Coverage Models from the States

Strategies for Expanding Health Coverage to the Direct-Care Workforce

HEALTH CARE *for* Health Care Workers
An Initiative of PHI

Health Care for Heath 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.

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 and employers 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.

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Introduction 1

Strategy #1: Make employer-based insurance more affordable 3
- North Carolina: Premium Subsidies Demonstration 4
- Maine: DirigoChoice 6
- Michigan: The Access Health Plan 8

Strategy #2: Expand public insurance coverage 10
- Vermont: Catamount Health Program 11
- Massachusetts: Healthcare Reform Law 13
- Rhode Island: RIte Care Child Care Program 16

Strategy #3: Establish coverage through collective bargaining 18
- New York: 1199SEIU Benefit and Pension Funds 19
- Washington: SEIU 775 Multi-Employer Health Benefits Trust 22
- Oregon: Home Care Union Benefits Board 24

Strategy #4: Build insurance costs into Medicaid reimbursement 26
- Montana: Health Care for Montanans Who Provide Healthcare 27
- New York: Health Care Enhancement Regulations 29
- California: HealthyWorkers 32

Srategy #5: Assist workers with health care expenses 34
- New Mexico: Health Care Reimbursement Arrangement 35

Summary and Conclusion 37

Coverage Models "At a Glance" 38

Our guiding philosophy…

As Americans we believe that everyone—young, old, able-bodied, or living with disabilities—deserves to live with dignity, with as much independence as possible.

As we age or become disabled, we want to remain at home or in communities where we can maintain our routines and our relationships. We want to have a choice, and for many Americans, being able to choose requires the assistance of a direct-care worker.

To ensure health care choices for ourselves and for our loved ones in the future, we need to begin caring about our caregivers today.

One of the first steps is ensuring that these workers have affordable health insurance coverage.

HEALTH CARE *for*
Health Care Workers

Introduction

Across the country, state policymakers are intensifying their focus on how to improve the quality of jobs within the long-term care sector. Stabilizing this workforce is essential in order to improve quality of care and to build the workforce necessary to address the long-term care needs of the baby boomers as they retire.

This report describes successful strategies for expanding health care coverage to direct-care workers—key to improving job quality, increasing retention of workers in these critical jobs, and reducing the overall number of Americans without health coverage. Each of the five broad strategies is illustrated with specific examples from individual states. These broad strategies are:

1. **Make employer-based insurance more affordable**
2. **Expand public insurance coverage**
3. **Establish coverage through collective bargaining**
4. **Build insurance costs into Medicaid reimbursement**
5. **Assist workers with health care expenses**

These strategies share the common purpose of expanding health care for caregivers, yet vary widely in scope. Some are statewide, including major coverage expansions and Medicaid reimbursement increases, while others target direct-care workers in a particular region of a state or specific group of employers. Some have expanded coverage to thousands of direct-care workers while others have had more limited impact.

Background: Who are direct-care workers and why do so many lack coverage?

Now totaling more than three million nationwide, direct-care workers are one of America's fastest-growing workforces.[1] These caregivers—aides in nursing homes, home care workers and personal assistants—provide 70 to 80 percent of all hands-on long-term care and personal assistance services.[2] Millions of older Americans and people with disabilities rely on them for the personal care and support they need to maintain a high quality of life.

Ironically, many of those who provide care do not have access to health care themselves. One in every four nursing home workers—and more than one in three home care workers—lack insurance coverage.[3] Direct-care workers lack coverage at a rate that is 50 percent higher than the general population under age 65.[4]

Why are there so many caregivers without health care coverage? Many simply fall through the cracks of our nation's health care system—they are not offered or cannot afford to accept health insurance plans offered by their employer and at the same time they do not qualify for many public insurance programs.

Continued on page 2

1 The Bureau of Labor Statistics officially reports 3 million paraprofessionals in long-term care but many hundreds of thousands more work in the "gray market."

2 Steven L. Dawson and Rick Surpin, Direct-care Health Workers: The Unnecessary Crisis in Long-term Care (Washington, DC: Aspen Institute, 2001).

3 PHI, *The Invisible Care Gap: Caregivers without Health Coverage* (2008).

4 Ibid.

Many of the examples combine one or more strategies. For example, a state could establish coverage through collective bargaining while at the same time make employer-based insurance more affordable by creating a large purchasing pool.

While expanding coverage to direct-care workers is challenging, the good news is that solutions exist. Across the country, state policymakers, employers, clients and their advocates, and unions are engaging in joint efforts to make health care coverage for direct-care workers accessible and affordable. This work is paying off. Researchers have found a strong positive link between health insurance and retention. In fact, health insurance may be even more important than wages in securing a stable, high-quality workforce in long-term care.[5]

This report provides a practical road map with specific models for advocates and policymakers to borrow from or replicate. Short of national universal health coverage, there is no "one size fits all" solution to expanding health care coverage for direct-care workers since the political, fiscal and regulatory environments differ across states. Yet as this report illustrates, there are strategies that work and that can be adapted to any state interested in guaranteeing affordable health coverage for their caregiving workforce.

5 For an overview of this literature see "Health Insurance Vital to Job Retention," a PHI/HCHCW fact sheet available at http://www.hchcw.org/uploads///pdfs/RetentionFactSheet.pdf

Strategy #1: Make employer-based insurance more affordable

Overview

Health insurance is a highly-valued benefit of employment for most working Americans. But for many direct-care workers, like many low-wage workers, having a job doesn't mean having the security of health care coverage. While nearly two thirds (62 percent) of all Americans under age 65 obtain health coverage through an employer, only 52 percent of direct-care workers do so.[6] The chief obstacle is high costs, both for employers and employees.

Many long-term care employers are too small to negotiate effectively with insurance companies for affordable group rates. As a result, small employers are less likely than larger employers to offer health coverage. As of 2007, 59 percent of small firms (3–100 workers) and only 45 percent of very small firms (3–9 workers) were offering health benefits, compared to 99 percent of large firms (200 or more workers).[7]

When their employers do provide coverage, many direct-care workers cannot afford to participate. Even modest premiums and minimal co-pays can be a deterrent. Research in this area shows that when premium costs reach 5 percent of family income, enrollment among low-income workers falls dramatically.[8]

Proven strategies exist for making employer-based health insurance more affordable and accessible for direct-care workers and their employers. Small businesses can join together to form purchasing pools to lower the cost of insurance. In addition, public funding can be used to subsidize employer and/or employee premiums. This section highlights examples from Michigan, North Carolina, and Maine that use either one or a combination of these two approaches to making employer-based insurance more affordable.

6 PHI, *The Invisible Care Gap: Caregivers without Health Coverage* (2008).

7 Kaiser Family Foundation, 2007, "Employer Health Benefits: 2007 Summary of Findings," available at www.kff.org.

8 L. Ku and T. Coughlin, 2000, "Sliding Scale Premium Health Insurance Programs: Four States' Experience," *Inquiry* (Vol. 36).

North Carolina: Premium Subsidies Demonstration

In North Carolina, "Caregivers Are Professionals, Too" (CAPT), a collaborative project involving four home care agencies, subsidized health premiums for home care workers. Eligible workers received a subsidy of $108 per month to apply towards the employee share of insurance premiums.

Funding for the subsidy came from a federal demonstration grant intended to strengthen the direct service workforce.[9] In 2004, CAPT was awarded approximately $1.4 million to fund a three-year demonstration project to test the impact of health care coverage on recruitment and retention of the direct-care workforce. The grant cycle ended in the fall of 2007.

Key Features of the Premium Subsidies Demonstration

Eligible Participants	Home care workers employed by four participating home care agencies who work a minimum of 30 hours per week and complete 12 weeks of employment.
Individual or Family Coverage	Individual coverage
Type of Coverage	Workers have a choice of private plans offered by their employer.
Scope of Benefits	Range from comprehensive coverage through traditional insurance plans to limited coverage through "mini med" plans.
Premium Costs	Varies by plan. Comprehensive plan costs $550 per member per month.
Employer Costs	For comprehensive coverage, employers pay $429.76 per month.
Employee Costs	Varies by plan. Comprehensive plan includes $13.84 per month premium fee, $1,000 deductible, and co-payments ranging from $10–$100 depending on service.

