19. Aide services are paid on an hourly basis regardless of whether the contractor receives a rate by discipline or receives payment via a method of capitation.
20. Schmitt, J., Waller, M., Fremstad, S., and Zipperer, B. *Unions and Upward Mobility for Low-Wage Workers*, Center for Economic and Policy Research, August 2007.
21. PHI. *Coverage Models from the States: Strategies for Expanding Healthcare Coverage for the Direct-Care Workforce*, 2007.
22. Ebenstein, W. "Health Insurance Coverage of Direct Support Workers in the Developmental Disabilities Field." *Mental Retardation*. Volume 44: No. 2, pages 128-134; April 2006; PHI. *Health Insurance Coverage of New York State's Home Care Aides: Findings from a 2008 Survey of Home Care Agencies Outside of New York City*, April 2009. Available at: **www.coverageiscritical.org**
23. Limited data was available regarding AFSCME Fund. There are eleven employers employing an estimated 9,000 home attendants. Email correspondence with Steve Kreisberg, AFSCME International Research Department, November 2008.
24. Similar data for AFSCME not available.
25. PHI analysis of the U.S. Census Bureau, Current Population Survey, Annual Social & Economic (ASEC) Supplement, pooled data from 2006, 2007, and 2008 for New York State.
26. Unfortunately, home health aides are included with nursing and psychiatric aides in one occupational code.
27. Cathy Schoen, Sara R. Collins, Jennifer L. Kriss, and Michelle M. Doty. "How Many are Underinsured? Trends Among U.S. Adults, 2003-2007," *Health Affairs*, Web Exclusive, June 10, 2008.
28. Average median income based on 1,750 hours per year (35 hours a week x 50 weeks per year).
29. New York State Department of Health. *Family Health Plus: Who Can Join?* Available at: **http://tinyurl.com/dzlb75**
30. Several studies document these problems including a 2008 survey of Pennsylvania direct care workers in which 25 percent reported having a chronic condition such as heart disease, diabetes or asthma. For additional studies, see **www.coverageiscritical.org**
31. PHI. *The Invisible Care Gap: Caregivers Without Health Coverage–Ten Key Facts*. 2008.
32. Average single premium per enrolled employee for employer-based insurance, 2006. Available at: **http://tinyurl.com/dzkuj7**

33. Calculations by the Center for Health Workforce Studies in *Health Insurance Coverage of New York State's Home Care Aides: Findings from a 2008 Survey of Home Care Agencies Outside of New York City*. Available at: **www.coverageiscritical.org**
34. Calculations by the Center for Health Workforce Studies. The number of enrolled aides across all agencies that offer coverage was divided by the number of all aides employed by agencies that offer coverage.
35. The Taft-Hartley Act is an amendment to the National Labor Relations Act, 29 USC 141-197, enacted in 1947. Multi-employer funds are labor-management partnerships that cover employees of multiple private employers usually in the same industry, who have signed a collective-bargaining agreement with the same union.
36. Though the NYS Legislature authorized $203 million for this demonstration program, only $165 million was awarded through the RFP process.
37. Fund members that did not meet the eligibility threshold for coverage but qualified for Medicaid were enrolled in state-funded COBRA coverage.
38. Berliner, H.S. *Home Care Workers Health Insurance Demonstration Project: Final Evaluation*, June 28, 2004.
39. Current income eligibility guidelines for Family Health Plus require that an individual's household income is above Medicaid eligibility levels and up to 100 percent of the federal poverty level for a single adult without children ($10,400); up to 150 percent of the federal poverty level for a parent in a household of three ($26,400). Additionally, to qualify for Family Health Plus, an applicant must be a citizen of the U.S.
40. New York State Governor's Office. Press Release. "Governor Signs Bills to Extend Family Health Plus to Cover More New Yorkers." July 9, 2007.
41. Exact numbers are difficult to track because the number of members enrolled changes each month due to lost hours. For example, in May of 2008, 2,443 workers lost hours and therefore eligibility for coverage.
42. Personal communication with staff at 1199/SEIU National Benefit Fund for Home Care Employees, February 2008.
43. Remarks by Assemblyman Richard Gottfried, February 10, 2009, annual Healthcare Legislative Update, School of Public Health, State University of New York, Albany. A request for this information was denied by the NYS Departments of Health and Insurance, as the data was deemed proprietary.
44. NYS Department of Health. DOH Medicaid Update. September 2005. Vol. 20, No. 10.
45. Ibid.
46. Personal communication, staff at 1199/SEIU National Benefit Fund for Home Care Employees. February 2008.
47. Personal communication, staff at FidelisCare, February 2008.
48. The NYS Department of Health has recently submitted a waiver request to the federal government to offer 12-month continuous eligibility to Family Health Plus enrollees. If approved, this continuous eligibility would eliminate the requirement that enrollees must notify local departments of social services of a change in eligibility. If approved, this continuous eligibility would likely extend to those enrolled in Family Health Plus through the Family Health Plus Buy-In.

