DIRECT CARE WORKER HEALTH INSURANCE FEASIBILITY STUDY

November 2004

IOWA BETTER JOBS BETTER CARE (BJBC) COALITION

1117 Pleasant Street, Suite 221
Des Moines, IA 50309
Phone: (515) 241-8697
Fax: (515) 241-8587

Email: iowacga@aol.com
National BJBC Website: www.bjbc.org
Contact: Linda Simonton, Iowa BJBC Project Director

Funded through a 3 ½ -year, $1.4 million grant from the Robert Wood Johnson Foundation and the Atlantic Philanthropies, The Iowa Better Jobs Better Care Coalition is a group of long-term care providers, workers, consumers, and policy makers that is working to reduce turnover among Iowa's direct care workers. The members of the Iowa BJBC Coalition as of September 2004 are:

Iowa CareGivers Association, Lead Agency
AARP Iowa
Aging Resources of Central Iowa
Alzheimer's Association, Greater Iowa Chapter
Center for Healthy Communities
Des Moines Area Community College
Direct Care Worker Advisory Council
Generations, Incorporated
Iowa Association of Area Agencies on Aging
Iowa Association of Homes and Services for the Aging
Iowa Commission on the Status of Women
Iowa Department of Elder Affairs
Iowa Department of Human Services, Bureau of Protective Services
Iowa Department of Inspections and Appeals, Health Facilities Division
Iowa Department of Public Health
Mid-Iowa Health Foundation
Northwest Iowa Community College
Office of the Long Term Care Ombudsman
Older Iowans Legislature
Lin Salasberry, Direct Care Worker
Southwestern Community College
University of Iowa College of Nursing Certification Center

IOWA CAREGIVERS ASSOCIATION (ICA)

1211 Vine Street, Suite 1120
West Des Moines, IA 50265
Phone: (515) 223-2805
Fax: (515) 226-3214

Email: iowacga@aol.com
Website: www.iowacaregivers.org
Contact: Di Findley, Executive Director

Founded in 1992, the **mission** of the Iowa CareGivers Association is "to enhance the quality of care through dedication to the direct care worker and all caregivers." To accomplish its mission, ICA fosters partnerships between and among workers, advocates, providers, consumers, policy makers, labor, educators, and others committed to quality care. ICA has three main **goals**: 1) increase access to quality care for those who need it, 2) increase the number of caregivers, and 3) enhance quality of care. ICA's focus is on four core **mission-driven activities**: 1) advocacy, 2) public awareness, 3) education, and 4) research and innovation.

PREPARED
BY

SELZER & COMPANY INC

540 42ND STREET
DES MOINES, IOWA 503212
VOX: 515.271.5700
FAX: 515.271.5710

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This report examines the status of health insurance coverage for Iowa's Direct Care Workers through an assessment of factors that bear on availability of coverage for themselves and their families.

Defining the workforce. The term Direct Care Workers (DCWs) is given to a group of some 2.4 million people nationally and approximately 55,000 statewide. The Iowa Department of Public Health provides 22 categories for those who are employed as DCWs. They include: Certified Nurse Assistants (CNAs), orderlies, personal and home care aides, adult day services workers, assisted living workers, hospice workers, respite care workers, mental health technicians, patient care technicians, rehabilitation aides, medication aides, and others. Home health care aides are another class of worker who provide hands-on care in private homes, providing home-support services such as housekeeping and meal preparation.* According to a national study by Leon and Franco in 1998, 29% of this group are self-employed.**

U.S. Department of Health and Human Services, National Center for Health Workforce Analysis, Occupational and Industry Definitions

***J. Leon and S. Franco, "Home and Community-based Workforce," Project HOPE Center for Health Affairs, 1998.*

Though DCWs come with many different job titles, together they provide an estimated 70-to-80% of the paid, hands-on daily care and personal assistance to those who are elderly, young, chronically ill or living with disabilities. Alarms have been raised throughout the state and the nation as the population ages, and the need for DCWs rises exponentially.

Why the question of health insurance for DCWs matters. A crisis looms as two numbers reach intersection: The growing demand for DCWs and the diminishing supply.

Ironically, DCWs are on the front lines of care and supportive services; yet they struggle to afford health care for themselves. In effect, as a society, we entrust the care and safety of our elders and people with disabilities to workers who are often not in a position to afford health care for themselves.

Objectives of this report. The purpose of this report is to explain the current policy environment for health insurance initiatives with specific focus on possible avenues to secure health insurance for all Iowa DCWs. We could write a textbook on how health insurance works and many ways Iowa and the other 49 states have ever thought about covering low-wage workers. Yet, that would not be a useful exercise. Instead, we've selected approaches that have been recently considered or enacted that would directly affect DCWs.

