PHI QUALITY CARE THROUGH QUALITY JOBS

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ISSUE BRIEF

The Impact of the Affordable Care Act on Health Coverage for Direct Care Workers

BY STEPHEN CAMPBELL

Direct care workers—nursing assistants, home health aides, and personal care aides who support older Americans and people with disabilities—are among America's lowest paid workers, often struggling to access health coverage. However, new coverage numbers show that this workforce benefited substantially from the Affordable Care Act (ACA). Between 2010 and 2014, half a million direct care workers gained coverage. At the same time, the uninsured rate across this workforce decreased by 26 percent. As the Trump administration and the new Congress consider the future of the Affordable Care Act (ACA) and Medicaid, it is important to consider the impact of these changes on this critical U.S. workforce.

BACKGROUND

Obstacles to Coverage Prior to the ACA

In 2010, more than one quarter (**28 percent**) of direct care workers lacked health coverage, as compared to **17 percent** of all American workers.[1] The uninsured rate was particularly high among home care workers, with one in three living without health coverage.

Prior to the expansion of coverage under the ACA, direct care workers faced several serious barriers that limited coverage. As a workforce that was primarily part time with low wages, workers had limited access to employer-sponsored coverage. In the private market, workers faced coverage with high costs. Preexisting conditions, which are disproportionate among low-income people, drove costs higher, or precluded workers from coverage altogether.

Despite their poverty status, direct care workers did not necessarily qualify for public coverage. Medicaid eligibility, prior to the ACA, was limited by most states to impoverished parents with dependent children and pregnant women.

DID YOU KNOW?

Direct care workers include personal care aides, home health aides, and nursing assistants. Direct care typically involves assisting older adults and people with disabilities with daily tasks such as eating, dressing, and bathing. In addition to assisting with these tasks, personal care aides provide non-medical social supports, and home health aides perform some clinical tasks under the supervision of a licensed professional. Nursing assistants provide essentially the same care and services as home health aides, but they primarily assist residents in institutional settings, such as nursing homes.

Expanded Coverage under the ACA

The ACA expanded coverage dramatically for direct care workers, though their part-time work schedules and low wages continue to create barriers. In 2014, **21 percent** of direct care workers were uninsured, compared to **16 percent** of the U.S. workforce.[2]

Of the three routes to coverage, employer-sponsored plans, federally subsidized plans purchased through health care marketplaces, and the expansion of Medicaid, the latter has had the greatest impact. Direct care workers have seen small gains in employer-sponsored coverage, but their part-time status often impedes eligibility. Even when plans are offered, the premiums are often too costly and take-up rates are low. Similarly, individual plans, even with generous tax credits, are often too expensive for workers whose annual earnings average less than $16,500 per year.

[1] US Census Bureau. Table B27011: Health Insurance Coverage Status and Type by Employment Status by Age. American Community Survey 1-Year Estimates. 2010, https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk

[2] US Census Bureau. Table B27011: Health Insurance Coverage Status and Type by Employment Status by Age. American Community Survey 1-Year Estimates. 2014, https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk

Medicaid Expansion

Under the ACA, the federal government offered states financial incentives to expand Medicaid eligibility to meet the needs of low-wage workers such as home care aides and nursing assistants. States were encouraged to provide coverage to all adults who live in households with incomes under 138 percent of the federal poverty level (FPL)—a threshold that nearly a third of the direct care workforce meets. Under these rules, eligibility is no longer limited by parental status; household income as a percentage of the federal poverty line is the sole determinant.

