



TOO SICK TO CARE: DIRECT-CARE WORKERS, MEDICAID EXPANSION, AND THE COVERAGE GAP

By Abby Marquand

Direct-care workers provide essential services to millions of elders and people with disabilities. This workforce totaled more than 3.4 million in 2014¹, and the need is expected to grow to nearly 5 million by 2022.² The ability of our nation to meet the skyrocketing demand for care created by these rapidly growing populations will depend in large part on quality jobs that attract and retain a sufficient number of workers to this field.

Currently, direct-care jobs are known for low wages, unpredictable hours, and few employment benefits. To ensure an adequate workforce supply in coming decades, affordable health coverage options will be crucial. Health coverage is critical to workers and to consumers, as it enables workers to remain healthy and provide the quality care that so many of us rely on.

The Affordable Care Act (ACA) has expanded health coverage to more than 25 million people since its passage in 2010.³ Key to this legislation is a provision that encourages states to expand Medicaid eligibility. Since 2010, more than half of states have expanded Medicaid and increased health care access to 12 million low-income individuals and their

families. PHI's research shows that direct-care workers in particular stand to benefit from more affordable health coverage options, including access to Medicaid—yet many states have chosen not to expand Medicaid eligibility, leaving millions of low-income adults without access to health care coverage.

This research brief examines how Medicaid expansion under the ACA impacts the direct-care workforce, with particular attention given to differences between states that have expanded Medicaid eligibility (“expansion states”) and states that have not (“non-expansion states”). We find that despite their critical role as care providers, roughly 400,000 direct-care workers live without health insurance in states that have opted not to expand Medicaid. By contrast, 650,000 direct-care workers are now eligible for health coverage because of their state’s decision to expand this vital program.

In response to this continuing gap in affordable health insurance, federal and state leaders should implement an array of policy reforms to ensure that direct-care workers have the coverage they need to remain healthy, which in turn ensures that they can maintain steady employment and provide

- 650,000 direct-care workers are eligible for Medicaid in the 29 states (plus Washington, DC) that have taken up Medicaid expansion under the Affordable Care Act.
- Nearly half a million direct-care workers who meet the expanded eligibility thresholds for Medicaid expansion under the Affordable Care Act live in states that have opted out of expansion. Two in five of these workers were uninsured in 2013.
- Decisions not to expand Medicaid eligibility disproportionately impact direct-care workers in Southern states, and direct-care workers who are under age 55, black, or Latino.
- In 2013, direct-care workers nationwide were 32 percent less likely to have employer-sponsored health insurance, and 65 percent more likely to be uninsured than the typical American worker.

better quality care. In the wake of the Supreme Court's June 2015 decision in *King v. Burwell*, which rightfully secured federal subsidies for health coverage nationwide, it is imperative that we continue to assess the extent to which low-income people can access affordable health coverage.

METHODOLOGY

To assess poverty levels for direct-care worker households we used data from the 2013 American Community Survey. This data reflects insurance status prior to the implementation of many provisions in the Affordable Care Act—most notably the individual mandate, which requires individuals to enroll in a health insurance plan or pay a penalty.⁴ For this reason, we did not make projections on actual Medicaid enrollment; we relied on the number of people eligible under various thresholds to estimate the impact of Medicaid expansion on the direct-care workforce.

The number of direct-care workers employed in each state and nationally comes from the Bureau of Labor Statistics, Occupational Employment Statistics program, May 2014 estimates. See Technical Notes for detailed methodology.