9 Three years of funding provided by the federal Centers for Medicare and Medicaid Services.

Track Record

The participating agencies employed a total of 1,139 direct-care workers during grant period. Of those, approximately 200 were participating in the health plans offered by their employers as of September 2006. A total of 298 participated cumulatively over the course of the grant. Participation rates were essentially at the level that the grantees predicted, as many of their workers were part-time and, therefore, ineligible for the benefit.

Key Advantages

The health premium subsidy was popular with both participating employers and employees and it was associated with positive outcomes in the areas of recruitment and retention.

Key Disadvantages

While the subsidy reduced—and in some cases eliminated—the employee share of monthly premiums, home care workers continued to face high out-of-pocket medical costs. The high costs concerned both employers and employees. Nonetheless, participating employers are seeking funds to sustain this intervention now that the grant period has ended. Employers anticipate a further shift away from comprehensive benefits towards low-cost "mini medical plans" that offer very limited coverage—such as those already offered by two of the participating agencies.

For More Information

For a more detailed description of this project, see "Emerging Strategies for Providing Health Coverage to the Frontline Workforce in Long Term Care" at: **www.coverageiscritical.org** (click on Resources).

See also CAPT study at: **www.directcareclearinghouse.org/l_art_det.jsp?res_id=263210**

Maine: DirigoChoice

In January 2005, Maine launched DirigoChoice, a state-supported health insurance plan aimed at small businesses and low-income workers. DirigoChoice is one part of Dirigo Health, Maine's new comprehensive health reform program, which aims to provide universal coverage for all of Maine's citizens. Advocates have engaged in specific outreach efforts with home care agency employers to use Dirigo as an opportunity to expand health care coverage to home care workers.

Key Features of DirigoChoice

Eligible Participants	Small businesses (2-50 employees), sole proprietors and low-income uninsured individuals who meet specific criteria. Cap on total participants from each category.
Individual or Family Coverage	Individual coverage

Key Features of DirigoChoice *(continued)*

Type of Coverage	Comprehensive health insurance products offered through a public/private collaboration between the State of Maine and, starting in 2008, Harvard Pilgrim Health Care.
Scope of Benefits	Two plan options, both of which include preventive care, prescription drugs, and mental health services. One plan has higher monthly premiums and lower out-of-pocket costs than the other.
Premium Costs	Plans range from $313 to $338 per month.
Employer Costs	60 percent of the monthly premium.
Employee Costs	0-40 percent of monthly premium plus co-pays and deductibles. Discounts based on income and family size reduce both monthly premiums and maximum out-of-pocket costs by 20 to 100 percent; no out-of-pocket costs for those whose incomes are less than 200 percent of the federal poverty level.

Track Record

DirigoChoice has encountered numerous challenges in meeting its goals and securing public, business, and political support. In addition to the complex terms of the product, the health reform act that generated it has been a source of controversy. The uncertainty surrounding its viability, along with higher than expected product costs, have contributed to lower than anticipated participation rates. To date, there are approximately 16,200 people participating in Dirigo Health, including almost 2,300 businesses.

Key Advantages

DirigoChoice is an established public/private program with good affordability criteria for low-income workers. If some of the enrollment and participation requirements were improved, DirigoChoice could work well for the direct-care workforce.

Key Disadvantages

The premium costs are not affordable for many long-term care employers. Home care agencies that serve MaineCare (Medicaid) clients report that their reimbursement rates are not adequate to cover the cost of employee health benefits. While DirigoChoice is a state-subsidized program, it still requires employers to pay 60 percent of premium costs, upwards of $180 per month per employee. Home care employers have not embraced the program.

For More Information

For more information about DirigoChoice, contact Maine Center for Economic Policy (MECEP) at **www.mecep.org/direct_care_worker_coalition.asp**.

For more information about Maine's CMS grant to expand coverage for its home care workforce, see *Health Insurance Coverage for the Home Care Sector: Experience from Early DirigoChoice Enrollment in Maine* **www.coverageiscritical.org** (click Resources)

Michigan: The Access Health Plan

The Access Health Plan (AHP) is one of seven county-based, publicly-funded "Third Share Programs" in Michigan. Third Share Programs are community health plans that divide premium costs three ways—between the employer, the employee, and the county. Dividing costs in this way provides an affordable health coverage option for small businesses.

Each Third Share Program is operated independently and establishes its own eligibility guidelines, benefit structures, and premium levels. AHP, based in Muskegon County, offers two health plan options: a standard plan and a wellness program called the C3 Health Program. The C3 Health Program links enrollees with community health programs to address health behaviors and chronic health conditions. AHP delivers care through a broad provider network, contracting with over 90 percent of the medical providers in Muskegon County.

Key Features of the Access Health Plan

Eligible Participants	Employers in Muskegon and Ottawa Counties who: – employ workers earning $12.00 per hour or less who are currently uninsured – do not already offer employer-sponsored insurance to their employees.
Individual or Family Coverage	Coverage for employees only. Children of eligible employees are screened for Medicaid eligibility.
Type of Coverage	AHP is a community-based health services plan, not a private health insurance plan.
Scope of Benefits	Comprehensive
Premium Costs	$175 per member per month.
Employer Costs	$46 per month if enrolled in the C3 Health Program; $60 standard premium.
Employee Costs	$46 per month if enrolled in the C3 Health Program; $60 standard premium. Modest co-payments for physician visits and prescription drugs.

Track Record

AHP is considered to be a very successful Third Share Program in Michigan. It currently provides coverage to approximately 1,000 individuals employed by over 300 local businesses, and has the capacity to bring in additional participants. Participants include adult foster care homes, home care agencies, and nursing homes that use it primarily for their part-time staff. Outreach efforts are underway to reach more long-term care employers and direct-care workers.

Key Advantages

AHP has tremendous support from both the medical provider and business communities in Muskegon County. The low premiums make the coverage affordable for both employers and employees. AHP is seen as a national model for this type of coverage and is being explored in other parts of the country.

Key Disadvantages

This program uses Medicaid Disproportionate Share Hospital (DSH) funds to run the program. Should this funding stream be eliminated or significantly reduced, the program would have difficulty continuing.

For More Information

See The Access Health Plan at **www.access-health.org**

Strategy #2: Expand Public Insurance Coverage

Overview

Medicaid and other public health insurance programs are important sources of health care coverage for the direct-care workforce. Many caregivers earn so little that they already qualify for Medicaid or other public programs under existing eligibility standards. In 2006, nearly 14 percent of all direct-care workers were covered by Medicaid.[10] Others are ineligible, either because they earn just above the income eligibility requirements or because they do not have children. But states have broad authority to extend Medicaid eligibility beyond the federal minimum standards, providing an opportunity to extend coverage to many more direct-care workers.

Several options exist for covering direct-care workers under Medicaid plans. Many states have extended Medicaid coverage to those with incomes up to 300 percent of the federal poverty level (e.g., Massachusetts). Others have covered childless adults through waiver programs (e.g., Minnesota). In addition, states can provide premium subsidies for employer coverage through their Medicaid program or via state-only programs. In pursuing these options, however, states should be aware that the the unique employment characteristics of the direct-care workforce require that reform legislation include provisions that facilitate enrollment (see "*Expanding Coverage for Caregivers: A Checklist for State Health Reform*," available at http://www.coverageiscritical.org). These and other state health reform efforts are windows of opportunity for expanding coverage to caregivers.

This section includes three examples of covering direct-care workers through new or existing public insurance programs. They include broad health reform measures in Vermont and Massachusetts and a state-subsidized program in Rhode Island, RIte Care, which covers child care workers. Child care workers are a population that often lacks health coverage and, in this regard, share similar characteristics with the direct-care workforce.

10 PHI (Forthcoming January 2008). *The Invisible Care Gap: Caregivers without Health Coverage*

Vermont: Catamount Health Program

In October 2007, Vermont launched Catamount Health, a new health coverage program for individuals with annual incomes up to 300 percent of the federal poverty level (less than $30,630 for an individual and $61,950 for a family of four).[11] Catamount Health is one of several publicly-funded health coverage programs — Medicaid, Vermont Health Assistance Plan (individual and family coverage) and Dr. Dynasaur (a program for children and pregnant women) — that fall under the umbrella of Green Mountain Health Care.