This report is divided into three sections. The first profiles Iowa DCWs, with specific emphasis on CNAs as documented by the Iowa Better Jobs Better Care Coalition's recent Wage and Benefits Survey of selected workers. The second section walks through a number of policy approaches, from expansion of existing government programs for the poor, to programs to increase enrollment in employer-sponsored plans, to statewide efforts to cover the full population. For each approach, we discuss the advantages and disadvantages for DCWs and offer our assessment of the outlook for the ideas—whether it looks promising that such a plan could be implemented in Iowa in the near-term.

The third section focuses on how the Iowa Better Jobs Better Care Coalition and the Iowa CareGivers Association can most effectively advocate for their cause.

SECTION I: CHARACTERISTICS OF THE DIRECT CARE WORKFORCE AS RELATED TO HEALTH INSURANCE

We begin this report by profiling the population of Direct Care Workers (DCWs) in Iowa. The recent Iowa Better Jobs Better Care Coalition's Wage and Benefits Survey of Certified Nurse Assistants (CNAs) provides the most recent data on this group.

Demographic Characteristics

Iowa's Direct Care Workers are among the state's oldest, poorest, and most rural working residents. The 2004 Better Jobs Better Care Coalition Wage and Benefit Survey of CNAs documents the demographics of Iowa DCWs.

- The median age of Iowa workers age 18 and over is 40 according to the 2000 Census. For CNAs, the median age is 44.4
  Certified Nurse Assistant Wage and Benefit Survey, Iowa Better Jobs Better Care Coalition, July, 2004. (Forward: BJBC 2004 Wage and Benefit Survey)

- Median household income for Iowans is $39,469, according to the 2000 Census. Among CNAs, the median household income is a full $10,000 less at $29,000.
  BJBC 2004 Wage and Benefit Survey

- In Iowa, slightly more than half the population (55%)* lives in urban areas, according to the 2000 U.S. Census. By comparison, just 23% of CNAs live in urban areas, while 77% live in rural areas.
  **Iowa State Fact Sheet, Economic Research Service, US Department of Agriculture, August 2, 2004.*
  ***BJBC 2004 Wage and Benefit Survey*

Iowa Direct Care Workers' high average age is climbing. Not only is the average age of DCWs higher than that of the average worker, it is climbing at a higher rate.

- The mean age of Iowa CNAs: 46.3, up from 38.5 three years ago.
  BJBC 2004 Wage and Benefit Survey.

- Iowa's health services industry has more workers aged 65 and older than any other industry in the state.
  Iowa Workforce Development Study, 2003.

- Of Iowa workers age 65 years and older, 11.2% are employed in health services.
  Iowa Workforce Development Study, 2003.

- If current trends continue, health services industry workers will top the list of Iowa workers 65 years and older in 2010 by an even greater margin.
  Iowa Workforce Development Study, 2003.

"In comparison with other states, Iowa's frontline Direct Care Workers have relative dismal wage prospects. Home health aides in Iowa, for instance, earn an abysmal $17,000, ranking 7th out of nine states in the region and 31st nationally."

The Iowa Policy Project 2003.

A substantial portion of Iowa Direct Care Workers live close to the poverty line. About one in every eight CNAs (13%) lives below the Federal Poverty Level (FPL). One in four (26%) live in a household with income less than $18,000.

Household size	Federal Poverty Limit	CNAs in Poverty
Single person household	$ 9,310	2.4
Two person household	12,490	3.8
Three person household	15,670	2.0
Four person household	18,850	1.5
Five person household	22,030	2.4
Six person household	25,210	0.5
Seven person household	28,390	0.5
Eight person household	31,570	-
Each additional person	3,180	
Total		**13.1**

BJBC 2004 Wage and Benefit Survey.
Federal Register, Vol. 69, No. 30, February 13, 2004, pp. 7336-7338

Total household income	CNAs (808)
Under $10,000	5%
$10,000 to $14,999	11%
$15,000 to $17,999	7%
$18,000 to $19,999	8%
$20,000 to $24,999	14%
$25,000 to $29,999	10%
$30,000 to $39,000	15%
$40,000 to $49,999	14%
$50,000 or more	12%
No answer	5%

BJBC 2004 Wage and Benefit Survey.