THE AFFORDABLE CARE ACT AND MEDICAID EXPANSION

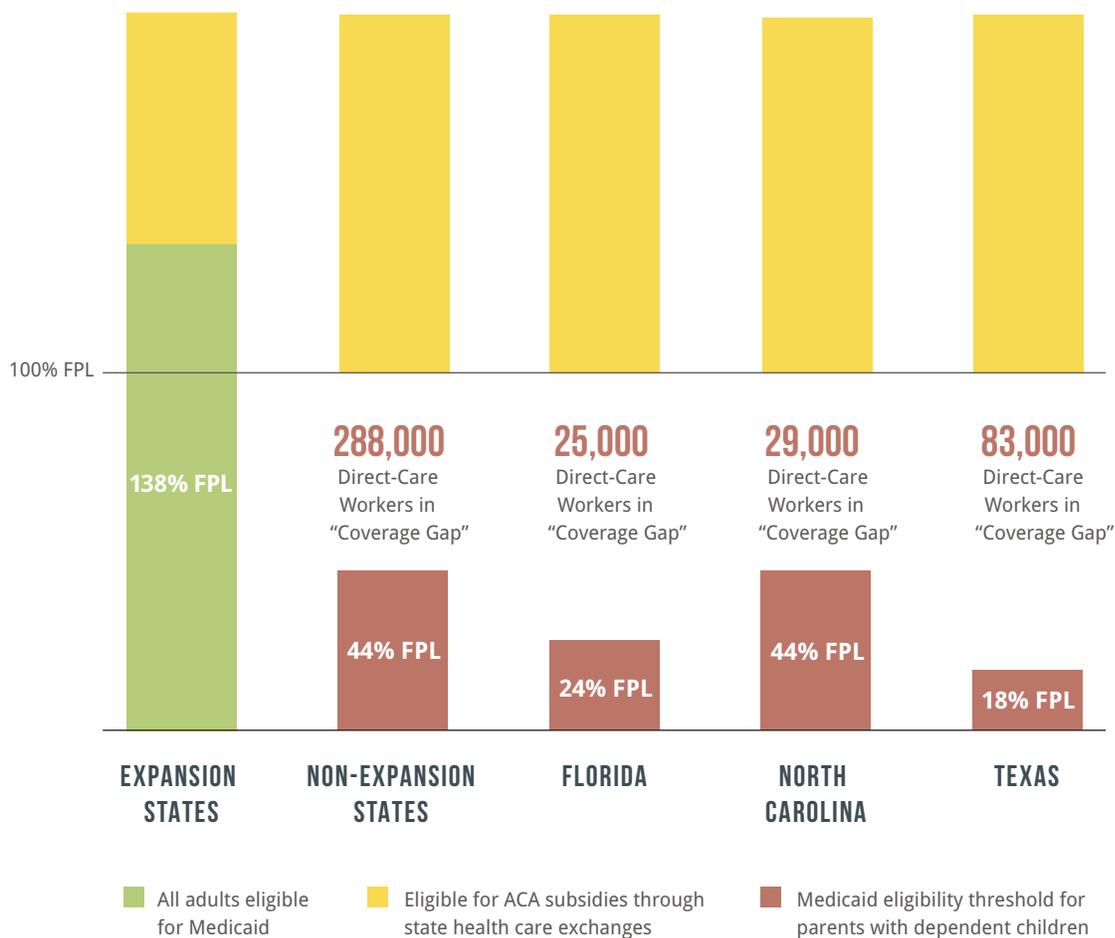
Enacted in 2010, the Affordable Care Act aimed to improve access to affordable health care for uninsured individuals and their families. Since its enactment, this legislation has helped to extend coverage to millions of people.⁵ The creation of online health care marketplaces for purchasing individual coverage, and the federal tax credits or subsidies provided to individuals with household income between 100 and 400 percent of the federal poverty line (FPL)⁶, have together resulted in more than 11.7 million people accessing affordable health care.⁷

Additionally, in order to improve health coverage for millions of the country's lowest-income families, the ACA included a provision meant to incentivize states to expand eligibility for Medicaid programs to cover individuals with household incomes up to 138 percent FPL.⁸ Original projections estimated that Medicaid expansion would extend coverage to more than 15 million uninsured people across all 50 states.⁹ However, in 2012 the Supreme Court ruled that states could opt out of this new Medicaid requirement without a penalty.¹⁰ As of July 2015, only 29 states and the District of Columbia have expanded their programs, covering 12 million people.¹¹

FIGURE 1 | The Impact of the “Coverage Gap” on Direct-Care Workers

While nearly all direct-care workers who live in states that have expanded Medicaid (“expansion states”) can access affordable health coverage, the picture is much grimmer for those living in states that have not expanded Medicaid (“non-expansion states”). In non-expansion states, like Florida, North Carolina, and Texas, notable health coverage gaps exist for direct-

care workers whose household incomes fall between current Medicaid eligibility thresholds and the point at which subsidies to purchase health coverage on the exchange kick in (100% of the federal poverty level). As of July 2015, 21 states have not expanded Medicaid. (See Figure 2 for more detail.)



THE COST OF POOR HEALTH COVERAGE Even one direct-care worker without health coverage can lead to significant costs for her personal health, the care she provides, and the public at large. Poor health coverage means that people are less likely to seek out necessary care, leaving illnesses untreated and undiagnosed until emergencies and incurring significant expenses on individuals and taxpayers. Moreover, a direct-care worker in poor health cannot provide the quality care we all want and deserve.