Catamount Health is funded by a combination of state and federal revenues. State funds were raised through an increase in tobacco taxes and fees charged to employers who do not provide health insurance for their employees. Vermont also received an 1115 waiver, Commitment to Global Health, which consolidates funding for all of the state's Medicaid programs (except long-term care) and converts the state Medicaid agency into a public Managed Care Organization.

Key Features of the Catamount Health Program

Eligible Participants	Vermont residents, over 18 years of age with income between 150 percent and 300 percent of poverty for singles and between 185 percent and 300 percent for families, who meet the following requirements: – Currently not eligible for any other Vermont health coverage program – Have been uninsured for the last 12 months – Do not have access to insurance through an employer or the insurance offered does not cover hospital or physician services Individuals who meet the first two requirements, but have access to insurance through their employer that is unaffordable, may be eligible for the Employer Sponsored Insurance Premium Assistance Program, a part of Catamount Health.

Continued on page 12

12 2007 Federal Poverty Guidelines available at http://www.cms.hhs.gov/medicaideligibility/downloads/POV07ALL.pdf.

Key Features of the Catamount Health Program *(continued)*

Individual or Family Coverage	Coverage is available only to adults; children are covered through other Medicaid programs.
Type of Coverage	Coverage is offered through two private carriers, Blue Cross Blue Shield of Vermont and MVP Health Care.
Scope of Benefits	Comprehensive
Premium Costs	$393 per member per month
Employer Costs	Employer-sponsored health insurance plan costs vary. Employers who do not cover their employees are assessed a quarterly fee of $91.25 ($365 annual) for each uninsured full-time employee for whom they do not provide health coverage.
Employee Costs	A Premium Assistance Program reduces the monthly premium of $393 to $60–$135, based on a sliding scale. Participants are also responsible for co-payments and a deductible. A separate program assists eligible individuals with their monthly employer premiums. To be eligible, individuals must have: – Household income less than 300% FPL – Access to an employer plan offering comprehensive benefits similar to what is offered under Catamount Health with a deductible of $500 or less.

Track Record

At the time of the publication of this report (December 2007), it was too early to assess the success of the program, which only began enrollment in October 2007.

Key Advantages

The Employer Sponsored Insurance Premium Assistance Program, offered as a part of Catamount Health, has the potential to make health insurance affordable for direct-care workers who have access to ESI but cannot afford to enroll. Direct-care workers without access to employer-sponsored health plans but who meet income eligibility requirements for Catamount may receive subsidized coverage.

Key Disadvantages

Although there is a subsidy to reduce monthly premium cost, the lowest premium level of $60 per month—in addition to out-of-pocket costs—may be unaffordable for many direct-care workers.

For More Information

See Green Mountain Care at **www.greenmountaincare.org**

Massachusetts: Health Care Reform Law

In spring 2006, Massachusetts enacted Chapter 58, a health care reform law aimed at providing universal health care access to state residents. In so doing, Massachusetts became the first state to mandate that all residents over the age of 18 have health insurance. The plan has three critical components: increasing the number of low-income people in MassHealth (Medicaid), offering financial assistance for middle-income people to buy private insurance through two new insurance programs (Commonwealth Care and Commonwealth Choice), and adding regulations to the private insurance market to eliminate discriminatory insurance practices.

Commonwealth Care provides health insurance plans and government subsidies on a sliding-scale basis to individuals with incomes of up to 300 percent of the federal poverty level. Commonwealth Choice provides unsubsidized insurance options for small employers and individuals who do not qualify for Commonwealth Care. Massachusetts residents can access Commonwealth Care and Commonwealth Choice through the Commonwealth Health Insurance Connector Authority, an independent public authority with responsibility for implementing health reform and for making affordable health insurance available to those who lack coverage and to small businesses.

Compliance will be enforced through the state income tax system. In 2007, the penalty for not obtaining insurance will be the loss of the individual's $219 personal exemption. Beginning in 2008, the penalty will equal 50 percent of the monthly cost of a standard insurance policy for an individual's income bracket.

Continued on page 14

Key Features of the Massachusetts Health Care Reform Law

Eligible Participants	Eligibility varies by program: – MassHealth: Based on income and family size; provides coverage to children in families up to 300 percent of poverty. – Commonwealth Care: Adults (age 19 and older) between 100 and 300 percent of poverty. – Commonwealth Choice: Individuals and families with incomes above 300 percent of poverty and small businesses.
Individual or Family Coverage	Families with incomes up to 300 percent of poverty can access both MassHealth for the coverage of children and Commonwealth Care for the coverage of adults (age 19 and older). Commonwealth Choice also provides family coverage.
Type of Coverage	Four private managed-care organizations currently providing coverage through MassHealth will exclusively provide Commonwealth Care coverage for the next several years. Coverage options for Commonwealth Choice are available through six of the state's leading insurance providers.
Scope of Benefits	Comprehensive
Premium Costs	MassHealth has no premiums. Premiums range from $0 to $105 per month for Commonwealth Care plans and premiums for Commonwealth Choice plans must meet an affordability standard set by the state based on income and plan type (individual, couple or family with children).
Employer Costs	Employer-sponsored health insurance plan costs vary. Employers who do not cover their employees are assessed an annual fee of $295 for each uninsured full-time employee for whom they do not provide health coverage.
Employee Costs	MassHealth requires no monthly premium payment and minimal copays for various services, ranging from $1–$3. Commonwealth Care offers four types of plans and includes options for lower monthly premiums with higher co-pays as well as higher monthly premiums with lower co-pays. A range of options are available through Commonwealth Choice plans, including premier plans which have the highest premiums but limited cost-sharing with no deductible, and basic plans which offer the lowest premiums and the highest out-of-pocket costs.

Track Record

In June 2006, Massachusetts had approximately 372,000 residents lacking health coverage. As of December 2007, the state estimated that almost 300,000 individuals were newly covered. Approximately 160,000 have enrolled in Commonwealth Care, the subsidized health insurance program offered through the Commonwealth Health Insurance Connector Authority; an additional 70,000 residents have signed up for MassHealth, the state's Medicaid program. In addition, 63,000 have enrolled in private insurance either through the Health Connector or private contractors. While the enrollment numbers are higher than anticipated, an additional 80,000 individuals will need to obtain coverage before the end of the year or face tax penalties.

Key Advantages

The program provides several options for comprehensive health care coverage with costs based on affordability standards developed by the state. Most direct-care workers will qualify for health coverage through MassHealth or Commonwealth Care.

Key Disadvantages

The new law is complex. Individuals are required to obtain insurance but some are confused about their options. For example, individuals currently covered by MassHealth are receiving notices requiring that they reapply. While the intended purpose of this is to connect individuals with the best plan for them under the new law, it may instead create confusion as individuals wade through paperwork and several new insurance options.

The individual mandate may not work for everyone. A waiver process is under consideration for individuals who find the insurance options available to them too financially burdensome. In addition, an estimated 60,000 individuals will be exempt from the mandate because they meet income eligibility requirements for subsidized insurance and yet will not have options available to them that meet the state's affordability standards.

For More Information

See the Commonwealth Connector for information about Commonwealth Care and Commonwealth Choice Plans: **www.mahealthconnector.org/portal/site/connector/**

For a more detailed report on the Health Reform Law see: **http://masshealthpolicyforum.brandeis.edu/publications/pdfs/31-May07/MassHealthCareReformProgess%20Report.pdf**

Rhode Island: Child Care Provider RIte Care Program

In Rhode Island, policymakers expanded RIte Care, a Medicaid managed-care program, to allow eligibility for certain child care providers. Child care providers are a population that often lacks health coverage and, in this regard, shares similar characteristics with the direct-care workforce. The state's goal was to increase access to child care services by subsidizing health care coverage for those who provide child care.

Key Features of the Child Care Providers RIte Care Program

Eligible Participants	Home-based child care providers who are certified to serve publicly subsidized children are eligible for Child Care RIte Care coverage if they have rendered at least $7,800 in child care services during the six months prior to applying and if their countable family income is under 350 percent of the federal poverty level. A provider with children must show she is not eligible for coverage under the regular RIte Care program (which is free to women and children up to 150 percent of poverty and available on a sliding scale for those between 150-250 percent of poverty). Eligibility redetermination occurs automatically every six months.