As of January 2017, 31 states and the District of the Columbia have expanded Medicaid eligibility, and in these states direct care workers fare better in regard to health coverage than in states that have not expanded Medicaid.[3] Yet half of direct care workers who would be eligible for expanded Medicaid live in non-expansion states. Some of these workers might earn incomes that are too high to qualify for their state Medicaid programs and too low to qualify for subsidies that make individual plans in the health insurance marketplaces affordable—a situation known as the "coverage gap."[4]

This issue brief is the first analysis of the ACA's effects on direct care workers. Our findings suggest that because direct care jobs are characterized by low annual earnings, Medicaid expansion drove the uninsured rate down. However, coverage gains among direct care workers were not distributed evenly across the country: the uninsured rate remains high in non-expansion states (see state data in Appendices B and C).

KEY FINDINGS

To understand how the ACA affects the health of direct care workers, as well as our nation's system of long-term services and supports, we examined two aspects of new health coverage data from the American Community Survey (ACS): overall gains in Medicaid coverage and changes in the uninsured rate following implementation of the ACA.

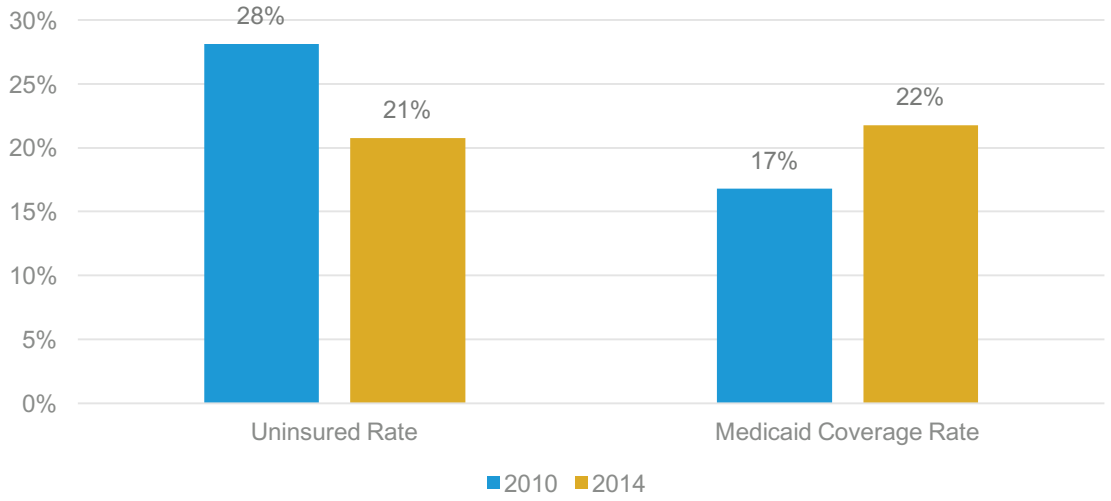
Nationwide Coverage Gains

- From 2010 to 2014, approximately **500,000** direct care workers nationwide gained health insurance following implementation of the Affordable Care Act (see Figure 1).
- The uninsured rate decreased **26 percent** during the same time frame, from 28 percent to 21 percent.
- These coverage gains are primarily attributable to a **30 percent increase** in the number of workers insured through Medicaid programs.

3 Seven states expanded Medicaid after 2014 and are not included as expansion states in our analysis.

[4] Subsidies are only available to individuals who live between 100 percent and 400 percent FPL. In every non-expansion state (except Wisconsin), parental eligibility is lower than 100 percent FPL, and childless adults are not eligible for Medicaid at all.