Source: Based on PHI Analysis of U.S. Census Bureau, American Community Survey 2014 5-year Estimate: Public Use Microdata Sample; Bureau of Labor Statistics, 2014 Occupational Employment Statistics (OES) Program Data

Non-expansion states have maintained their traditional Medicaid eligibility standards, meaning an individual must be a member of an eligible group (e.g., children, pregnant women, parents, etc.) and meet the financial eligibility criteria set by the state for that group. For children and pregnant women, each state is required to set the eligibility threshold somewhere between 100 and 133 percent FPL. Parental eligibility can be set much lower; the eligibility threshold ranges from 18 to 100 percent FPL, depending on the state. Under traditional Medicaid, states have no requirement to cover childless adults, and only one non-expansion state (Wisconsin) offers any coverage for this group.¹²

In 21 states, the decision not to expand Medicaid has resulted in a large gap between current Medicaid eligibility and the income level at which an individual or family qualifies for subsidies to purchase health insurance in the state health care exchanges (100 percent FPL).¹³ This gap, known as the Medicaid “coverage gap,” has left about 4 million Americans without access to affordable coverage.¹⁴ (For more information, see Figure 1 on page 3.)

DIRECT-CARE WORKERS AND EXPANDED MEDICAID COVERAGE

Direct-care jobs are characterized by low wages, lack of employment benefits, and unpredictable, part-time hours. Workers across settings earn, on average, \$10.85 an hour.¹⁵ Part-time hours further reduce median earnings for this workforce to approximately \$16,100 a year.¹⁶ As a result of low and unpredictable incomes, 44 percent of direct-care workers live in households that rely on some form of public assistance, such as food stamps, cash assistance, and Medicaid.¹⁷

Nationally, one-third of direct-care workers live in households with income under 138 percent FPL—the eligibility threshold under Medicaid expansion. Nearly half a million of these workers live in non-expansion states, and of these over 200,000 were uninsured in 2013 (see Table 1 below). One in five direct-care workers (750,000) live below 100 percent FPL, making them ineligible for federal subsidies needed to purchase affordable insurance on the health care exchanges. In non-expansion states, nearly 300,000 direct-care workers have no new health care coverage options under the ACA (see Figure 2 on the next page).

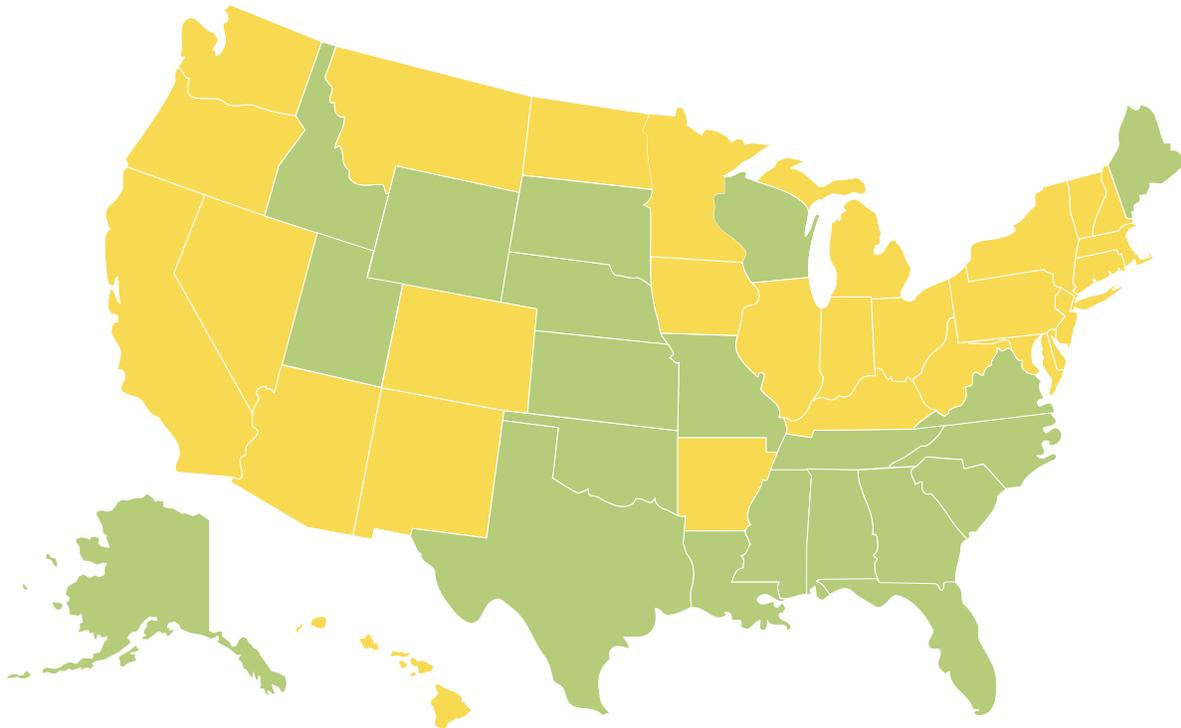
TABLE 1 | Direct-Care Workers’ Insurance Status in Expansion and Non-Expansion States, 2013

