

Health Insurance Coverage for Direct Care Workers: Key Provisions for Reform

Introduction

As an organization dedicated to our nation's 3 million direct-care workers and the millions of elders and people with disabilities they serve, PHI supports Congressional efforts to make health care coverage more affordable and accessible to all Americans. As a workforce that is more likely to be uninsured, with high rates of chronic health conditions and a very high incidence of workplace injuries, direct-care workers have much to gain from reform that both expands coverage and increases attention to screening, prevention, and health promotion services. We also encourage Congress to take special note of the nation's direct-care workforce as it considers improvements to our health care delivery system. This vast and underleveraged workforce is ideally positioned to assist with chronic care management, health promotion, disease prevention and control of health care costs.

Health Coverage

Benefit Options: We strongly recommend that a broad range of benefits and categories of services be offered in the non-group and small group market. We support the inclusion of dental and vision benefits as standard benefits for all populations, not just children. We oppose lifetime limits on coverage or annual limits on any benefits, and support provisions eliminating cost-sharing on preventive care services. This will encourage low-wage direct-care workers to seek the medical care they need, rather than putting off going to the doctor for preventive care because of cost of co-pays or deductibles.

Preventive Services: PHI strongly supports options to improve access to preventive services and encourage healthy lifestyles. These provisions are important for direct-care workers for two reasons:

- **Direct-care workers have high rates of chronic medical conditions**, such as diabetes and hypertension. Broader inclusion of screening and prevention services would improve the lives and health of these workers and help to stabilize the workforce overall.
- **Direct-care workers are an underutilized public health resource.** Every day, over 3 million direct-care workers are in direct contact with millions of Americans with chronic diseases and disabilities. With increased training and a more expansive view of their

role, these workers are a substantial human capital asset to be leveraged in operationalizing new models of care aimed at preventing illness and promoting health. PHI encourages Congress to identify direct-care workers as key participants in team-based care aimed at promoting health and managing chronic health conditions and further that it invest in appropriate training for this function.

Benefit Board: We support the creation of a public/private entity -- Benefit Board or Commission of some type -- that would recommend, define, and redefine as needed, the benefits and services covered within approved plans. This should be an independent board, consisting of consumers and medical experts, charged with: a) evaluating new data that emerges from comparative effectiveness studies, and b) ensuring that necessary services and benefits are included in plans approved by an Exchange (see below).

Insurance Reforms

Insurance Rules: PHI supports proposals that would create new federal rating standards for private insurance plans, including guaranteed issue and renewability, and prohibitions against pre-existing condition exclusions and lifetime and annual caps. In addition, we support provisions that would prohibit rating based on health status, gender, and occupation. We also support the inclusion of a risk adjustment mechanism to ensure that different pools and/or plans do not suffer from adverse selection and urge Congress to apply this mechanism to the largest pools possible. We encourage creating standard insurance forms to ensure a simplified process for consumers filling in claims as well as to reduce the high administrative costs of excessive paperwork.

We urge the phasing out of age rating. This insurance company practice has resulted in many direct-care workers and their employers paying higher rates for insurance. Many of these workers are older women – 40% of direct-care workers are over the age of 45 -- who live with chronic health conditions. The statistics are even more troubling for personal and home care aides –among the fastest growing jobs in the country – with nearly half (48.8%) over the age of 45. Provisions that prohibit rating on age and health status are very important to improving access and affordability.

Health Insurance Exchange: PHI supports the creation of a health insurance exchange (the Exchange) that can serve as a purchaser of coverage as well as a strong negotiator of premiums with private insurance plans. Creating an entity that is responsible for ensuring a level playing field for insurers and access to quality plans for consumers is critical to eliminating some of the inequities in our current system. We would encourage the Exchange to be the sole venue for buying both individual and small group coverage. Allowing insurers to operate outside the system could encourage adverse selection and prevent the Exchange from having a large enough pool for rating.

We urge Congress not to allow multiple exchanges to compete within an area. The insurance system is complex and confusing, and one of the goals of reform is to simplify access to

coverage options for consumers, rather than add navigation difficulties. In addition, we recommend limiting the number of permissible benefit levels available from the Exchange. Our concern is that multiple levels will result in “tiering,” leaving lower income enrollees at the lowest level of coverage.

Role of Public Programs

Medicaid Coverage: The Medicaid program has been a crucial source of coverage for direct-care workers and their families, with one-third of direct-care workers living in households receiving Medicaid benefits. The low wages of direct-care workers, combined with the often part-time nature of the work, has meant that many more workers would be uninsured if it were not for the Medicaid program.

Yet state Medicaid programs have many eligibility categories, each of which is often associated with a different income threshold. This complicated array of eligibility rules results in inequitable access to health care for low-income Americans across the country. We strongly support the creation of a uniform Medicaid eligibility for families with children with the minimum eligibility threshold of 150 % FPL for pregnant women, children, and parents. Further, it is critical to ensure that states do not roll back their commitments to currently covered populations above 150% FPL. A maintenance of effort provision that protects currently covered populations is essential.

We urge Congress to include low-income childless adults in the new national Medicaid eligibility floor. In most states, regardless of how low their income level is, childless adults are not eligible for publicly sponsored health insurance. Many direct-care workers are childless adults and fall between the cracks of eligibility for public coverage and employer-sponsored insurance (either because it is not offered, they can't afford it if it is offered, or they are not eligible because they work less than full-time).