FIGURE 1: U.S. DIRECT CARE WORKER COVERAGE CHANGES, UNINSURED AND MEDICAID COVERAGE RATES, 2010 TO 2014

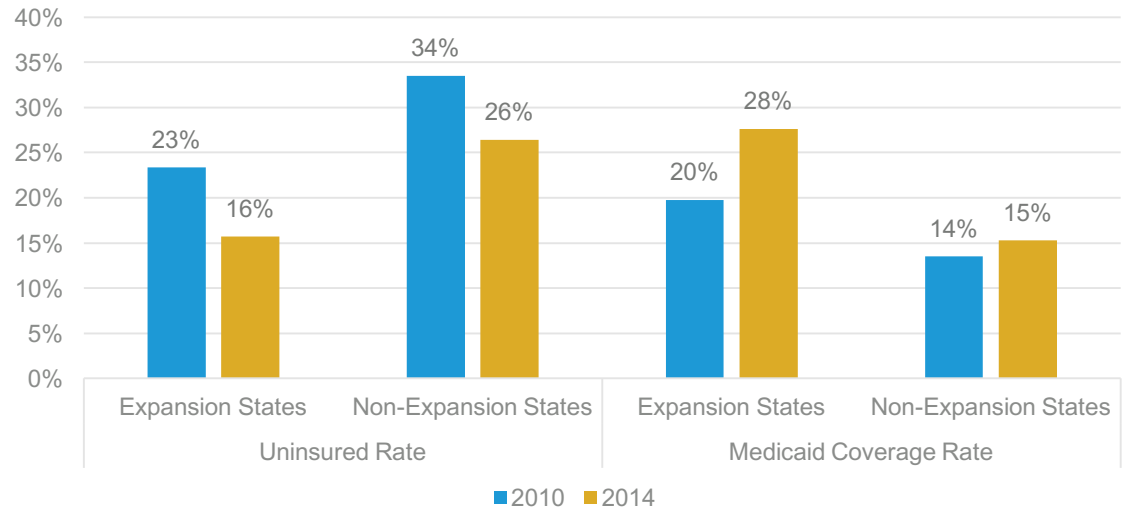


Source: PHI analysis of the U.S. Census Bureau, American Community Survey (ACS), 2010-2014 1-Year Public Use Microdata Sample (PUMS), with statistical programming and data analysis provided by Carlos Figueiredo.

Impact of Medicaid Expansion

- In expansion states, the uninsured rate fell **33 percent**, as compared to 21 percent in non-expansion states (see Figure 2).
- In expansion states, Medicaid coverage increased from 20 percent to 28 percent among direct care workers, a **40 percent** increase in coverage.
- Non-expansion states saw a small increase in Medicaid coverage, with coverage expanding from 14 percent to 15 percent among direct care workers. This change represents a **13 percent** increase in Medicaid coverage in these states.

FIGURE 2: U.S. DIRECT CARE WORKER COVERAGE CHANGES, UNINSURED AND MEDICAID COVERAGE RATES, BY MEDICAID EXPANSION STATUS, 2010 TO 2014