Key Features of the Child Care Provicers RIte Program *(continued)*

Individual or Family Coverage	Coverage for participants and dependents
Type of Coverage	Coverage is offered through three managed-care private carriers. If the child care provider's spouse is insured at work, the state will pay for enrolling the provider and children in the spouse's employer-based coverage.
Scope of Benefits	Comprehensive
Premium Costs	RIte Care plans cost the state $333 per member per month.
Child Care Provider Costs	Participants with income above 150 percent of poverty pay a monthly cost-sharing premium based on a sliding scale, ranging from $61 to $130 per month; plan has no co-payments.

Track Record

Out of 10,000 home-based child care providers in the state, approximately 1,000 qualify for RIte Care coverage. The state estimates enrollment at approximately 300 (about equally split between providers and dependents). Participation in the Child Care RIte Care Program has declined since 2006 when the state changed the program to allow providers who qualified based on income eligibility to be served by the regular RIte Care Program. The state focused the Child Care RIte Care Program more narrowly on providers without children whose earnings are above RIte Care income eligibility requirements.

Key Advantages

The program provides affordable, comprehensive coverage that is accessible to caregivers and their children, even if they work less than full time.

Key Disadvantages

Coverage is available for child care providers only; the program does not apply to the direct-care workforce in long-term care.

For More Information

See Rhode Island Department of Human Services, Child Care Provider RIte Care program description at **http://www.dhs.state.ri.us/dhs/heacre/drchiccf.htm**

Strategy #3: Establish coverage through collective bargaining

Overview

While the strength of labor unions in the industrial sector has been declining steadily over the past 20 years due to lay-offs, plant closures, and contracting out,[12] unionization in the long-term care industry is on the rise. Today, 11 percent of home care aides and 14 percent of nursing home and home health aides are members of a union.[13]

Most of the recent growth in unionization among the direct-care workforce is attributable to new organizing among home care workers who are hired and managed directly by the client they serve. Previously, these workers served as independent contractors. In the past decade, the Service Employees International Union (SEIU) has been establishing new models—such as public authorities—that establish an "employer of record" for independent home care workers for the purposes of collective bargaining, while maintaining consumers' right to manage their own care.[14]

Unionized workers are more likely than non-union workers to have health care coverage. A recent study of 15 low-wage occupations found that unionized workers were 25 percent more likely to have employer-based health insurance than were non-union workers in the same occupation.[15] Among direct-care workers, the study found that:

- 49 percent of unionized home care aides had employer-sponsored insurance compared to only 22 percent of non-union home care aides; and
- 71 percent of unionized nursing home and home health aides had coverage compared to 37 percent of non-union workers in these occupations.[16]

Through the process of collective bargaining, thousands of direct-care workers have negotiated for employer-sponsored health care coverage. Health care benefits established through collective bargaining are administered in a variety of ways. One common approach is to establish a multi-employer benefit fund, often known as a "Taft-Hartley Fund."[17]

Multi-employer benefit 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. They operate as a single risk pool covering all of the eligible employees of contributing employers. These funds purchase insurance for the group through one or more private carriers. Generally the collective bargaining agreement will require the employers to make either a "cents per hour" or monthly premium contribution on behalf of each employee based on the number of hours worked during a reporting period.

12 According to the Bureau of Labor Statistics, union density has declined from 20.1 percent in 1983 to 12 percent in 2006, see: http://www.bls.gov/news.release/union2.nr0.htm.

13 Schmitt, John, Mary Waller, Shawn Fremstad and Ben Zipperer, "Unions and Upward Mobility for Low-Wage Workers," Center for Economic and Policy Research, August 2007.

14 For more on these models see: Mareschal, Patrice, "Innovation and Adaptation: Contrasting Efforts to Organize Home Care Workers in Four States," *Labor Studies Journal*, Spring 2006.

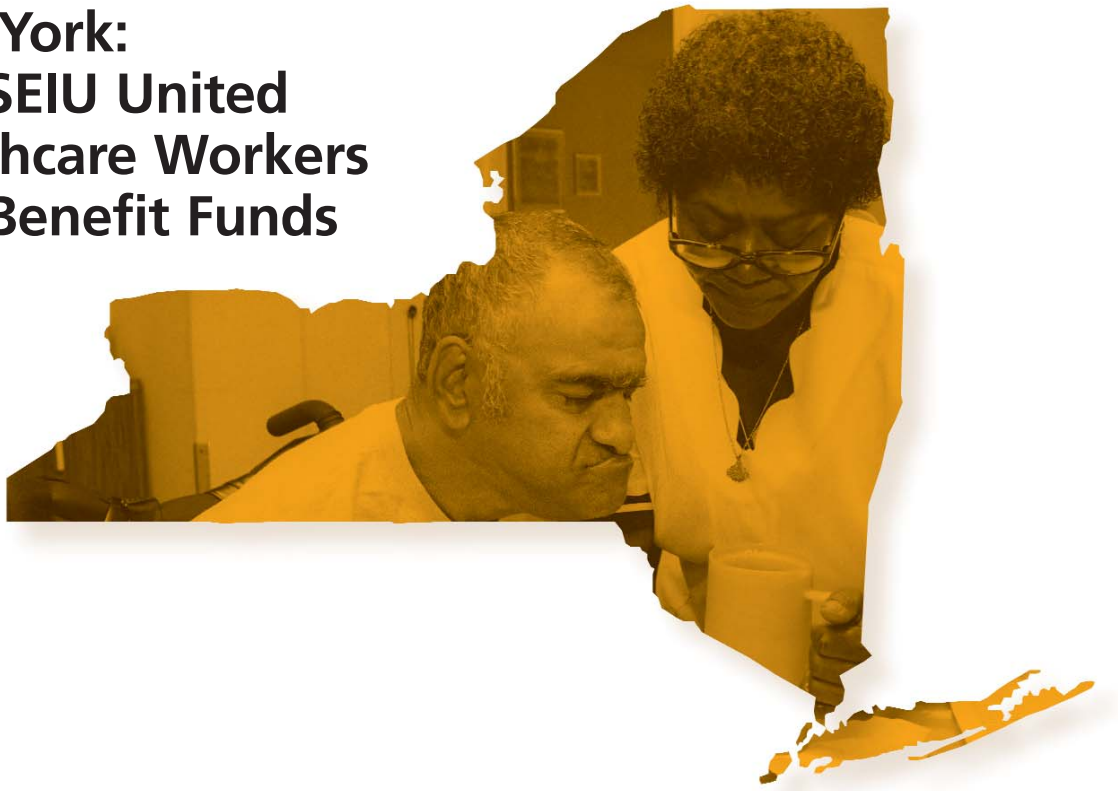
15 Schmitt, John, Mary Waller, Shawn Fremstad and Ben Zipperer, "Unions and Upward Mobility for Low-Wage Workers," Center for Economic and Policy Research, August 2007.

16 Data based on CEPR analysis of CEPR extract of the Current Population Survey Outgoing Rotation Group and UNICON extract of March Current Population Survey data.

17 The Taft-Hartley Act is an amendment to the National Labor Relations Act, 29 USC 141—197, enacted in 1947.

This section describes two examples of multi-employer funds, including a fund established for home care attendants in New York and a fund for independent home care workers in Washington State. The third example is a limited liability corporation created by a union to act as a third party administrator for health benefits for home care workers in Oregon.

New York: 1199SEIU United Healthcare Workers East Benefit Funds



The 1199SEIU Benefit and Pension Funds ("The Funds") are not-for-profit, self-administered Taft-Hartley trust funds that provide health and pension benefits to more than 440,000 1199SEIU members and their dependents. Members of the union who work in voluntary hospitals, nursing homes, mental health clinics, pharmacies, and home care and social service agencies—in New York City, the Hudson Valley, and Rochester—can receive comprehensive health coverage, life and disability insurance, and pension benefits. The Funds are principally funded by employer contributions negotiated by the union in collective bargaining agreements.