Enrollment and Retention Simplification: PHI strongly supports a requirement for states to adopt simplified Medicaid enrollment processes, such as eliminating requirements for face-to-face interview and assets tests and establishing 12-month continuous eligibility. While Medicaid and other public programs remain major sources of health coverage for direct-care workers, 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 these workers.

In the current system, this can lead to “churning” between employer-sponsored insurance and Medicaid. Guaranteed continuous eligibility would break this cycle. Continuous eligibility would not only improve overall coverage, but would significantly reduce the administrative work caused by workers transitioning in and out of coverage. To promote stability in coverage beyond 12 months, efforts should be made to minimize churning at the point of annual recertification.

Medicare Coverage: PHI supports proposals that would allow 55-64 year-old adults to buy into the Medicare program. Allowing an early Medicare buy-in program for those 55-64 in age would benefit many direct-care workers. Overall, 15% of all direct-care workers are between the ages of 55 and 64; that number rises to an astonishing 20% for personal and home care aides. To ensure that the buy-in option expands access to coverage in an equitable and meaningful way for low-income individuals, a low-income tax credit or other form of subsidy for purchasing health coverage must also be available to individuals buying into the Medicare program.

Public Health Insurance Option: PHI strongly supports the proposal to include a public health insurance option for consumers. This could provide critical competition and choice for consumers purchasing health insurance in the Exchange, and help ensure accountability and transparency in this new insurance market. Many areas of the country lack meaningful competition among health insurers – leaving consumers little or no choice of insurance plans. Studies show that a public health insurance option would help drive down costs for all competing plans in a market. The experience with Medicare provides an informative example for the potential value of a public option. In addition to low administrative costs, Medicare has succeeded in controlling cost growth better than private coverage. Between 1997 and 2006, private health insurance spending per enrollee rose an average of 7.3% per year. Spending under Medicare grew only 4.6% per year. Administrative efficiencies and better cost controls under a new Medicare-like plan could inject competition into the market and force private plans to develop strategies to deliver a more cost efficient, high-quality product. Finally, as indicated by extensive public opinion research, a public health insurance option would provide consumers with “peace of mind,” knowing that there will always be a plan available regardless of their circumstances.

Affordability and Financing

PHI strongly believes that reform must ensure that everyone has access to affordable coverage and that individuals, employers and government should share in the responsibility for paying for that coverage.

Individual Responsibility: PHI believes that any requirement for individuals and families to obtain coverage must be contingent upon the following:

- Coverage must be affordable to the individual or family, including an annual limit on total enrollee cost-sharing -- not only premiums – and must protect them over time from rising health care costs;
- The defined benefit package must be sufficiently comprehensive and ensure access to services, and
- A corresponding responsibility for employers for providing coverage or making a payment in lieu thereof must also be established.

Direct-care workers most often cite the high cost of premiums and copayments as their biggest obstacle to participating in employer-sponsored plans. Many surveys of health insurance coverage for direct-care workers document this. For example, a recent survey of home care agencies in New York State (outside of New York City) found that one in five home care workers are offered coverage but do not enroll primarily due to unaffordable premium costs. In Iowa, a survey of certified nursing assistants found a 41 percent increase from 2001 to 2004 in the number of workers who, due to cost, did not take the coverage offered by their employers. Workers whose median hourly wage was \$10.48 in 2007, \$4.62 per hour less than the median wage for all US workers, can only be asked to contribute a minimal amount towards their health coverage. Without ensuring that an individual's contribution is affordable, many workers will continue to lack access to coverage

Employer Responsibility: PHI believes that all employers should share in the financing of coverage whether it is in the provision of health insurance to their employees or a payment in lieu of coverage. We also believe that for direct-care workers, their employers must pay for a significant portion of the premium if employees are to enroll in that coverage. Studies have shown that the two major reasons why direct-care workers do not participate in employers-sponsored insurance are 1) it is too expensive or 2) they do not work enough hours to be eligible.

Several unique characteristics of long-term care employers, however, must be addressed. First, many workers who provide in-home care are hired directly by consumers. Some states and counties have formalized these arrangement and established structures for providing benefits to this workforce, but many workers do not have any employer but the client they assist. Secondly, many employers are heavily dependent on public funding (Medicaid and Medicare) to pay for services, and inadequate reimbursement rates are a major barrier to offering health insurance. Some states, like Montana, have recently passed laws providing an enhanced Medicaid reimbursement rate specifically to pay for health insurance for employees of Medicaid-funded providers who deliver in-home personal assistance and private duty nursing services to elders and people with disabilities.

We urge Congress to address both these trends by ensuring that these workers have access to an affordable public health insurance coverage option and by providing sufficient funds to enable long-term care employers providing services paid for by public dollars to pay for employee coverage. Any employer requirement should apply to all workers, with a contribution requirement proportional to hours worked. This would reduce the incentive for employers to drop hours of work in order to avoid contribution liability.

The elder care/disability services industry employs more people than nearly any other industry in the country and is a leading industry for job growth. Yet many employers in this industry are small businesses and are unable to afford health coverage for their workers. Providing assistance in the form of tax credits to these small employers would be beneficial. PHI urges that any proposed credit be structured so that it could be applied against the payroll taxes paid

by both for-profits and non-profits. Precedent for this can be found in the American Reinvestment and Recovery Act where the COBRA subsidy for employers operates as a credit against payroll taxes. Whatever form the tax credit takes, it is important that it take a simple form in order to ensure the highest levels of participation.