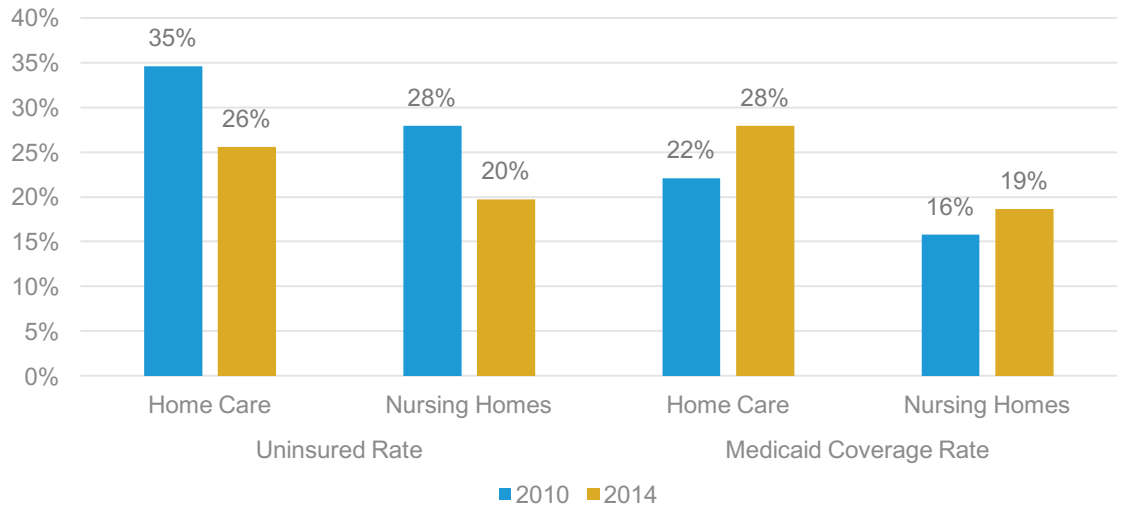


Source: PHI analysis of the U.S. Census Bureau, American Community Survey (ACS), 2010-2014 1-Year Public Use Microdata Sample (PUMS), with statistical programming and data analysis provided by Carlos Figueiredo.

Home Care Aides vs. Nursing Home Workers

- The overall uninsured rate for home care aides dropped **26 percent**, from 35 percent to 26 percent (see Figure 3).
- The uninsured rate among nursing assistants working in nursing homes dropped **29 percent**, from 28 percent to 20 percent.
- Home care workers—37 percent of whom lived below 138 percent of the federal poverty level in 2014—benefited most from Medicaid expansion, with coverage under Medicaid increasing from 22 percent to 28 percent, a **27 percent** increase.
- Among nursing home workers, Medicaid coverage increased from 16 percent to 19 percent, a total increase of **18 percent**. Among these workers, 29 percent lived in households below 138 percent of the poverty level in 2014.

FIGURE 3: U.S. DIRECT CARE WORKER COVERAGE CHANGES, UNINSURED AND MEDICAID COVERAGE RATES, BY INDUSTRY, 2010 TO 2014



Source: PHI analysis of the U.S. Census Bureau, American Community Survey (ACS), 2010-2014 1-Year Public Use Microdata Sample (PUMS), with statistical programming and data analysis provided by Carlos Figueiredo.

DISCUSSION

Low-income people, which includes most direct care workers, are more likely than their counterparts to struggle with chronic health conditions.[5] For direct care workers, chronic illnesses are compounded by a higher risk for injury and infection on the job than for the average U.S. worker.[6] Consequently, direct care workers rely heavily on affordable health insurance to manage their health and well-being.

When these workers lack coverage, several consequences ensue. For individual workers who cannot access affordable care, a minor untreated condition could lead to costlier health issues in the long term.[7] For example, individuals who don't treat their Diabetes could end up in dialysis treatment for kidney failure. Disabling conditions and health emergencies force workers to miss work, or they could compel workers to leave the caregiver workforce altogether. These dynamics contribute to high rates of turnover and workforce instability in this sector, which undermines the quality of care for older people and people with disabilities.

PHI's research and experience in the field show that a growing shortage of direct care workers is exacerbated by high turnover rates. Without access to affordable health coverage, these problems will worsen. Unprecedented demand for direct care, fueled by the steep growth in the older adult

[5] Brown, Alyssa. "With Poverty Comes Depression, More Than Other Illnesses." Gallup.com. October 30, 2012. http://www.gallup.com/poll/158417/poverty-comes-depression-illness.aspx.

[6] Marquand, Abby. *Too Sick to Care: Direct-Care Workers, Medicaid Expansion, and the Coverage Gap.* Bronx, NY: PHI, 2015. http://phinational.org/sites/phinational.org/files/research-report/toosicktocare-phi-20150727.pdf

[7] Gareld, Rachel, Melissa Majerol, Anthony Damico, and Julia Foutz. *The Uninsured: A Primer.* Menlo Park, CA: Kaiser Family Foundation. Retrieved from http://kff.org/report-section/the-uninsured-a-primer-2013-4-how-does-lack-of-insurance-affect-access-to-health-care/

population, is creating a growing crisis.[8] By 2024, our nation will need an estimated one million new direct care workers.[9] Without public policies that support living wages, affordable health care, and quality training to stem turnover and improve recruitment, shortages will worsen, increasing the caregiving burden on America's families.