49. Personal communication, staff at FidelisCare, February 2008.
50. PHI. *Health Insurance Coverage of New York State's Home Care Aides: Findings from a 2008 Survey of Home Care Agencies Outside of New York City*. Available at: **www.coverageiscritical.org**
51. Ibid.
52. Personal communication, staff at 1199/SEIU National Benefit Fund for Home Care Employees, February 2008.
53. General Accounting Office. "States Report that Citizenship Documentation Requirement Resulted in Enrollment Declines for Eligible Citizens and Posed Administrative Burdens," June 2007; Ross, D.C. "New Medicaid Citizenship Documentation Requirement is Taking a Toll," Center on Budget and Policy Priorities, March 2007.
54. Verbal communication with Ann Hardiman, Executive Director, NYS Association of Community and Residential Agencies, August 28, 2008.
55. Under HCE I, 20 agencies that did not offer health insurance at the time applied for funding. They were allowed to reimburse employees for out-of-pocket expenses instead as many employees had coverage through a spouse or parent. Of those 20 agencies, 9 chose to reimburse employees for out-of-pocket expenses and 11 added health coverage.

Appendices

A. Public Health Insurance Programs in New York State

B. Family Health Plus Benefits

C. New York State Budget 2009-2010: Changes in Public Coverage and Eligibility Provisions

D. Health Insurance for Home Care Workers: How FHP Buy-In Measures Up

Appendix A: Public Health Insurance Programs in New York State

Medicaid, Family Health Plus and Child Health Plus are means-tested public health insurance programs for low-income adults and children. For both Medicaid and Family Health Plus in New York State, the federal and state government split the cost of total expenditures. Child Health Plus (CHP) began in New York State in 1990 (with state funds); after the federal enactment of the State Children's Health Insurance Program (CHIP) in 1997, New York State began to draw down federal funds to help finance the program. Over the years, New York State has incrementally expanded the program, primarily by expanding benefits and income eligibility levels.

Any individual who meets the eligibility criteria for these public programs is able to enroll. Given the low wages associated with home care, some workers qualify for and enroll in Medicaid or Family Health Plus. Because eligibility limits for children are more generous, it is even more likely that children of home care workers will qualify for Medicaid or Child Health Plus. If an individual lives in New York State, meets the income requirements, has no other health insurance (only for Family Health Plus and Child Health Plus enrollees), is a citizen (only for Medicaid and Family Health Plus enrollees), she or he may qualify.

Federal and state law dictates enrollment requirements, which vary by program and generally require the documentation of income, citizenship, and residency. In New York State, new enrollments for Medicaid and Family Health Plus require an in-person appearance at either a local department of social service—the local government arm responsible for Medicaid and Family Health Plus enrollment—or a facilitated enroller employed by a community-based organization or managed-care plan. Renewal is required annually for all enrollees and can be done by mail or in person.

The table below describes eligibility and enrollment requirements for Medicaid, Family Health Plus and Child Health Plus.