Health Insurance

A substantial proportion of Iowa DCWs go bare when it comes to health insurance. One in four (25%) CNAs say they are not currently covered by health insurance of any kind*. By comparison, the state average for adults age 19 to 64 is 14%, according to the U.S. Census estimate.** Nationally, 40-50% of home care workers are uninsured.***

**BJBC 2004 Wage and Benefit Survey.*

***Census Bureau, March 2003-224 Current population survey, pooled estimate.*

***Better Jobs Better Care. Issue Brief No. 3, March 2004

Accessibility exceeds take-up. Health insurance for adults under age 65 is nearly always tied to employment. DCWs in Iowa are, for the most part, offered health care insurance by their employers. According to the BJBC 2004 Wage and Benefit Survey, 80% of Iowa CNAs are offered health insurance coverage by their employers. However, just 50% of those take-up the coverage. Of those who don't enroll in the employer-sponsored plan, some are insured through other sources (spouse's policy, Medicare, etc.) and some opt to have no health insurance.

Cost is the single-greatest barrier to coverage. More than half of those who work for an employer who offers a plan (59%) cite the cost of participating in the plan as the reason they are not enrolled.
BJBC 2004 Wage and Benefit Survey.

The data on wages offer explanation. The authors of an issue brief in Better Jobs Better Care noted: "At the salaries paid to full-time nursing home aides, individual coverage that averages $3,380 is almost 25% of total income, and family coverage of $9,000 annually…is clearly out of reach for them."
Better Jobs Better Care. Issue Brief No. 3, March 2004

Many Direct Care Workers are not eligible for their employers' health insurance plans because of waiting periods and part-time status. High turnover among DCWs may affect individuals' eligibility for employer-sponsored plans. The American Health Care Association calculated a national turnover rate of 71.7% for CNAs in 2002.
New HHS/Department of Labor Study on Future Long Term Care Worker Need.May, 2003. www.ahca.org

Employers often require up to six months of continuous employment before workers are eligible. DCWs will often change jobs for an opportunity to increase their wages, even a small amount, according to Long Term Care administrators in a June, 2004 survey. "…Take-home pay is a significant issue for many CNAs who are young single mothers and will change workplaces for even a 10-cent increase in hourly wages*."*
Long-Term Care Employers in Iowa Speak Out: A Call to Action, June 2004. Center for Workforce Planning, *Bureau of Health Care Access, Iowa Department of Public Health.*

Part-time workers are usually ineligible for employer coverage as well. In Iowa, 68% of CNAs are full-time, with the balance (24%) working part-time, on-call, in a pool, or are self-employed.
BJBC 2004 Wage and Benefit Survey.

While lack of eligibility for an employer-sponsored plan ranks second as a reason not to have health insurance (15% of CNAs indicate this is a reason they don't have coverage), it pales compared to the problem of cost, cited by 75% of CNAs.
BJBC 2004 Wage and Benefit Survey.

Profile of CNAs Without Insurance

The Iowa Better Jobs Better Care Coalition's survey of CNAs gives us detailed information about the demographic makeup of those without health insurance, which accounts for one in four Iowa CNAs (25%). As policy options are considered, these demographics of this group lay the groundwork. Here are demographic characteristics of uninsured CNAs to keep in mind:

Income. Not surprisingly, the demographic that distinguishes those who do not have health insurance from DCWs as a whole is income. With a median household income of $21,000, CNAs without health insurance fall far short of the overall average among all Iowa CNAs ($28,300).
BJBC 2004 Wage and Benefit Survey.

Age. Perhaps surprisingly, CNAs without health insurance are younger as a group, with a median age of 42, compared to the overall median of 44. Just 33% of the uninsured group is over the age of 50, compared to 41% overall.
BJBC 2004 Wage and Benefit Survey.

Dependent children. CNAs without health insurance are more likely to have children (48%) than the group as a whole (38%).
BJBC 2004 Wage and Benefit Survey.

Tenure in the job. A solid majority of uninsured CNAs has been in the profession more than 10 years (62%). That is on a par with the total population of CNAs (66%).
BJBC 2004 Wage and Benefit Survey.

Job status. CNAs without health insurance are only slightly less likely to be employed full-time (60%, compared to 68% overall).
BJBC 2004 Wage and Benefit Survey.

Access to health insurance. One in three CNAs who do not have health insurance work for an employer who does not offer a plan. For this group, cost is an even greater concern, as they may be expected to explore the individual market for a policy. Median household income for this subgroup is $18,000, with about one in three (36%) earning less than $15,000 per year. Half this group is age 50 and over, another factor that affects the cost of a health insurance policy.
BJBC 2004 Wage and Benefit Survey.

As individuals and as members of a small, individually-rated group, uninsured DCWs face some actuarial challenges. A few principles guide health insurance costs:

- The older you are, the higher the health insurance premium.
- Without children in the household, government assistance is almost impossible to get.
- Part-time workers are typically not eligible for employer-sponsored programs.
- Uninsured women may be especially vulnerable to cardiovascular disease and other chronic diseases. However, screening, intervention, and treatment services for these risk factors are often beyond the reach of uninsured women.