CONCLUSION

This analysis demonstrates that access to affordable health coverage markedly improved for the direct care workforce following passage of the ACA. Given the elevated risk for acute and chronic conditions among these workers, and the nature of jobs with low pay and part-time status, ensuring they have access to coverage would improve workforce retention at a time when direct care workers are in high demand and short supply. Conversely, policies that limit access to affordable coverage would exacerbate the growing workforce shortage, which in turn would compromise the quality of care for older people and people with disabilities.

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PHI works to transform eldercare and disability services. We foster dignity, respect, and independence for all who receive care, and all who provide it. As the nation's leading authority on the direct care workforce, PHI promotes quality direct care jobs as the foundation for quality care. Drawing on 25 years of experience working side-by-side with direct care workers and their clients in cities, suburbs, and small towns across America, PHI offers all the tools necessary to create quality jobs and provide quality care. PHI's trainers, researchers, and policy experts work together to:

- Learn what works and what doesn't in meeting the needs of direct care workers and their clients, in a variety of long-term care settings;
- Implement best practices through hands-on coaching, training, and consulting, to help long-term care providers deliver high-quality care;
- Support policymakers and advocates in crafting evidence-based policies to advance quality care

For more information, visit our website at www.PHInational.org.

[8] Espinoza, Robert. *8 Signs the Shortage in Paid Caregivers Is Getting Worse.* Bronx, NY: PHI, 2017. https://60caregiverissues.org/the-future-of-long-term-care.html

[9] PHI analysis of Bureau of Labor Statistics, Employment Projections Program, Employment by Detailed Occupation, 2014 and Projected 2024.

APPENDIX A: METHODOLOGY

We define "direct care workers" to include home health aides, personal care aides, and nursing assistants, as defined by the Standard Occupational Classification (SOC) system developed by the Bureau of Labor Statistics (BLS) at the U.S. Department of Labor (DOL). To assess the ACA's impact on health insurance coverage for direct care workers, we analyzed American Community Survey (ACS) data by state and industry from 2010 to 2014.[10]

We separately sampled the home care and nursing home industries—the two industries that employ a large plurality of direct care workers. The home care industry includes home health services and non-medical services for older adults and people with disabilities.[11] Nursing homes provide nursing care and 24-hour personal assistance to residents.[12]

State-level data were aggregated into two categories: "expansion states" that expanded Medicaid coverage to parents and childless adults in households under 138 percent of the federal poverty line (FPL), and "non-expansion states."[13]

[10] PHI analysis of the U.S. Census Bureau, American Community Survey (ACS), 2010-2014 1-Year Public Use Microdata Sample (PUMS), with statistical programming and data analysis provided by Carlos Figueiredo.

[11] For a full definition of the home care industry, see *U.S. Home Care Workers: Key Facts*, available at http://phinational.org/home-care-workers-key-facts

[12] For a full definition of the nursing home industry, see *U.S. Nursing Assistants in Nursing Homes: Key Facts*, available at http://phinational.org/nursing-assistants-nursing-homes-key-facts

[13] "Status of State Action on the Medicaid Expansion Decision." *Kaiser Family Foundation*. January 1, 2017. http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0#notes

APPENDIX B: U.S. DIRECT CARE WORKER UNINSURED RATE CHANGES, BY STATE, 2010 TO 2014

STATE	MEDICAID EXPANSION STATUS	2010	2014	PERCENT CHANGE
Alabama	Non-Expansion	33%	24%	-28%
Alaska**	Non-Expansion	33%	29%	-12%*
Arizona	Expansion	25%	23%	-7%*
Arkansas	Expansion	38%	26%	-33%
California	Expansion	30%	20%	-34%
Colorado	Expansion	33%	16%	-52%
Connecticut	Expansion	12%	11%	-5%*
Delaware	Expansion	10%	12%	22%*
District of Columbia	Expansion	16%	6%	-62%*
Florida	Non-Expansion	35%	29%	-18%
Georgia	Non-Expansion	38%	25%	-33%
Hawaii	Expansion	10%	8%	-12%*
Idaho	Non-Expansion	41%	38%	-8%*
Illinois	Expansion	27%	17%	-38%

APPENDIX B: U.S. DIRECT CARE WORKER UNINSURED RATE CHANGES, BY STATE, 2010 TO 2014 (CONT.)