Eligibility and Enrollment Requirements for Public Health Insurance Programs in New York State. (April 1, 2009–April 1, 2010)

	Target Populations	Income Eligibility	Eligibility Criteria
Medicaid	Children and adults	Infants to age 1 and pregnant women–200% of FPL; children age 1–5 yrs–133% of FPL; children age 6–18 yrs–100% of FPL. Parent: 150% FPL Individuals on SSI: 74% FPL; 87% of FPL for other individual adults	• Meet income eligibility levels • Citizen* • Resident of NYS
Family Health Plus	Adults 18–64	• Single adults and couples: 100% of federal poverty level • Parents with a child under 21: 150% of federal poverty level	• Meet income eligibility levels • Citizen* • Resident of NYS • Proof of no other health insurance

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	Target Populations	Income Eligibility	Eligibility Criteria
Child Health Plus	Children under 19	Children under 19 up to 400% of federal poverty level	• Meet income eligibility levels • Resident of NYS • Proof of no other health insurance

*Some non-citizen immigrants, known as Persons Residing Under the Color of Law (PRUCOLs), may qualify for coverage under these programs.

Source: New York State Department of Health website at: **www.health.state.ny.us/** and **www.statehealthfacts.org**

The benefit packages for all three programs are comprehensive, with some variation. In New York State, most Medicaid and all Family Health Plus and Child Health Plus recipients must enroll in a managed-care plan, which coordinates their care, with exclusions and exemptions for some high needs populations. Co-payments are not required for children enrolled in Medicaid or Child Health Plus.

The table below describes the co-premium levels required for families with children enrolled in Child Health Plus B up to July 1, 2009, when the family contributions for Child Health Plus coverage will increase for children above 250 percent of the Federal Poverty Level. Co-premiums are on a per child basis, with a per child per family maximum, and on a sliding scale based on family income. As described above, these co-premiums are paid for by the Fund.

Child Health Plus Family Premiums (for applications up to July 1, 2009)

% of FPL	Per Child Monthly Premium	Per Child per Family Monthly Premium (Maximum)
< 160%	Free	Free
160%–222%	$9	$27
223%–250%	$15	$45
251%–300%	$20	$60
301%–350%	$30	$90
351%–400%	$40	$120

Source: NYS Department of Health, Child Health Plus: Who is Eligible at:
http://www.nyhealth.gov/nysdoh/chplus/who_is_eligible.htm

Appendix B: Family Health Plus Benefits

- Physician services
- Inpatient and outpatient hospital care
- Prescription drugs and smoking cessation products
- Lab tests and x-rays
- Vision, speech and hearing services
- Rehabilitative services (some limits apply)
- Durable medical equipment
- Emergency room and emergency ambulance services
- Behavioral health and chemical dependence services (including drug, alcohol and mental health treatment – some limits apply)
- Diabetic supplies and equipment
- Hospice care
- Radiation therapy, chemotherapy and hemodialysis
- Dental services (if offered by the health plan)
- Family planning and reproductive health services