There are eight different benefit and pension funds providing coverage to union members. Two funds specifically serve home care workers. The first, the National Benefit Fund for Home Care Employees serves approximately 40,000 home attendants—and an additional 38,000 family members—employed by vendors contracted with the New York City Human Resources Administration to provide Medicaid personal care services. The second, the 1199SEIU Home Health Aide Benefit Fund, serves approximately 10,000 home health aides employed by home care agencies serving a mix of Medicare, Medicaid, and private-pay clients.

Continued on page 20

From 2000–2007, the 1199SEIU National Benefit Fund for Home Care Employees received additional funding from the Home Care Workers Health Insurance Demonstration Project, a state program to address recruitment and retention issues for home attendants in the home care industry.[18] As of April 1, 2008, funds from this program will be replaced by legislation that will allow employers and Taft Hartley funds to offer Family Health Plus—a state-administered health care program.[19] Fund members will be entitled to the same benefit package currently available to Family Health Plus enrollees.

According to this new law, known as the "Family Health Plus Buy-In," participating Taft-Hartley funds can purchase the Family Health Plus package. The state will assume a portion of the cost by subsidizing premiums based upon those members who are eligible for public health insurance programs.

Key Features of 1199SEIU United Healthcare Workers East Benefit Funds

Eligible Participants	Home attendants who work 80 hours per month for 2 consecutive months; home health aides who work 120 hours per month for 2 consecutive months.
Individual or Family Coverage	The fund for home attendants provides spouse and dependent coverage including children up to age 19 (age 23 if they continue in school). In order to have spouse coverage, members must work 170 hours per month (about 40 hours per week). Children are covered at the 80-hour threshold. The home health aide fund covers union members only.
Type of Coverage	The home attendant fund is self-insured and self-administered; home health aides receive coverage through Health Insurance Plan of New York (HIP), the largest HMO in New York City.
Scope of Benefits	Comprehensive for home attendants; home health aides have coverage for medical and hospital services up to $5,000 or $11,000 per year (depending on the plan chosen by the employer), plus prescription drugs.
Premium Costs	Coverage for home attendants: $589 per member per month including health and ancillary benefits. Coverage for home health aides: $208 per member per month.
Employer Costs	Employers pay into the benefit funds a cents/hour worked rate for each eligible employee.
Employee Costs	Home attendants pay no premium or deductible and limited co-pays. Home health aides pay no premium, no deductible for in-network care and limited co-pays; however, there is an annual maximum benefit, excluding prescription drugs, of either $5,000 or $11,000 per year, depending on the coverage selected by the employer.

18 The Home Care Worker Rate Demonstration was created through Section 107, Chapter 1 of the Laws of 1999. For more information see "Home Care Workers Health Insurance Demonstration Project: Final Evaluation," Howard SC.D., New School University, June 28, 2004.

19 Family Health Plus "Buy-In", Laws of New York, Chapter 95 of 2007.

Track Record

The 1199SEIU Benefit Funds have successfully provided comprehensive health care coverage for home care workers for over a decade. Currently, approximately 80,000 participants are enrolled in the National Benefit Fund for Home Care Employees, half of whom are spouses or dependents. In addition, approximately 10,000 participants are enrolled in the 1199SEIU Home Health Aide Benefit Fund—but eligibility is very limited and there are tens of thousands more home health aides throughout the state without coverage.

Key Advantages

The 1199SEIU Benefit Funds provide affordable coverage for tens of thousands of low-income workers and their dependents who might otherwise lack coverage. These individuals have access to comprehensive health care coverage with limited out-of-pocket costs.

Key Disadvantages

Due to rapidly rising health care costs nationwide, the actual cost of coverage has become significantly higher than the $0.87 cents per hour per worker employer contribution established through the home health aide collective bargaining agreement, and the average base contribution of $1.42 per hour that home attendant employers contribute to the National Benefit Fund for Home Care Employees. To bridge these gaps, it has been necessary to secure supplemental funding from the state, to tighten eligibility requirements, and to reduce benefits.[20] For the home attendants in the National Benefit Fund for Home Care Employees, uncertainty surrounds the recent transition to a new financing mechanism through the Family Health Plus buy-in legislation.

For More Information

See 1199SEIU Family of Funds at **http://www.1199seiubenefits.org/**

20 For example, 1) the hours eligibility requirement has increased to 170 from 80 hours per month for the home attendants to earn coverage for their spouses and 2) home health aides are now subject to an annual hospital and medical benefit maximum of either $5,000 or $11,000.

Washington: The SEIU 775 Multi-Employer Health Benefits Trust

This multi-employer benefit fund, established in 2004, is a labor-management partnership between the Service Employees International Union (SEIU) 775 Northwest and participating employers.[21] The Trust administers health care benefits for more than 23,500 Individual Provider (IP) home care workers and approximately 5,000 home care agency workers represented by the union.

IP home care providers serve Medicaid and other state-subsidized consumers who direct their own care. Prior to organizing with SEIU, this workforce did not have any form of employer-sponsored health insurance coverage. Today, all IP home care workers who meet eligibility requirements can enroll in health plans administered by the Trust and also have the option of enrolling in Washington's Basic Health Plan, a state-administered plan for low-income residents.

21 For a more detailed description see "Case Study: Washington State, Comprehensive Health Coverage for Consumer-Directed Home Care Workers," a PHI publication available at http://www.hchcw.org/uploads///pdfs/CaseStudy-WA-1.pdf

Key Features of The SEIU 775 Multi-Employer Health Benefits Trust

Eligible Participants	Home care workers who have completed 3 consecutive months of employment, who maintain 86 hours of work per month and who are not eligible for other family or employment-based coverage.
Individual or Family Coverage	Individual coverage
Type of Coverage	Private carriers, including Premera, Kaiser and Group Health Cooperative, serve different regions of the state.
Scope of Benefits	Comprehensive
Premium Costs	$532 per month
Employee Costs	$17 per month premium plus modest co-pays for specific services; no deductible.

Track Record

Enrollment has increased steadily since the Trust was formed in 2004. As of August 2007, 6,399 IP home care workers and 3,003 agency home care workers were enrolled in the Trust.[22]

Key Advantages

The $17 premium and limited out-of-pocket cost make comprehensive coverage affordable and accessible to direct-care workers who earn modest wages. The union's strong advocacy ensures a stable funding base over time.

Key Disadvantages

While increasing, enrollment is still significantly below the 9,000 IP participants originally predicted. Obstacles to enrollment include part-time status (not meeting the hours eligibility requirement), the absence of a traditional workplace, as well as cultural and geographical barriers. The union and its partners are engaging in an aggressive outreach campaign to enroll more workers.

For More Information

See the SEIU Healthcare 775 NW, fact sheet on the Health Care Trust available at:
www.seiu775.org/benefits/Health_Insurance_for_IPs_and_Home_Care_Workers.aspx

22 Data provided by the SEIU 775 Multiemployer Health Benefits Trust Agency.

Oregon: Homecare Union Benefits Board (HUBB)

The Homecare Union Benefits Board (HUBB) is a limited liability corporation created by the Service Employees International Union (SEIU) Local 503 Oregon Public Employees Union. HUBB administers health care benefits for 9,500 home care workers covered under the collective bargaining agreement between the Homecare Commission and SEIU Local 503. HUBB enrolls workers in health plans, bills the state of Oregon for insurance premiums, collects insurance premiums from the state and workers, and sends the insurance premiums to participating insurance companies.

Workers covered by HUBB are employed through one of three consumer-directed home care programs, including the Client Employed Providers (CEP), Spousal Pay Providers, and Oregon Project Independence. All of the workers in these programs are paid by the Department of Human Services (DHS). Specific eligibility criteria and funding per employee are determined by collective bargaining agreements.

Key Features of the Oregon Homecare Union Benefits Board

Eligible Participants	Independent home care workers compensated by Oregon's Department of Human Services who do not have other health care coverage other than Medicare or Veterans benefits. Must work 80 or more hours per month for two consecutive months to qualify.
Individual or Family Coverage	Individual only; spouse and dependent children coverage available at employees' expense. Separate assistance program available on sliding scale.
Type of Coverage	Either Kaiser Permanente or the ODS Companies depending on region within the state.
Scope of Benefits	Comprehensive plan, both medical and dental coverage and routine visual.
Premium Costs	Kaiser individual plan $462.93, $637.50 for ODS (medical only)
Employee Costs	Kaiser: No deductible, limited co-pays, $600 per year out-of-pocket maximum. ODS: $100 deductible plus co-pays; $2,500 annual out-of-pocket maximum.