DIRECT-CARE WORKERS	ALL STATES		EXPANSION STATES		NON-EXPANSION STATES	
ALL	3.4 MILLION		2.2 MILLION		1.2 MILLION	
INSURED	74%	2.5 MILLION	78%	1.7 MILLION	66%	823,000
UNINSURED	26%	893,000	22%	473,000	34%	420,000
HOUSEHOLD INCOME UNDER 138% FPL	1.14 MILLION		31%	667,000	38%	473,000
INSURED	69%	786,000	78%	521,000	56%	265,000
UNINSURED	31%	354,000	22%	146,000	44%	208,000

**FIGURE 2 | Two States of Care:
Health Coverage in Expansion and Non-Expansion States**

Hundreds of thousands of direct-care workers nationwide are affected by their inability to access health coverage in their states—a barrier that’s more profound in states that have not expanded

Medicaid (“non-expansion states”) than in states that expanded Medicaid following the passage of the Affordable Care Act (“expansion states”). This chart quantifies the impact of these expansion decisions on the direct-care workforce.



EXPANSION STATES: AZ, AR, CA, CO, CT, DE, HI, IL, IN, IA, KY, MD, MA, MI, MN, MT, NV, NH, NJ, NM, NY, ND, OH, OR, PA, RI, VT, WA, WV, and WASHINGTON D.C.

2.2 MILLION

direct-care workers provide support to older people and people with disabilities.

1 IN 5

direct-care workers is uninsured.

667,000

direct-care workers are eligible for Medicaid under their state’s expansion.

288,000

direct-care workers fall in the “coverage gap” between Medicaid eligibility and 100% FPL—the income that would qualify them for ACA subsidies. These workers have no new affordable health coverage options. (See Figure 1 for more detail.)

NON-EXPANSION STATES: AL, AK, FL, GA, ID, KS, LA, ME, MS, MO, NE, NC, OK, SC, SD, TN, TX, UT, VA, WY, and WI.

1.2 MILLION

direct-care workers provide support to older people and people with disabilities.

1 IN 3

direct-care workers is uninsured.

473,000

direct-care workers would be eligible for Medicaid if their state opted for expansion.

Source: Based on PHI Analysis of U.S. Census Bureau, American Community Survey 2014 5-year Estimate: Public Use Microdata Sample; Bureau of Labor Statistics, 2014 Occupational Employment Statistics (OES) Program Data