The nature of the work itself exposes DCWs to health risks. The work environment for DCWs was described this way: "Nursing Aides and Orderlies walk or stand most of the day. They must take precautions to guard against back strain from lifting patients and equipment, exposure to radiation and caustic chemicals, and catching diseases such as AIDS, tuberculosis, and hepatitis. Using proper safety procedures reduces personal risk. The work is emotionally and physically demanding, but can be satisfying to those who value assisting people in need."
California Occupational Guide Number 442, 2002.

Without insurance, DCWs may not get needed preventative care, thus shortening their earning years and making ultimate treatment more expensive. Among women, heart disease is the leading cause of death and is often not diagnosed until it has progressed to an advanced stage. Addressing risk factors such as high cholesterol, high blood pressure, obesity, sedentary lifestyle, and smoking greatly reduces women's risk for illness and death from heart disease. However, screening, intervention, and treatment services for these risk factors are often beyond the reach of uninsured women. Among women aged 40 years or older, 71% of those who are insured report having had a mammogram in the previous year, compared with only 46% of uninsured women. Uninsured U.S. adults are also less likely to be screened for high blood pressure and high cholesterol and to be advised to lose weight and quit smoking.

WiseWoman: Improving the Health of Uninsured Women. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, 2004.

Prognosis

The current situation will only get worse in coming years. In 1999, DCWs accounted for approximately 2.2 million workers. The General Accounting office reported that the number of jobs increased at the phenomenal rate of 40 percent during the decade of 1988 through 1998. Clearly, a growing need is outpacing the aging workforce of DCWs.

The Bureau of Labor Statistics projects that the need for workers to fill direct care jobs will continue to increase dramatically due primarily to the aging of the nation's population.

- Personal and Home Health aides rank 8th among all occupations in terms of the fastest growing jobs projected between 1998 and 2008.
- Nurse aides rank 12th in terms of having the largest job growth projected between 1998 and 2008.
- Vacancy Rate of Certified Nurse Assistants in Iowa: 7.6%
- Vacancy Rate of Certified Nurse Assistants in US: 8.5%

A Workforce Development report projects that healthcare support occupations will increase by more than 17% in ten years: from 39,005 in 2000 to 47,120 in 2010.

Dr. Charles Roadman, President American Health Care Association: "In addition to the chronic underfunding of Medicaid, the high vacancy and turnover rates of key front line personnel combined show the underlying fragility of the nation's long term care workforce."

American Health Care Association, June 30, 2002.

Those currently insured are also at risk. Some currently insured DCWs fear losing coverage. Thirteen percent (13%) of CNAs say they are very concerned about losing the health insurance coverage they currently have. Among CNAs (the group with a stable enough sample size to allow this breakout), these concerned workers are disproportionately age 51 to 60 (34% compared to 23% of all CNAs), and have little time in the profession (33% have been working as DCWs less than three years, compared to 1% of all CNAs).

BJBC 2004 Wage and Benefit Survey.

As the next section of the report will show, getting coverage under existing programs and current proposals is difficult and often impossible for low wage-earners.

SECTION II: CURRENT POLICY AND HEALTH CARE PROPOSALS AFFECTING DIRECT CARE WORKERS

Direct Care Workers who have health insurance protection may have taken one of a number of roads to get there. In a July, 2004 survey, 80% of Iowa Certified Nurse Assistants (CNAs) reported having health insurance available through their employers. Of these, half (or 40% of all CNAs) are enrolled. One in four (25%) have no health insurance, which leaves 35% getting insurance from other sources. From the CNA survey, here is how coverage breaks down:

Single coverage just for CNA	30%
Single coverage just for CNA's spouse	1%
Family coverage	34%
hawk-i coverage	3%
Medicaid just for children	6%
Medicaid for family	3%
Medicare	8%
Other	7%
No coverage for CNA	25%
No coverage for rest of family	16%

Totals more than 100% due to multiple responses

Certified Nurse Assistant Wage and Benefit Survey, Iowa Better Jobs Better Care Coalition, July, 2004. (Forward: BJBC 2004 Wage and Benefit Survey)

State governments have approached the problem of the uninsured from a number of angles. In 2000, the U.S. Department of Health and Human Services made a grant program available for development of state level initiatives to expand health insurance. Iowa was in the first class of grantees, receiving over $1 million for a comprehensive analysis.

In October 2001, the Iowa Department of Public Health released a comprehensive report, "Iowa State Planning Grant: Striving to Expand Health Insurance to All Iowans," (Iowa SPG) examining health care in the state, evaluating a range of options for expansion of health care coverage and offering a combination of approaches that would extend coverage to most of the uninsured. For Iowa, this document is the most wide-ranging assessment of what it might take to cover the uninsured, including Direct Care Workers (DCWs).