Track Record

HUBB has been operating successfully since April 2004. Out of total of 9,500 home care workers, 5,000–5,500 are eligible at any given time. Of those workers, approximately 3,500 (64 percent) are currently enrolled. Workers hours are determined by hours authorized by the case worker for clients, which fluctuate. Of those who are enrolled, a group of approximately 500 workers fall in and out of coverage as the hours approved for their clients change.

Key Advantages

HUBB provides comprehensive and affordable health insurance coverage to direct-care workers who previously lacked coverage. The union was able to secure coverage for this workforce through established relationships with carriers. Ongoing union advocacy ensures stable funding.

Key Disadvantages

The hours eligibility requirement is an obstacle to initial enrollment and continuity of coverage. More than 40 percent of the workforce does not qualify for HUBB because they work fewer than 80 hours per month. While some can afford to cover these gaps by purchasing COBRA coverage, others cannot. Outreach is also a challenge. Without a traditional workplace, it is difficult to reach the workers with information about their benefits and eligibility.

For More Information

See the Homecare Union Benefits Board, available at: **http://www.seiu503.org/benefits/**

Strategy #4: Build insurance costs into Medicaid reimbursement

Overview

Many long-term care employers rely heavily on Medicaid reimbursement. While long-term care is financed through a combination of public and private sources, the Medicaid program is by far the single largest payer of long-term care services, financing 49 percent of long-term care services in 2005.[23] It covers the cost of both institutional care and home- and community-based services.

Limited Medicaid reimbursement rates are an obstacle for employers who want to provide health care coverage for their employees. These reimbursement rates, which vary by state and sector, do not always account for the cost of health insurance or other benefits for workers.

A recent study found that most states set reimbursement rates for Medicaid-funded personal care services in a relatively ad hoc manner and without knowledge of whether the provider agencies they contract with provide health care coverage.[24] In addition, while Medicaid reimbursement rates for nursing facilities are typically updated annually based on an inflation factor, this is extremely rare for Medicaid reimbursement for home- and community-based services. Too often, rates fail to keep up with provider costs and inflation.

Limited Medicaid reimbursement leads to tight budgets that do not allow for health insurance expenditures —averaging $400 per month—for workers who earn $10 per hour or less. In the long run, addressing this problem will require reforming state reimbursement systems so that they are based on actual costs for competitive wages and benefits and include systematic methods for updating or rebasing.

In the short run, some states are enacting Medicaid rate enhancements targeted specifically to covering the cost of health care benefits. This section describes recently enacted legislation in Montana, a rate enhancement program available to developmental disability providers in New York State, and a program in California.

23 Komisar, Harriet L. and Lee Shirey Thompson, 2007. "National Spending for Long-Term Care," Washington DC: Georgetown University Long Term Care Financing Project.

24 Seavey, Dorie PhD. and Vera Salter Ph.D., "Paying for Quality Care: State and Local Strategies for Improving Wages and Benefits for Personal Care Assistants," AARP Public Policy Institute, 2006.

Montana: Healthcare for Montanans Who Provide Healthcare

Healthcare for Montanans Who Provide Healthcare (known as HCM) is a policy initiative recently passed by the Montana legislature.[25] It creates an enhanced Medicaid reimbursement rate for Medicaid-funded home care agencies that provide health insurance to their direct-care employees. Eligible employers who accept the enhanced reimbursement rate will have to verify to the state that they are providing health care coverage that meets certain established criteria. Participation will be completely voluntary. This program, scheduled to begin in January 2009, is predicted to expand coverage to approximately 1,000 home care workers who lack health coverage.

Continued on page 28

25 For a more detailed description of this program see "Healthcare for Montanans Who Provide Healthcare: A Case Study on Expanding Health Coverage for Direct Care Workers," A HCHCW / PHI publication, forthcoming at www.coverageiscritical.org

Key Features of Healthcare for Montanans Who Provide Healthcare

Eligible Participants	To participate, providers must: • Be home care agencies that deliver Medicaid-funded personal assistance or private duty nursing services. • Agree to offer health insurance to direct-care employees and verify this for the state. *Note: specific eligibility rules are under development.*
Individual or Family Coverage	Individual only; family coverage could be offered at workers' own expense.
Type of Coverage	Providers can choose any type of insurance carrier that offers plans that meets the state's requirements.
Scope of Benefits	Comprehensive. The state will determine what services must be covered.
Premium Costs	Actual premium costs will vary by plan. The level of the rate enhancement is not yet determined.
Employer Costs	Will vary according to what type of plan is offered.
Employee Costs	The state is directed to establish limits on employee premiums, co-payments and out-of-pocket contributions.

Track Record

While not yet implemented, HCM is a promising model. Policymakers are developing regulations and plan to begin awarding enhancements to eligible agencies in January 2009.

Key Advantages

HCM is simple to understand and flexible for employers. In addition, because it is embedded within Medicaid reimbursement, it will trigger federal Medicaid matching funds. In Montana, nearly 70 cents out of every dollar of the enhanced rate will be paid by the federal government. It has the potential to provide comprehensive, affordable coverage to a significant number of direct-care workers who now lack coverage.

Key Disadvantages

The degree to which coverage is comprehensive and affordable for workers will be determined by the specific requirements for coverage established by the state. Direct-care workers employed by agencies that choose not to apply for a rate enhancement may remain uninsured. Continued advocacy will be necessary to ensure that rate enhancements keep up with rising health care costs.

For More Information

Contact Mike Hanshew, Montana Health Solutions, LLS: mikeh@consumerdirectonline.net

New York: OMRDD Health Care Enhancement Initiatives

The New York State Office of Mental Retardation and Developmental Disabilities (OMRDD) is encouraging employers to offer health care coverage to direct-care workers through additional funding built into the Medicaid reimbursement rate. To achieve this goal, they have implemented Health Care Enhancement Initiatives effective January 1, 2006 (HCE I); January 1, 2007 (HCE II); and January 1, 2008 (HCE III). These initiatives primarily provide additional funding to enable agencies to enhance health-care-related benefits for their OMRDD program employees, particularly their direct-care and -support staff. Secondarily, they assist providers in staff recruitment and retention efforts.

All three initiatives require applicants to submit plans, subject to OMRDD approval, which establish new or additional health care benefits. Benefits realized directly by employees may include new or expanded coverage (e.g., health, dental, vision, more comprehensive coverage, lower co-pays), a reduction for employees in the share of premiums that they pay, or direct reimbursement of documented employee out-of-pocket health care expenditures. In addition, HCE III recognizes that escalating health care costs that confront providers affect their employees. Consequently, HCE III permits use of initiative funds to offset a portion of the employer share of premium increases subject to stringent guidelines.

OMRDD extended eligibility to all employees working in OMRDD-funded, -authorized, or -certified programs although providers were granted authority to determine eligibility criteria. In so doing, providers could address agency specific health care issues. In many instances where employers exercised this option, eligibility mirrored terms already in place for existing benefits.

Continued on page 30

Providers identified as historically offering comprehensive health coverage above a benchmark level received funding without applying (HCE I & HCE III). Thus, the health benefit packages of the benchmark agencies were identified as both examples and targets toward which all other agencies should strive.

With respect to HCE I and HCE II, agencies which applied and did not have adequate funding to offer health insurance were awarded amounts sufficient to institute coverage ($2,500 per eligible employee per year) and agencies that applied and had previously offered coverage were awarded amounts to support increased benefits ($325 and $425 per eligible employee per year respectively). HCE III will provide additional funding ranging from 1 percent to 3 percent of operating costs depending on two variables—the provider's status with respect to the benchmark and the programs that the provider operates.[26]

Successive initiatives do not supplant preceding initiatives; thus, many providers are receiving HCE I, HCE II and HCE III funds simultaneously.

Key Features of the New York OMRDD Health Care Enhancement Initiatives

Eligible Participants	Direct-care and support staff working in OMRDD-funded, -authorized, or -certified programs. More specific eligibility criteria established by participating agencies.
Type of Coverage	Varies by agency. Health Reimbursement Arrangements (HRAs) are the most common type of benefit funded.
Scope of Benefits	Varies by agency. HRAs typically provide discounts or limited reimbursement on prescriptions and other defined health care services.
Premium Costs	Varies by agency.
Employer Costs	Varies by agency.
Employee Costs	Varies by agency. Initiative funds may be used to reduce premiums and/or out-of-pocket costs.