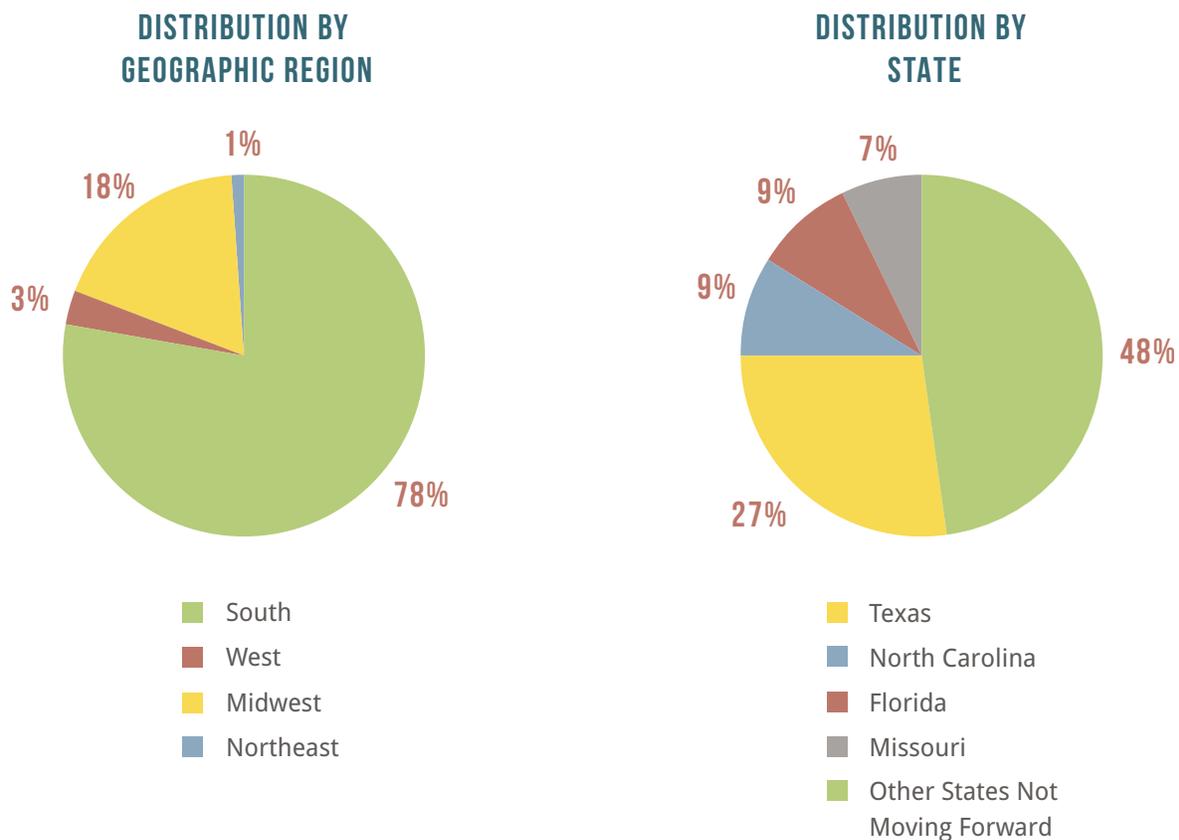
REGIONAL AND DEMOGRAPHIC FINDINGS

Economic conditions for direct-care workers are difficult across the country, but more so in non-expansion states. For example, the percentage of direct-care workers living under 138 percent FPL is 25 percent higher in non-expansion states than in

those that expanded Medicaid. In 2013, workers in non-expansion states were 55 percent more likely to be uninsured and 18 percent less likely to have employer-sponsored coverage.

The gap in coverage between expansion and non-expansion states likely increased in 2014 and 2015 as more eligible direct-care workers enrolled in Medicaid—particularly after the implementation of the individual mandate.

FIGURE 3 | Direct-Care Workers in Non-Expansion States with Household Incomes under 138% of the Federal Poverty Level (by Region and State, 2013)



Source: PHI Analysis of the 2013 American Community Survey

DID YOU KNOW?

The PHI State Data Center provides critical data on personal care aides, home health aides and nursing assistants in all 50 states.

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- Wage trends

- Health coverage statistics
- Training requirements
- Key legislative and regulatory initiatives

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DISPROPORTIONATE IMPACT ON DIRECT-CARE WORKERS IN THE SOUTH

More than a third of the U.S. population lives in southern states¹⁸, where residents are more likely to be uninsured and live in poverty than in other regions of the country.¹⁹ Only six out of seventeen southern states have expanded their Medicaid programs. Two states that have not expanded Medicaid are Texas and Florida—states with some of the largest numbers of direct-care workers, as well as growing demand.²⁰

Of the 1.1 million direct-care workers employed in southern states, 38 percent live in households with incomes below 138 percent FPL, and one in four live in households with income below 100 percent FPL. In 2013, Texas alone accounted for 11 percent of the nation's direct-care workers living under 138 percent FPL, and 22 percent of the uninsured workers below the 138 percent FPL threshold. North Carolina and Florida together account for 84,000 direct-care workers living under 138 percent FPL, and more than two out of five of these workers were uninsured in 2013.

But Southern states are not alone. Missouri—another non-expansion state—has the fourth-largest number of direct-care workers under 138 percent FPL: a staggering 34,000 people. Nearly half of these workers were uninsured in 2013.