In this section of the report, we will review the following approaches included in the Iowa SPG analysis—noting how they would work, what their advantages and disadvantages might be, how the approaches address the availability and affordability of health insurance and whether DCWs would benefit.

- Expanding Medicaid coverage for adults;
- Approaches to help individuals purchase private coverage;
- Approaches to help employers purchase coverage for their workers;
- A combined strategy, using multiple approaches to create a comprehensive plan.

In addition, we fold in several other approaches with potential relevance to Iowa DCWs.

- Federal tax credits and health savings accounts;
- Short-term coverage to the temporarily unemployed; and
- Small business pools.

None of these approaches has been adopted. No legislation was passed during the 2004 Iowa legislative session that would have expanded health care coverage options. A number of amendments were offered in drafting legislation that were voted down in committee and never reached the floor of either the House or Senate chamber. Sen. Jack Hatch offered an amendment to an appropriations bill that would have expanded Medicaid benefits, for example, that did not make it out of committee. The potential is slightly brighter for the 2005 session, according to Dick Oshlo, Democratic Research Analyst for Human Services, Judiciary and Health and Human Services (HHS) Appropriations. According to Oshlo, the 25-25 Democrat/Republican balance in the Iowa Senate may well mean new emphasis on health issues. He cited the possibility of legislation to raise the cigarette tax, with resultant funds to be directed to health care, as an example.

Interview with Dick Ohslo, November, 2004.

All policy options discussed in this section are receiving increasing consideration and attention. Before we move into these policy options, we review how we will evaluate their potential benefits to DCWs.

Eligibility and Affordability

In evaluating the approaches for DCWs, we pay particular attention to eligibility—whether coverage would be extended to uninsured DCWs, and if so, whether it would be affordable. Consideration will be given to what might be expected financially, in terms of partial premium payment, co-pays and deductibles.

Eligibility. A high turnover rate and part-time job status are significant barriers to eligibility and DCWs have a high employment turnover rate. Part of this turnover may be due, in fact to part-time status. Just 68% of CNAs have full-time jobs. The bulk of the remainder work part-time, with the rest in on-call or pool positions.

BJBC 2004 Wage and Benefit Survey

Many employers do not offer coverage to part-time employees. This is significant for the one in four Iowa CNAs who are not currently insured (26%) who work part time.

BJBC 2004 Wage and Benefit Survey

Affordability. Direct Care Workers, among the lowest paid employees in Iowa, cite cost as the greatest barrier to purchase of health insurance. Median household income for CNAs without health insurance is about $22,000.

BJBC 2004 Wage and Benefit Survey.

If a DCW is not part of an employer-sponsored plan with an employer contribution to the premium, the cost of an individual policy is prohibitive. In 2002, an average health insurance policy in Iowa cost $2,058 for a healthy 25-year old woman and $4,152 for a 55-year old healthy woman. A healthy single woman with earnings equal to the poverty level of $8,980 would have to spend 20% to 50% of income on health insurance to buy such a policy.* Rates are high, and rising. Since 2000, the average premium cost for small businesses (under 50 employees) has more than doubled.**

**Who's Uninsured and Why In Iowa. Families USA, Nov. 2003.*

***2003 Iowa Employer Benefits Study by David P. Lind & Associates, L.L.C.*

With these overarching issues as a foundation, we turn now to a review of possible ways to extend coverage to uninsured DCWs.

Policy Option 1: Expand Medicaid

Medicaid is not primarily for working adults without children or disabilities. Jointly funded with federal and state dollars, Medicaid provides health coverage for children in low-income families and sometimes their parents; subsidies for employers with low-wage workers; and working people with disabilities. Under Medicaid, the federal government pays about 63% of the program costs under the traditional Medicaid program and about 73% of costs under the hawk-i (state children's health insurance) program. This makes Medicaid an attractive, cost-efficient mechanism for states looking for the means to expand coverage.

Iowa State Planning Grant Report, 2000, p. 124. (Forward: Iowa SPG, 2000.)

At this time, Iowa's Medicaid eligibility has been extended to 200 percent of the Federal Poverty Level (FPL) only for pregnant women and children, but adult eligibility has remained limited and that is a major barrier for DCWs. The Iowa Medicaid website lists the following groups as Medicaid-eligible:

- A child under age 21;
- A parent living with a child under age 19;
- A woman who is pregnant;
- A woman who needs treatment for breast or cervical cancer;
- A person who is aged (over 65);
- A person who is blind or disabled;
- Certain Medicare beneficiaries; or
- A person who is disabled and working.