Family Health Plus Co-pays

Service	Amount	Details about Co-pay	No Co-pay for These Services
Physician Visits	**$5.00**	One co-payment for each visit to a physician, nurse practitioner or physician assistant.	• Emergency Services • Family Planning Services • Maternity Care
Clinic Visits	**$5.00**	Outpatient clinics in hospitals or freestanding clinics such as Community Health Centers	• Emergency Services • Mental Health Clinics • Family Planning/Prenatal Services • Chemical Dependence Clinics MR/DD Clinics
Brand Name Prescription Drugs	**$6.00**	One co-payment for each new prescription and for each refill	• Drugs to treat mental illness (psycho-tropics) • Birth Control Drugs • Tuberculosis Drugs
Generic Prescription Drugs	**$3.00**	One co-payment for each new prescription and for each refill	• Drugs to treat mental illness (psycho-tropics) • Birth Control • Tuberculosis Drugs
Over-the-Counter Medications (OTCs)	**$0.50**	Covered OTCs—Smoking cessation (e.g.: patches, gum) Insulin	No other OTCs are covered by FHP
Medical Supplies	**$1.00**	Covered supplies—diabetic supplies (e.g., test strips, glucose monitor, lancets, and syringes), enteral formulae and hearing aid batteries.	No other supplies are covered by FHP
Lab Tests	**$0.50**	One co-payment for each laboratory test	• Pregnancy or prenatal tests • Laboratory services related to emergencies
Radiology Services	**$1.00**	Radiology services, including diagnostic radiology, ultrasound, nuclear medicine and radiation oncology services	Radiology services related to emergencies
Inpatient Hospital	**$25.00**	One $25 co-payment for each hospitalization of any length involving at least one overnight stay	Hospital stays for childbirth, miscarriage, family planning services or, prenatal care.
Emergency Room	**$3.00**	Only for non-urgent or non-emergency services	Urgent or emergency services
Dental Visits	**$5.00**	Co-pay for each non-emergency visit, but only up to $25 a year	• Emergency services • Non-emergency visits once the $25 cap has been met

Source: Family Health Plus at: **http://www.health.state.ny.us/nysdoh/fhplus/**

Appendix C: New York State 2009–2010 Budget—Changes in Public Coverage and Eligibility Provisions

The New York State Budget for 2009–2010 (approved April 3, 2009) makes numerous modifications in public coverage programs that will expand coverage and streamline and simplify the eligibility process. Several of these changes will have a direct effect on home care workers due to their low income levels and the public programs that they could be eligible for.

Legislative Changes in Public Coverage

Program Change	Coverage Program(s)	Implementation Date
Elimination of face- to- face interview	Medicaid and Family Health Plus (FHP)	April 1, 2010
Elimination of resource test for Medicaid and FHP applicants (except for SSI or SSI-related)	Medicaid and FHP	October 1, 2009
Elimination of finger-imaging requirement for adults applying	Medicaid	July 1, 2009
Authority for DOH to seek federal approval and financial support to expand FHP coverage to low-income adults up to 200% of FPL	FHP	Contingent upon federal approval; no additional expenditure of State dollars; funding mechanism not identified

Source: New York State Medicaid Update, April 2009, Vol. 25, No. 4 "2009–2010 New York State Budget: Health Reform Highlights at: **http://www.nyhealth.gov/health_care/medicaid/program/update/2009/2009-04_special_edition.htm**

CHP Monthly Premium Increases (Effective July 1, 2009)

Eligibility Category	Current Amount	Revised Amount
Below 160% of Federal Poverty Level (FPL)	None	None
160% - 222% FPL	$9	$9
223-250% FPL	$15	$15
251-300% FPL	$20	$30
301-350% FPL	$30	$45
351-400% FPL	$40	$60

Source: New York State Medicaid Update, April 2009, Vol. 25, No. 4 "2009-2010 New York State Budget: Health Reform Highlights at: **http://www.nyhealth.gov/health_care/medicaid/program/update/2009/2009-04_special_edition.htm**

Coverage Eligibility Changes (Effective April 1, 2010)

Eligibility Group	Revised Income Level Based on Gross Income
Children aged 1 to 19	Medicaid eligibility set at 160% of Federal Poverty Level (FPL)
19 and 20 year olds	Medicaid eligibility set at 100% FPL. Family Health Plus eligibility set at 160% FPL.
Parents	Medicaid eligibility set at 100% FPL. Family Health Plus eligibility set at 160% FPL.
Pregnant Women and Infants	Medicaid eligibility set at 230% of FPL.
Childless adults	Eligibility maintained at 100% of FPL

Source: New York State Medicaid Update, April 2009, Vol. 25, No. 4 "2009-2010 New York State Budget: Health Reform Highlights at: **http://www.nyhealth.gov/health_care/medicaid/program/update/2009/2009-04_special_edition.htm**