DISPROPORTIONATE IMPACT BY AGE AND RACE

The decision by 21 states to opt out of Medicaid expansion has had a disproportionate impact on younger direct-care workers. A higher proportion of direct-care workers under age 55 live in poverty—in general, younger workers are more likely to be supporting dependents and to have higher rates of unemployment, and are less likely to have supplemental sources of income like Social Security.²¹ More than one-third of direct-care workers under 55 live in households with income under 138 percent FPL while the same is true for only 25 percent of workers over 55.

Racial and ethnic disparities are more pronounced within the population of direct-care workers earning less than 138 percent FPL than for those with higher incomes. Thus, the decision by states not to expand eligibility for Medicaid disproportionately impacts these populations.²² Among direct-care workers below the 138 percent threshold, 35 percent are black, 17 percent are Latino, and 41 percent are white. Among those with incomes over 138 percent of FPL, more than half are white and only 40 percent are black or Latino. Such disparities in income and access to health coverage among direct-care workers merit particular attention for policymakers.

The federal government will cover the full cost of Medicaid expansion until 2016, at which point it will pay 90 percent of the cost. Economists have noted that the corresponding influx of federal dollars will benefit state economies in terms of growth in GDP and employment.⁴² For example, in Arkansas and Kentucky, the costs of implementing Medicaid expansion will be offset by the savings and revenue gains for at least six years, if not longer. Additionally, states that had been providing Medicaid coverage

to high-need groups through waiver programs are realizing savings from transitioning these individuals to the new expansion program with the enhanced federal match. In Washington, these savings will amount to \$342 million through 2015. Other gains in revenue will be realized from fees and taxes on new or growing networks of providers and health plans, which for New Mexico will amount to \$60 million in 2015.⁴³

DISCUSSION

THE IMPORTANCE OF AFFORDABLE HEALTH COVERAGE

Direct-care workers experience much higher injury rates than most other workers. Bathing, dressing,²³ and moving individuals are strenuous activities, involving repetitive motions, which result in large numbers of musculoskeletal injuries leading to long absences from work.^{24 25 26} This is especially true of nursing assistants, who are more likely to be injured on the job than any other occupation, including construction workers, police officers, and fire fighters.²⁷

Additionally, like other health care workers, direct-care workers may be exposed to communicable diseases, but they are far less likely to have completed training on safety and infection control.²⁸

For direct-care workers, affordable health insurance increases access to preventive care and allows direct-care workers who sustain injuries or illnesses to effectively recover and return to work.²⁹

Yet because of their irregular hours and low wages, direct-care workers are less likely than other workers to have affordable, continuous coverage. Two-thirds of direct-care workers in non-expansion states (800,000) reported that they had coverage through either private insurance, employer-sponsored plans, or Medicaid in 2013, yet for many of these individuals coverage is tenuous at best. That is because:

- Eligibility for employer-sponsored insurance is usually dependent on maintaining “full-time” hours, which is particularly difficult in the direct-care sector. Hours are often unpredictable, and part-time employment is the norm. In non-expansion states, less than 40 percent of workers worked full time for the entire year in 2013.³⁰
- Cost-sharing for individuals who purchase their own coverage, including exchange plans available through the Affordable Care Act, poses a significant financial burden on low-income people. The average premium for a bronze plan³¹ on the exchanges is more than 20 percent of income for people living below the FPL—\$207 per month—and at this level of poverty, federal subsidies are not available to assist with the cost.^{32 33}

- In non-expansion states, direct-care workers who qualify for Medicaid under pre-Affordable Care Act eligibility guidelines are likely covered because of a temporary status, such as being a parent or pregnant.

These factors result in a high level of “churn”—the movement into and out of insurance programs as a result of income-based eligibility, which often leads to disruption in coverage.³⁴ By expanding Medicaid eligibility, states could reduce churning by providing a more consistent, affordable option for direct-care workers with incomes under 138 percent of the FPL.

THE IMPLICATIONS OF THE EMPLOYER MANDATE

The employer mandate, which requires employers with 50 or more full-time employees to offer coverage to their workers, is an important provision of the Affordable Care Act, but it will not be implemented until 2016.³⁵

Though we cannot assess the impact of the employer mandate on extending coverage to low-income workers, we do know that the mandate will be particularly challenging for providers of long-term services and supports as their revenue largely comes from government sources, primarily Medicaid and Medicare. Funding for these programs is never guaranteed in the constant competition for federal and state funds.