Parents must have a very low income to qualify. Working parents living with children are eligible only if their annual income is less than about 84% of the FPL, or $15,834 for a family of four. Non-working parents are eligible only if their annual income is less than 33% of the FPL, or $6,220 for a family of four. (This is a net income number after adjustments for money spent on child care, child support income, etc.) Keep in mind the minimum wage is $5.15 per hour or $10,712 annually for a 40-hour per week job.

Federal Register, Vol. 69, No. 30, Feb. 13, 2004, p.7336

2004 HHS POVERTY GUIDELINES	
Size of Family Unit	**48 Contiguous States**
1	$ 9,310
2	12,490
3	15,670
4	18,650
5	22,030
6	25,210
7	28,390
8	31,570
Each extra person, add:	3,180

Federal Register, Vol. 69, No. 30, Feb. 13, 2004, p.7336

In short, non-disabled adults who do not live with children are not eligible, regardless of income.
State Health Facts.org. Kaiser Family Foundation.

Medicaid expansion as a way to cover more low-income adults. In 2001, the Iowa SPG report estimated that an additional 107,400 adults could enroll in Medicaid if income levels were increased to 200 percent of FPL *for all custodial parents*. The report estimated costs of $506.5 million, of which the state would be responsible for $380.3 million. However, there would be no federal match for coverage of non-custodial adults, leaving the state to pay the whole cost for this segment of the population.
Iowa SPG 2000, pp. 101-103

Advantages. For those who are eligible, Medicaid provides comprehensive health coverage. Also, in Iowa, Medicaid does not currently require point-of-service cost sharing such as deductibles and co-payments for office visits, tests, and prescriptions. Expansion would be built on an already existing Medicaid infrastructure. Expansion of Medicaid also builds on what is already a useful mechanism for covering Direct Care Workers. Nationally, nearly 10% of all nursing home health aides and 11% of all home health aides rely on Medicaid to provide health insurance.
Cheating Dignity, Benefit Eligibility. afscme.org.

For state governments, Medicaid offers a cost-effective way to cover low-income parents in that almost two-thirds of the cost (63%) is borne by the federal government. In addition, Iowa's low reimbursement rate works to the state's advantage. It costs less to enroll an Iowan in Medicaid than in any other state.

Disadvantages. There are many obstacles to caregiver advocates wanting to push this option as a way to cover more DCWs.

Medicaid funding depends on the state of the budget. Expansion of Medicaid is contingent on availability of *both* state and federal funds. Iowa spends less as a percentage of the state budget on health care for the poor (20%) than is average across the country (30%).
Des Moines Register editorial, September 29, 2002.

The state budget is finite. Just because state lawmakers may *want* to enroll more Iowans in Medicaid and take advantage of the inflow of federal dollars, they still must come up with

37% the state pays. When the budget is tight, as it has been the last few years, programs contract rather than expand.

In 2002, the effect of reduced state revenues on Medicaid were obvious. Not only were K-12 programs and state workers' salaries at risk, so was the Medicaid budget. With less money to spend, fewer could be served. "The gap exists because of spending promises made in past legislative sessions that exceed projected revenue, as well as special funds that are no longer available next year."

"Medicaid: The Cuts that Bleed," Lynn Okamoto, The Des Moines Register, September 29, 2002, Pg 10.

In such an environment of budget cutbacks, Iowa is unlikely to expand Medicaid. In this, Iowa is not alone. Most states are cutting Medicaid budgets.* In addition to budget obstacles, there are practical obstacles that restrict the viability of this approach. Many health care providers are reluctant to take Medicaid patients as Medicaid reimbursement rates do not adequately pay for services rendered. In 2002, Iowa ranked among the lowest of the 50 states in Medicaid reimbursement.**

**"Medicaid and the Uninsured," The Kaiser Commission, January 2004.*

***David C. Grabowski, Zhanlian Feng, Orna Intrator, and Vincent Mor, "*Recent Trends In State Nursing Home Payment Policie," Health Affairs, web exclusive.*

In addition, federal receptivity to waivers changes with budget pressure. When there was an annual surplus of federal funds, policy-makers were looking to grant waivers to states that would result in an increased flow of federal dollars to states. Now they are much more circumspect in granting waivers that would deviate from the norm of revenue neutrality.

Interview with Anne Kinzel, December 2004.