Track Record

Out of a total of 700 agencies, 312 participated in HCE I and 276 participated in HCE II; information is not yet available for HCE III. During HCE I and HCE II, a total of 17 agencies used the initiative funds to establish new coverage. The most frequently reported uses of funds reported in HCE II were:

1) Funding Health Reimbursement Arrangements (90 agencies)

2) Reimbursing out-of-pocket health-related expenses (30 agencies)

3) Reducing premium contributions made by employees (27 agencies)

4) Funding Flexible Spending Accounts (15 agencies)

26 Proposed regulation available at http://www.omr.state.ny.us/hp_healthcare_summary.jsp

Key Advantages

The HCE initiatives create an incentive for OMRDD employers who have not previously provided coverage while also rewarding employers who are already doing so. Employers have considerable flexibility as to how to use the funds. Enhancement funds are mitigating the high cost of coverage for many employers and reducing out-of-pocket costs for many employees.

Key Disadvantages

Initiative funds do not cover the full cost of providing comprehensive insurance coverage. Less than half of all agencies are participating in the HCE initiatives and relatively few agencies are using funds to establish new coverage. Health Reimbursement Arrangements and Flexible Spending Accounts, while affordable for employers, do not protect workers with chronic health care conditions or a major illness from high out-of-pocket costs. This initiative applies only to OMRDD providers.

For More Information

See New York State Office of Mental Retardation and Developmental Disabilities at
http://www.omr.state.ny.us/index.jsp

California: HealthyWorkers

HealthyWorkers is a health care benefit designed for Independent Provider (IP) home care workers in San Francisco, a workforce that now numbers more than 15,000. These workers provide care through the In-Home Supportive Services (IHSS) program, a consumer-directed home care model funded by a mix of federal, state, and county funds. Prior to 1999, a significant number of the IP home care workers in San Francisco lacked health coverage and relied on the county-funded indigent care program to meet their health care needs. Today, workers who meet eligibility requirements can enroll in HealthyWorkers, an HMO plan that provides comprehensive coverage for just $3 per month.[27]

HealthyWorkers is a joint effort of the IHSS San Francisco Public Authority (which acts as the employer of record for the home care workers), the Service Employees International Union-United Healthcare Workers West (which represents the workers), city departments and the San Francisco Health Plan, a county-run health plan. The health benefit was established through a collective bargaining agreement between the public authority and the union and delivered through a network of county-run clinics and hospitals.

27 IHSS workers in nine other California counties also have health care benefits according to collective bargaining agreements with SEIU. Each of these plans functions differently.

Financing is shared among state, county, and federal government entities. In 2000, state legislation established a formula for increasing direct-care worker wages and/or benefits, specifying the percentages to be paid by the state and counties for the non-federal share of any increases.[28] The cost of the health benefit is built into the hourly cost or claim rate of providing IHSS services through the Public Authority. As part of the public authority claim rate, county funds spent on health care receive federal Medicaid matching funds. Since the county already held responsibility for covering the cost of health care for these workers prior to the establishment of HealthyWorkers (as unreimbursed care), this federal Medicaid funding reduces county costs and extends or improves the services provided.

Key Features of HealthyWorkers

Eligible Participants	Home care workers employed through the In-Home Supportive Services program. Must work 25 or more hours per month and complete a 60-day waiting period to be eligible.
Individual or Family Coverage	Individual coverage
Type of Coverage	The San Francisco Health Plan, a county-operated Medicaid managed-care plan that uses a Community Health Network composed of 8 to 10 city public clinics and pharmacies and 2 public hospitals.
Scope of Benefits	Comprehensive
Premium Costs	$280 per member per month
Employee Costs	$3 per month premium, with very limited co-payments

Track Record

HealthyWorkers has been operating successfully since 1999. Currently, approximately 10,000 out of 15,000 IP home care workers (66 percent) are enrolled. Based on past surveys, it is estimated that 40 percent of those not enrolled have coverage through a spouse, Medi-Cal (Medicaid), or Medicare.

Key Advantages

HealthyWorkers provides IP home care workers with affordable, comprehensive health care coverage. It enjoys strong support and stable funding and is the model for "Healthy San Francisco"—a plan to provide universal health care coverage for all San Francisco residents.

Key Disadvantages

HealthyWorkers relies on the public health system. When at capacity, there can be problems such as long waits for appointments and limited choice of a primary care physician.

For More Information

See the San Francisco IHSS Public Authority at **http://www.sfihsspa.org/content.asp?CT=6&CC=0**

28 See CA AB2876, Chapter 108, Statutes of 2000.

Strategy #5: Assist workers with health care expenses

Overview

Rising health care costs have led some long-term care employers to embrace limited benefit health care products such as prescription discount cards, "mini-med" plans, health savings accounts (HSAs), and health care reimbursement arrangements (HRAs). These products offer workers limited assistance with health care expenses but do not provide comprehensive coverage for the full range of health care needs.

HSAs are tax-preferred savings accounts into which an individual, an employer, or both can make tax-deductible contributions.[29] Withdrawals from an HSA are used to pay for out-of-pocket health care expenses. By law, HSAs must be offered in conjunction with traditional health plans, which are typically high-deductible health insurance plans, known as "catastrophic plans." These plans require workers to cover several thousand dollars of their own health expenses before coverage begins.

Limited benefit health products can be offered on their own or as a step towards full coverage. For example, an employer could offer a prescription discount card for part-time workers or for workers during their first few months of employment, followed by comprehensive insurance coverage for full-time workers or all workers who have completed a probation period.

While more affordable for employers, limited benefit health care products are not effective in protecting workers with high medical needs. Discounts and limited reimbursements, while perhaps sufficient for some young, healthy workers, do not allow workers with chronic illnesses to effectively manage their conditions or protect workers who have a serious illness or injury from bankruptcy. The demographics of the direct-care workforce make them uniquely vulnerable to products that offer less than comprehensive coverage.[30]

29 Established as part of the Medicare Modernization Act of 2003, HSAs offer tax benefits for people who purchase insurance policies with high deductibles. To qualify for the tax break, the policy must have a deductible of at least $1,000 (for individual) or $2,000 (for family) but may run as high as $10,200.

30 "Consumer-Directed Health Plans: Early Enrollee Experiences with Health Savings Accounts and Eligible Health Plans," August 2006, U.S. General Accountability Office (GAO). See www.gao.gov/cgi-bin/getrpt?GAO-06-798.

New Mexico: Healthcare Reimbursement Arrangement

Seven developmental disability providers in New Mexico developed a Health Care Arrangement (HRA) for direct-care workers, a low-cost option for assisting workers with health care expenses. None of these providers previously offered health coverage to direct-care workers.

Funding for the HRA came from a federal demonstration grant intended to strengthen the direct service workforce.[31] In 2004, grantees were awarded approximately $1.4 million to fund a three-year demonstration project to test the impact of health care coverage on recruitment and retention of direct-care workers. The grant cycle ended in the fall of 2007.

The HRA package, which is continuing to be offered by five of the seven employers at least through 2008, includes three components:

- **Basic Health Care Insurance.** The OptiMed Med Choice Open Access Plan is a minimal health insurance policy that reimburses set amounts for selected health care services but does not cover the full cost of care. Workers are responsible for paying the difference between the set amounts and the actual charge for services.
- **Prescription Discount Card.** This card provides 10 percent or greater discounts on prescription drugs and other medical equipment needs. The amount of savings is determined by geographical location, dosage amount, and brand or generic drug type.

Continued on page 36

31 Three years of funding provided by the federal Centers for Medicare and Medicaid Services.

- **Monthly Cash Benefit Account**. This is a tax-free health reimbursement account established for each enrolled direct service worker. Employees who work 30 hours or more per week receive a $60 per month contribution to their account, for a total of up to $720 per calendar year. Part-time employees who work 29 hours or less per week receive a $30 per month contribution to their account, for a total of up to $360 per year. Employees can use the money in their account to cover allowable medical or health care expenses not covered by the basic health insurance or the prescription discount card.