In most states, public reimbursement rates that fund direct-care services don’t fully account for employment costs such as wages and benefits, making it particularly difficult for direct-care providers to offer affordable employer-sponsored coverage. Additionally, with the employer mandate, direct-care workers will be required to accept employer-sponsored insurance, even if the coverage offered by their employers costs more or is of lesser quality than a subsidized plan bought through the state’s health care exchange.

Consequently, it is essential that implementation of the employer mandate in the direct-care sector account for employers that rely heavily on capped reimbursement rates in public programs, as well as large numbers of low-wage workers who could end up with inferior coverage as an unintended consequence of this provision.

ADDITIONAL COVERAGE GAPS

Outside of the Medicaid “coverage gap” described in this brief, certain segments of the population remain uninsured in large numbers, in spite of the success of many provisions of the ACA. For example, many low-income people are eligible for Medicaid but haven’t enrolled—a problem that requires targeted outreach and education.³⁶

Additionally, a reported 2 million individuals, including many direct-care workers, are affected by the “family glitch.” These individuals are offered affordable health care coverage for themselves through their employers—making them ineligible for subsidies to purchase insurance on the exchange—yet the plans offered by their employers to cover their spouses or family members are not affordable.³⁷ Once the employer mandate goes into effect, the number of people faced with this situation will likely grow, especially in low-wage jobs such as those in direct-care.

The largest group of individuals who remain uninsured, in spite of the efforts of the ACA, are specific segments of the immigrant population. Lawfully residing immigrants who have lived in the U.S. for less than five years—while eligible for subsidies to purchase health care on the exchanges—cannot acquire Medicaid coverage for themselves or their children. Undocumented immigrants are not eligible for Medicaid or allowed to purchase health insurance through the exchanges.³⁸ Until these remaining gaps in coverage are addressed, many more direct-care workers and other low-income people will continue to fall through the cracks of our health care system.

RECOMMENDATIONS

The research findings and challenges outlined in this brief require policy reforms at the federal, state, and local level. We recommend various strategies to promote access to affordable, quality health coverage for low-income people, in particular direct-care workers.

MEDICAID EXPANSION AND THE AFFORDABLE CARE ACT

To ensure that millions of people, including direct-care workers, can retain their coverage, the Affordable Care Act must be protected from attacks that chip away at essential aspects of the law, such as the recent challenge of the legislation's federal subsidies. Additionally, the ACA should be monitored, assessed, and improved to ensure that each provision is resulting in equitable access to high-quality care.³⁹

State governments should expand Medicaid in every state, reaping benefits for their residents and their state economies. For example, to improve the political feasibility of Medicaid expansion, seven states have asked the Centers for Medicare and Medicaid Services (CMS) to waive certain Medicaid requirements, through 1115 waiver programs. This has enabled states to introduce cost-sharing options for new enrollees, as well as private insurance options into their expanded Medicaid programs.⁴⁰ Though these waivers have limitations, they nevertheless allow for enhanced Medicaid enrollment in places where it would be otherwise politically unfeasible.

Additionally, states that have expanded Medicaid eligibility could choose to further expand eligibility, as three states have done for parents or childless adults, or take up the “Basic Health Program”—an option offered in the ACA to make care more affordable and ease churning for individuals with incomes up to 200 percent FPL.⁴¹

EMPLOYER-SPONSORED HEALTH COVERAGE

Affordable health coverage for direct-care workers is especially tenuous in non-expansion states. Providers such as nursing facilities and home care agencies could elect to make employer-sponsored coverage more accessible, particularly if states would create the incentives for providers to do so. Efforts could include:

- **Differential reimbursement rates.** To support providers in covering the costs associated with increased wages and benefits for direct-care workers, a handful of states have increased their Medicaid reimbursement rates. Higher rates make it more feasible for providers to offer health coverage to employees. In light of the employer mandate, all states should consider similarly increasing rates to ensure providers can afford to offer quality employer-sponsored health care coverage at affordable rates.
- **Small-employer pools.** Small direct-care providers for whom providing employer-sponsored insurance is particularly challenging could join with other small providers as a pool to negotiate better rates with insurance plans, and in turn help provide coverage to their workers.
- **Stable work schedules.** Direct-care workers are often faced with unpredictable schedules, and most work part-time hours, which makes them ineligible for employer-sponsored insurance even where it is offered. Providers could offer more predictable schedules and guarantee a minimum number of work hours to direct-care workers, helping stabilize their incomes and their eligibility for Medicaid, health care subsidies, or employer-sponsored insurance.