To be effective for uninsured DCWs, Medicaid needs to direct resources to adults in childless homes. DCWs without dependent children at home are rarely eligible for coverage under Medicaid. "Without a waiver, Medicaid programs are forbidden from covering...childless adults, no matter how poor. Accordingly, more than half of poor, uninsured Americans are now childless adults."* Changing the eligibility requirements so that more low-income earners could qualify would undoubtedly open the door wider to uninsured Direct Care Workers. But only, however, for DCWs with children in the household. That excludes 52% of CNAs who are not currently insured.**

**Medicaid and Other Public Programs for Low-Income Childless Adults: An Overview of Coverage in Eight States." Dorn, et al. Kaiser Commission on Medicaid and the Uninsured, July 9, 2004.*

***BJBC Wage and Benefit Survey, 2004.*

Outlook: Expanding Medicaid is unlikely to happen anytime soon. A Medicaid expansion strategy must contemplate a requisite increase in either or both the federal and state funding. This is a mixed blessing. Medicaid eligibility rules are a complex mix of federal and state requirements and options, and vary widely among states. Most significantly, federal and state budget issues are a controlling factor in expanding Medicaid eligibility.

In Iowa, state revenues declined in 2003, leaving a gap of $90 million to be made up in cuts to existing programs. And, Iowa is far from alone.

While many states working under the State Planning Grant federal grant program believe Medicaid expansion to be the most obvious route to cover the uninsured, not one has passed legislation or written new regulations to increase accessibility in proportion to the problem of the

uninsured. Most states have, in fact, cut their budgets that fund Medicaid programs. The likelihood of expansion of Medicaid eligibility is dim under current budgetary problems. Even if income restrictions were loosened, this approach would not help the majority of care workers—those without children at home.

Interview with Anne Kinzel, State Planning Grant Director, November 2004.

Across the U.S., the pattern is similar, evidenced in a December 2003 Fiscal Survey of States, published by the National Governors Association and the National Association of State Budget Officers. Their survey confirmed that while the economy was improving, states have continued to have difficulty balancing their budgets during State Fiscal Year 2003. Medicaid is a major expense for states, and the report indicates that every state has taken at least one step to control Medicaid costs during the State Fiscal Years 2002-2004. The report listed the following key actions:

- All 50 states either reduced or froze payments to provider organizations;
- All 50 states took steps to control prescription drug costs;
- 35 states reduced benefits;
- 34 states took steps resulting in reduced or restricted eligibility for services; and
- 32 states increased co-payments required by consumers.

"Medicaid and Other Public Programs for Low-Income Childless Adults: An Overview of Coverage in Eight States." Dorn, et al. Kaiser Commission on Medicaid and the Uninsured, July 9, 2004.

In other words, the current environment is one of restricting not expanding Medicaid benefits.

Opportunity: Perhaps more Iowa DCWs who are eligible should be enrolled. Only 3% of Iowa CNAs currently have family coverage through Medicaid.* This is far lower than the national average for DCWs, which averages about 10%.**

** BJBC 2004 Wage and Benefit Survey*

*** Cheating Dignity, Benefit Eligibility. afscme.org.*

There may be varying reasons for this, including the exclusion of DCWs without dependent children at home. Even so, the low participation rate suggests an opportunity for the Iowa CareGivers Association and the Iowa Better Jobs Better Care Coalition to expand their outreach and educational efforts.

Policy Option 2: Cover More Adults Through Private Plans

The Health Insurance Premium Assistance Program (HIPP) provides coverage to adults in homes with a Medicaid-eligible member. For Iowa DCWs, HIPP may already be helping as many adults as it can. HIPP was developed as a way to reduce Medicaid expenditures for children. As a *side* benefit, it covers some adults in homes with Medicaid-eligible children. At the time of enrollment in Medicaid, an assessment is made weighing the cost of covering the children against the cost of subsidizing the employer-sponsored policy of a working adult in the household. If buying a family coverage policy for the household is deemed to cost less than coverage for the children independently through Medicaid, then Medicaid buys the policy. Accidentally, the adults get coverage.

About one third of HIPP beneficiaries are family members who otherwise would not be enrolled in Medicaid. In Iowa, more than 8,000 people, including more than 2,000 family members who would not qualify for Medicaid are covered through HIPP.

State Options for Expanding Health Care Access, Barbara Youndorf, et al. National Conference of StateLegislatures, March 2004.

Advantages. Adults have some aversion to Medicaid, even the ones who qualify. The bureaucracy of supplying the information needed to apply and jumping through an assortment of administrative hoops may be difficult for adults working a full-time and perhaps another part-time job.

In addition, Anne Kinzel, the Iowa Department of Public Health's State Planning Grant Director, notes that Iowans tend to refer to the entitlement program by the authorizing language, "Title XIX," rather than its colloquial name "Medicaid," such is their distaste. She notes anecdotally that the take-up rate is lower than in other states as one more bit of evidence that even Iowans who might benefit do not want to be part of this government program. HIPP provides private insurance, giving the employee the same benefits and the same access to doctors as his or her co-workers. It also offers the ease of enrolling with fellow-workers.