STATE	MEDICAID EXPANSION STATUS	2010	2014	PERCENT CHANGE
Indiana**	Non-Expansion	28%	23%	-19%
Iowa	Expansion	18%	12%	-34%
Kansas	Non-Expansion	31%	27%	-12%*
Kentucky	Expansion	36%	18%	-48%
Louisiana**	Non-Expansion	42%	34%	-19%
Maine	Non-Expansion	19%	17%	-9%*
Maryland	Expansion	21%	14%	-33%
Massachusetts	Expansion	7%	7%	-7%*
Michigan**	Non-Expansion	25%	18%	-29%
Minnesota	Expansion	21%	10%	-54%
Mississippi	Non-Expansion	41%	26%	-37%
Missouri	Non-Expansion	37%	29%	-22%
Montana**	Non-Expansion	28%	22%	-21%*
Nebraska	Non-Expansion	24%	15%	-37%

APPENDIX B: U.S. DIRECT CARE WORKER UNINSURED RATE CHANGES, BY STATE, 2010 TO 2014 (CONT.)

STATE	MEDICAID EXPANSION STATUS	2010	2014	PERCENT CHANGE
Nevada	Expansion	28%	26%	-7%*
New Hampshire**	Non-Expansion	16%	20%	27%*
New Jersey	Expansion	22%	22%	-2%*
New Mexico	Expansion	44%	27%	-40%
New York	Expansion	14%	10%	-30%
North Carolina	Non-Expansion	33%	23%	-32%
North Dakota	Expansion	10%	12%	25%*
Ohio	Expansion	25%	17%	-30%
Oklahoma	Non-Expansion	43%	34%	-20%
Oregon	Expansion	26%	14%	-47%
Pennsylvania**	Non-Expansion	21%	18%	-12%*
Rhode Island	Expansion	9%	10%	14%*
South Carolina	Non-Expansion	29%	27%	-7%*
South Dakota	Non-Expansion	27%	17%	-37%*

APPENDIX B: U.S. DIRECT CARE WORKER UNINSURED RATE CHANGES, BY STATE, 2010 TO 2014 (CONT.)

STATE	MEDICAID EXPANSION STATUS	2010	2014	PERCENT CHANGE
Tennessee	Non-Expansion	28%	24%	-12%*
Texas	Non-Expansion	51%	39%	-23%
Utah	Non-Expansion	27%	20%	-26%*
Vermont	Expansion	15%	10%	-32%*
Virginia	Non-Expansion	29%	27%	-7%*
Washington	Expansion	30%	15%	-51%
West Virginia	Expansion	38%	21%	-45%
Wisconsin	Non-Expansion	15%	13%	-12%*
Wyoming	Non-Expansion	35%	36%	1%*

*Difference between 2010 and 2014 uninsured rates was not statistically significant at the 90 percent confidence level (α=.10).

**State expanded Medicaid eligibility after January 1, 2014.

Source: PHI analysis of the U.S. Census Bureau, American Community Survey (ACS), 2010-2014 1-Year PUMS, with statistical programming and data analysis provided by Carlos Figueiredo.