Appendix D: Health Insurance for Home Care Workers

How FHP Buy-in Measures Up

Criteria	**Family Health Plus Buy-in** (as of February 2009)
Accessible to all individuals regardless of their family status, their employment status, or how many hours they work.	
✓ Will the majority of direct-care workers fall within the income eligibility limits (for subsidized coverage)?	Maybe: Current subsidies only cover parents w/ family incomes up to 150% FPL and single adults or childless couples up to 100% of FPL, which will extend to many but not all workers
✓ Are individuals who are not parents of minor children eligible for coverage?	Yes, through their employer but are subject to different income eligibility limits for subsidized coverage
✓ Do requirements that are intended to maintain employer-sponsored insurance (ESI) exempt those who are offered ESI but cannot afford it?	Yes
✓ If the reform is designed to expand access to ESI, are part-time workers or those with more than one employer eligible for coverage?	Maybe; this is the employers' discretion
Affordable for workers and their employers.	
✓ Are the premiums and co-payments less than 5 percent of income?	Not known; could be higher if subsidy is not sufficient
✓ Does the plan have low ($10 or less) co-payments for health care services?	Yes
✓ Does the plan have minimal (or no) deductibles?	Yes
✓ Are premium subsidies available to help individuals enroll in ESI?	Yes
✓ If employers are required to offer ESI, what incentives or exemptions are in place for small business to make it more affordable?	Currently no financial incentives or exemptions for small businesses.

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Criteria	**Family Health Plus Buy-in** (as of February 2009)
Adequate, with a full range of benefits and services to protect older workers, those with chronic health conditions, and injured workers.	
✓ Is the insurance package comprehensive, providing a full range of services and benefits without annual limits?	Yes
✓ In addition to basic preventive services, does it include prescription drugs, mental health, and dental services?	Yes
✓ Does the plan include disease management for chronic illnesses and physical and occupational therapy services?	Nothing specifically required; physical and occupational therapy services are offered as part of the standard FHP benefit package, with some limits.
Simple, easy to understand and enroll in.	
✓ Is the marketing and outreach strategy the responsibility of or closely monitored by the state agency responsible for administering the health care reform?	Yes; New York State Department of Health
✓ Will specific outreach efforts target direct-care workers?	Unknown
✓ Is information provided in a concise and streamlined manner?	Unknown
✓ Is information available in appropriate languages?	Unknown
✓ Will information be provided in a non-written format?	Unknown
✓ Are enrollment forms short and easy to fill out and available both on-line and by mail?	Unknown

Source: PHI, *Policy Issue Brief 2: Expanding Coverage for Caregivers: A Checklist for State Health Reform*, November 2007

Note: The New York State 2009–2010 Budget includes several provisions that expand eligibility, including the authority for the New York State Department of Health to seek federal approval and financial support for an expansion of Family Health Plus coverage for low-income adults up to 200 percent of the federal poverty level for local districts that elect to participate.

Selected Publications from Health Care for Health Care Workers

For more information and other publications go to **www.coverageiscritical.org**.

Policy briefs

Caregivers without Coverage: A Critical Gap in Long-Term Care (2006). Available at: **http://tinyurl.com/dkqpjk**

Expanding Coverage for Caregivers: a Checklist for State Health Reform (2007). Available at: **http://tinyurl.com/cuuby7**

Reports

Invisible Care Gap: Caregivers Without Coverage (2007). Available at: **http://tinyurl.com/df4d3b**

Coverage Models from the States: Strategies for expanding health care coverage to the direct-care workforce (2007) Available at: **http://tinyurl.com/c6dz73**

Fact Sheets

Caregivers without Health Care—Fact Sheet: New York (2008). Available at: **http://tinyurl.com/cfvfzx**

Health Insurance Vital to Job Retention (2007). Available at: **http://tinyurl.com/dc9c2b**

Myths and Realities: Health Coverage for Direct-care Workers. Available at: **http://tinyurl.com/c5fedx**

For more information on direct-care workers in New York City:

Addressing New York City's Care Gap: Aligning Workforce Policy to Support Home and Community-Based Care (2006). **Available at: http://tinyurl.com/d2drv5**

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