DID YOU KNOW?

For direct-care workers and other workers with low income, good health care coverage should meet basic criteria related to:

ACCESSIBILITY. Regardless of family structure, employment status, or the number of hours worked, individuals should be able to access high-quality health care coverage.

AFFORDABILITY. For direct-care workers, affordability is likely a determining factor of whether or not an individual is able to access health care. Programs that require cost-sharing, like premiums, copays, or deductibles, must take into account what level of out-of-pocket costs will be unaffordable to low-income workers and ensure that costs do not exceed that level.

ADEQUACY. The benefits provided must be comprehensive, especially for direct-care workers, who are likely to be older than workers in general, to have chronic diseases, and to suffer job-related injuries.

SIMPLICITY. The process of enrollment is often a barrier for low-income people to access health insurance and other benefits. Outreach and marketing targeting eligible populations is essential, as is simplifying the enrollment process for individuals with low literacy levels and non-native English speakers.

For more on health coverage for direct-care workers, visit www.phinational.org/policy/issues/health-coverage.

CONCLUSION

The decision by 21 states not to expand Medicaid has left 4 million low-income people languishing in the Medicaid “coverage gap,” unable to access affordable health care coverage. Many of these individuals are the working poor, including hundreds of thousands of direct-care workers who care for our nation’s elders and people living with chronic illnesses and disabilities. This work is both emotionally and physically taxing—yet wages

are low, hours are unpredictable, and on-the-job injury rates are high. Direct-care workers in particular would benefit from access to preventive care and timely health care interventions, which would enable them to live healthier lives and provide high-quality care to the people they serve. Policymakers, advocates, and employers all have a responsibility to address this inequity.

TECHNICAL NOTES

To assess the poverty levels for direct-care workers, five-year estimates from the 2013 American Community Survey (ACS) were analyzed. “Direct-care worker” included the following occupations: “nursing, home health, and psychiatric aides” and “personal and home care aides” employed in “employment services,” “home health care services,” “hospitals,” “nursing care facilities,” “residential care facilities without nursing,” “individual and family services,” “vocational rehabilitation services,” and “private households.”

Non-expansion states were grouped into average parental Medicaid eligibility levels: 102% FPL, 49% FPL, 36% FPL, and 21% FPL. For instance, the 102% FPL data was used to assess the number of direct-care workers eligible for Medicaid in Wisconsin (100% FPL parental threshold), Tennessee (101% FPL parental threshold), and Maine (105% FPL parental threshold). We also assessed the insurance status for direct-care workers under 138 percent FPL.

In order to identify direct-care workers who were parents (which allowed us to assess parental eligibility for Medicaid), we examined survey respondents with children who were either “householders” (individuals responding to the survey for the entire household) or spouses of householders. Beyond these measures for householders and their spouses, the relationships between adults and children residing within a household cannot be determined.

While the best resource available for this assessment, the ACS is limited by the fact that some survey respondents classified as direct-care workers might have been unemployed at the time of the survey. Respondents are classified by the last job held in the five years prior to the survey. A high number of unemployed individuals might result in reduced household income and a potentially skewed number of direct-care workers under the poverty line.

Direct-care workforce poverty rates—determined by our analysis of the ACS—were applied to counts of direct-care workers from the Bureau of Labor Statistics, Occupational Employment Statistics program, May 2014 estimates. We included the following occupations, by Standard Occupational Classification (SOC) code, in our estimates of the total number of direct-care workers: nursing assistants (31-1014), home health aides (31-1011), and personal care aides (39-9021).

SOURCES

1. The count of direct-care workers is based on employment estimates from the Bureau of Labor Statistics, Occupational Employment Statistics (OES) program, 2014 estimates for the following three occupations: Nursing Assistants (SOC code 31-1014), Home Health Aides (SOC code 31-1011), and Personal Care Aides (SOC code 39-9021). Missing from this count are workers who are employed directly by households under Medicaid consumer-directed programs (“independent providers”), for which data on poverty levels or insurance coverage are not available. Additionally, there are no reliable counts of direct-care workers who are paid privately and employed directly by private households. The statistics reported in this paper refer to direct-care workers identified by the preceding occupational titles.
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400 East Fordham Road, 11th Floor
Bronx, NY 10458

P: 718.402.7766

F: 718.585.6852

E: info@PHInational.org

www.PHInational.org