APPENDIX C: U.S. DIRECT CARE WORKER MEDICAID COVERAGE RATE CHANGES, BY STATE, 2010 TO 2014

STATE	MEDICAID EXPANSION STATUS	2010	2014	PERCENT CHANGE
Alabama	Non-Expansion	10%	14%	36%*
Alaska**	Non-Expansion	14%	22%	51%*
Arizona	Expansion	21%	22%	4%*
Arkansas	Expansion	6%	21%	236%
California	Expansion	18%	27%	54%
Colorado	Expansion	10%	26%	160%
Connecticut	Expansion	20%	32%	56%
Delaware	Expansion	30%	29%	-1%*
District of Columbia	Expansion	25%	57%	134%
Florida	Non-Expansion	12%	12%	4%*
Georgia	Non-Expansion	8%	10%	24%*
Hawaii	Expansion	19%	15%	-21%*
Idaho	Non-Expansion	7%	10%	42%*
Illinois	Expansion	20%	27%	33%

APPENDIX C: U.S. DIRECT CARE WORKER MEDICAID COVERAGE RATE CHANGES, BY STATE, 2010 TO 2014 (CONT.)

STATE	MEDICAID EXPANSION STATUS	2010	2014	PERCENT CHANGE
Indiana**	Non-Expansion	13%	18%	32%*
Iowa	Expansion	19%	23%	24%*
Kansas	Non-Expansion	12%	16%	34%*
Kentucky	Expansion	10%	20%	86%*
Louisiana**	Non-Expansion	18%	19%	5%*
Maine	Non-Expansion	18%	28%	56%*
Maryland	Expansion	17%	23%	34%*
Massachusetts	Expansion	33%	38%	15%*
Michigan**	Non-Expansion	21%	23%	10%*
Minnesota	Expansion	24%	28%	18%*
Mississippi	Non-Expansion	10%	13%	40%*
Missouri	Non-Expansion	17%	14%	-14%*
Montana**	Non-Expansion	6%	17%	174%*
Nebraska	Non-Expansion	10%	9%	-2%*

APPENDIX C: U.S. DIRECT CARE WORKER MEDICAID COVERAGE RATE CHANGES, BY STATE, 2010 TO 2014 (CONT.)

STATE	MEDICAID EXPANSION STATUS	2010	2014	PERCENT CHANGE
Nevada	Expansion	8%	20%	162%*
New Hampshire**	Non-Expansion	6%	10%	69%*
New Jersey	Expansion	16%	19%	20%*
New Mexico	Expansion	29%	36%	26%*
New York	Expansion	26%	32%	25%
North Carolina	Non-Expansion	14%	15%	13%*
North Dakota	Expansion	6%	7%	19%*
Ohio	Expansion	19%	27%	41%
Oklahoma	Non-Expansion	10%	12%	20%*
Oregon	Expansion	15%	28%	88%
Pennsylvania**	Non-Expansion	15%	18%	21%*
Rhode Island	Expansion	13%	31%	144%*
South Carolina	Non-Expansion	11%	17%	60%*
South Dakota	Non-Expansion	5%	11%	98%*

APPENDIX C: U.S. DIRECT CARE WORKER MEDICAID COVERAGE RATE CHANGES, BY STATE, 2010 TO 2014 (CONT.)

STATE	MEDICAID EXPANSION STATUS	2010	2014	PERCENT CHANGE
Tennessee	Non-Expansion	19%	18%	-4%*
Texas	Non-Expansion	10%	12%	20%*
Utah	Non-Expansion	9%	11%	33%*
Vermont	Expansion	34%	33%	-4%*
Virginia	Non-Expansion	8%	11%	26%*
Washington	Expansion	12%	22%	87%
West Virginia	Expansion	10%	27%	182%
Wisconsin	Non-Expansion	29%	23%	-20%*
Wyoming	Non-Expansion	2%	13%	498%*

*Difference between 2010 and 2014 uninsured rates was not statistically significant at the 90 percent confidence level (α=.10).

**State expanded Medicaid eligibility after January 1, 2014.

Source: PHI analysis of the U.S. Census Bureau, American Community Survey (ACS), 2010-2014 1-Year PUMS, with statistical programming and data analysis provided by Carlos Figueiredo.