Key Features of the Healthcare Reimbursement Arrangement

Eligible Participants	Full- and part-time employees employed by the seven agencies participating in the DSW grant. Workers are eligible after they have been employed for 30 consistent days as long as they are not already insured.
Individual or Family Coverage	Workers have the option to enroll family for basic health care insurance and can use funds from the cash benefit account for this purpose.
Type of Coverage	Basic health care insurance offered by OptiMed, a private carrier.
Scope of Benefits	Limited
Premium Costs	Together, the three components of the HRA cost $111 per employee per month ($40 insurance premium, $5 prescription discount card, $66 cash benefit program)
Employer Costs	All costs covered by funding from CMS.
Out-of-pocket Costs for Workers	While employees are not required to contribute to the basic cost of the three components of their health plan, they experience upfront costs for any health care services they receive.

Track Record

Approximately 200 workers out of a total of 286 direct-service workers employed by the seven agencies enrolled during the course of the grant.[32] Enrollment rates were high in part because there were no upfront costs to employees.

Key Advantages

The HRA provides a low-cost, flexible alternative to assisting workers with health care expenses. Employers and employees expressed that they were grateful for the HRA because it is "better than nothing," but do not believe it is a total solution.

Key Disadvantages

The HRA is complex and therefore difficult to explain. It allows for limited assistance with health care expenses but does not provide comprehensive health care insurance. With this type of product, individuals carry a risk of high out-of-pocket costs if they have a chronic health condition or a major illnesses or injury.

For More Information

For a more detailed description of this program see: "Emerging Strategies for Providing Health Coverage to the Frontline Workforce in Long Term Care." Available at **www.coverageiscritical.org** (click Resources).

32 The grantee reported 203 enrollees as of June 30, 2006 and 186 enrollees as of November 30, 2006.

Summary & Conclusion

The lack of access to guaranteed affordable health coverage for direct-care workers is a crisis that needs immediate attention. Advocates and policymakers are encouraged to draw from these models to develop health coverage policies in their states that reflect the needs of the direct-care workforce. In many cases, the best solution may combine two or more of the strategies described above.

PHI has developed a check list to assist advocates and policymakers evaluate initiatives to expand health care coverage. To address the unique needs of direct-care workers, efforts to expand coverage should be:

- ✓ ***Accessible*** to all individuals regardless of their family or employment status and how many hours they work;
- ✓ ***Affordable*** for workers and their employers;
- ✓ ***Comprehensive***, with a full range of benefits to protect older workers and those with chronic health conditions;
- ✓ ***Simple*** and easy to understand and enroll in;
- ✓ ***Sustainable*** over time.

For assistance in analyzing how to expand coverage to direct-care workers in your state, contact Health Care for Health Care Workers at **HCHCW@PHInational.org**.

Coverage Models "At a Glance"

Strategy	State Example	Description	Advantages	Disadvantages
1. Make employer based insurance more affordable	North Carolina: Premium Subsidies Demonstration	Used CMS funding to subsidize employee share of insurance premiums for home care workers employed by four home care agencies; 200 workers participated.	✓ Popular ✓ Associated with improved recruitment and retention	✓ High costs for employers ✓ High out-of-pocket costs for employees ✓ Funding source expired
	Maine: DirigoChoice	A state-supported health insurance plan aimed at small businesses. Provides subsidies for employee premiums.	✓ Established public program ✓ Affordable for low-income workers if subsidies are available	✓ Premium costs unaffordable for small home care employers
	Michigan: Access Health Plan	One of several county-based health care plans that divide insurance premiums between the employer, employee, and county.	✓ Comprehensive ✓ Affordable for employers and employees ✓ Community-based wellness program	✓ Relies on Medicaid DSH funds ✓ Funding stream may not be secure

Strategy	State Example	Description	Advantages	Disadvantages
2. Expand public insurance coverage	Vermont: Catamount Health Program	New public health care program for individuals below 300 percent FPL. Funded through a combination of state funds (tobacco taxes and employer assessments) and a Medicaid waiver to provide coverage to adults with incomes between 150 and 200 percent of FPL.	✓ Comprehensive ✓ Includes program to subsidize employer-sponsored health insurance	✓ High premium and out-of-pocket costs for workers
	Massachusetts: Health Reform Law	A state mandate requires all adults age 18 and older to have health insurance. Three public programs (MassHealth, the state's Medicaid program; Common-wealth Care; and Commonwealth Choice) provide comprehensive insurance options for individuals and families and offer subsidized options to those at or below 300 percent of the FPL.	✓ Comprehensive ✓ Affordable ✓ Accessible	✓ Options are complex and difficult for some to understand ✓ Mandate does not work for those who cannot find affordable option.
	Rhode Island: RIte Care Child Care Program	A Medicaid managed-care program, expanded to allow eligibility for certain child care providers; 300 currently enrolled.	✓ Comprehensive ✓ Affordable	✓ Does not cover direct-care workforce

Strategy	State Example	Description	Advantages	Disadvantages
3. Establish coverage through collective bargaining	New York: 1199SEIU Benefit and Pension Funds	Two Taft-Hartley multi-employer benefit funds governed by a labor-management partnership. Participants include 80,000 home attendants and their families and 10,000 home health aides.	✓ Comprehensive ✓ Affordable ✓ Union advocacy ensures ongoing funding	✓ Uncertainty regarding new financing mechanism.
	Washington: SEIU 775 Multi-Employer Health Benefits Trust	A Taft-Hartley multi-employer benefit fund governed by a labor-management partnership. Participants include 6,399 Individual Provider home care workers and 3,003 agency home care workers.	✓ Comprehensive ✓ Affordable for workers ✓ Union advocacy ensures stable funding	✓ Hours eligibility requirement (86 hours per month) ✓ Outreach is challenging
	Oregon: Home Care Union Benefits Board	Union-run third party administrator of health benefits for 3,500 independent home care workers.	✓ Comprehensive ✓ Affordable ✓ Union advocacy ensures stable funding	✓ Hours eligibility requirement (80 hours per month) ✓ Outreach is challenging

Strategy	State Example	Description	Advantages	Disadvantages
4. Build insurance costs into Medicaid reimbursement	Montana: Health Care for Health Care Workers	Beginning January 2009, the state will offer enhanced rate to Medicaid-funded home care agencies to provide affordable health insurance coverage for an estimated 1,000 uninsured home care workers.	✓ Simple and easy to understand ✓ Utilizes federal matching funds ✓ Potential to provide comprehensive, affordable coverage	✓ Specifics on benefit design and affordability protections not yet defined ✓ Participation is voluntary ✓ Ongoing advocacy needed
	New York: Health Care Enhancement Initiatives	Additional funding to enhance health care related benefits built into the Medicaid reimbursement rate for providers of services for the developmentally disabled under contract with the state Office of Mental Retardation and Developmental Disabilities.	✓ Incentive for employers to establish new coverage ✓ Reward for employers already offering coverage ✓ Funds can reduce costs for employers and employees.	✓ Only available to OMRDD providers ✓ Funding not sufficient to ensure comprehensive coverage ✓ Less than half of all agencies are participating. ✓ Limited accountability for how funds are spent
	California: HealthyWorkers	Joint effort between union, public authority and government officials to offer county-run Medicaid HMO to independent home care workers; 10,000 currently enrolled.	✓ Comprehensive ✓ Affordable ✓ Stable funding ✓ Broad support from multiple stakeholder groups	✓ Delivery through county health system means some waits and limited choice

Strategy	State Example	Description	Advantages	Disadvantages
5. Assist workers with health care expenses	New Mexico: Health Care Reimbursement Arrangement	A package of three components, including a basic health care insurance, a prescription discount card and monthly cash benefit account; 200 workers employed by 7 developmental disability providers participated.	✓ Low-cost for employers ✓ Flexible for employees	✓ Complex ✓ Limited assistance only ✓ Not comprehensive

These workers provide a level of care that far exceeds what we, as a society, have any reason to expect—given what we pay aides, and how we treat them. Ensuring health care for these workers should be something every policymaker supports.

–Dr. Bruce Vladeck
Former Administrator of the Health Care Financing Administration, US Department of Health and Human Services

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