Interview with Anne Kinzel, State Planning Grant Director, November 2004.

Disadvantages. The downsides of this plan are really not on the side of those who get coverage, but rather on the side of the employer. In Iowa, 50% of all firms pay the entire cost of the premium, at least as of March 2004. Some may, and some may not, offer a cash payment to employees who opt out of the company-sponsored plan. For those who do not, a new entrant into the pool, with a family policy, comes as an added expense because Medicaid only picks up the employee's portion of the premium. That makes the program unpopular with small businesses.

Iowa SPG Survey of Iowa Businesses, 2004

Outlook. Because the decision for HIPP coverage is not initiated or controlled by the adults in the household and is purely an economic decision made by Medicaid administrators, there is little chance adults that could be covered through HIPP are not.

Anita Smith, a Medicaid expert in Iowa's Department of Health and Human Services, says it's harder to find employer-sponsored policies that are cost-effective for the state. First, Iowa has a low Medicaid reimbursement rate, which means it is not very costly, compared to other states, for Iowa to pay for health care. Second, employers are increasingly shifting health insurance premium increases to employees. The cost to the employer of a family policy is rising, which makes HIPP less affordable to the state. Only when several children are in the home does HIPP become a viable option.

Interview with Anita Smith, November 2004.

A couple of states (Connecticut and Washington) are experimenting with opening public insurance plans to home care workers, as a way of addressing barriers in the private insurance market. The burden of paying the full premium, however, still falls to the individual worker.

National Governor's Association Aging Initiative, Issue Brief: "State Support of Family and Paid Home Care Workers". Page 3.

Policy Option 3: Help Individuals Purchase Private Coverage

The 2001 State Planning Grant report summarizes an analysis by the Lewin Group regarding a tax credit for individuals purchasing non-group coverage. The idea was to subsidize uninsured adults who do not have access to an employer-sponsored plan by providing a tax credit capped at the amount the individual would spend on health insurance. The credit would phase out between 200% and 300% of FPL and would be refundable—meaning those who pay little in tax would get a cash refund for the balance if they owed less in taxes than the value of the credit.

Advantages. The tax code is a relatively easy way for the government to transfer payments.

Disadvantages. The tax code works by reimbursing taxpayers for money they spend out-of pocket. For low-income earners, the burden of paying for health insurance in the first place is not eased one bit. They must still pay the premiums each month and then, after as many as 18 months later, be reimbursed. By illustration, if a person purchases a health insurance policy starting January 15, 2005, they must pay in the total cost of the premium (hundreds of dollars) each month. When they file their tax forms for 2005 in April 2006, they will already have paid 15 months' of premiums. The incentive of getting a reimbursement a year and a half later is likely insufficient for most low-income families to take the government up on this offer.

Outlook. This plan is attractive because it seems easy to do without adding bureaucracy. Yet, it is ineffective by its design. It begins at the wrong place—what *could* the government do to address the problem of the uninsured without creating a new government program. Only if this program were coupled with vouchers that paid eligible recipients *in advance* could this approach cut the uninsured rate among Iowa's DCWs.

This may be more likely to happen with the re-election of George Bush, however, even with the voucher option. More on that in the next section.

Policy Option 4: Provide Short-term Coverage to the Temporarily Unemployed

Working through Workforce Development, the state could offer health insurance to those receiving unemployment compensation. To be eligible, the person must have lost employer-sponsored coverage and be unable to afford continued coverage through COBRA. Federal law requires employers to let terminated employees continue participation in their health insurance plan so long as the employee pays the full premium, and in some case an administrative fee of 1% or 2%. That coverage can last up to 18 months. But, for many unemployed who are not getting a regular paycheck, simply having enough for food and shelter is often the first priority. Health insurance premiums can be considered an unaffordable luxury and going without as a necessary gamble.

Advantages. This approach might not cost the state very much. Part of that is due to the relatively low cost of health insurance in this state—Iowa ranks twentieth of the 50 states in per capita heath care expenditures.* Moreover, the period of unemployment is relatively short (9.23 weeks, according to the Lewin Group's evaluation of 2000 data). Using these numbers, they estimate that covering the unemployed as part of their unemployment compensation would cost about $77.1 million.**

**State Health Facts.org. Kaiser Family Foundation.*

***IA SPG,2000 p.112.*

Disadvantages. This is a short-term solution that may reduce some of the churn—caused by the same individuals moving in and out of the uninsured pool for a few weeks or months at a time counted numerous times—that inflates the state's number of uninsured. It increases the costs to the unemployment program by 35% to be paid by employers.

Outlook. For Iowa's DCWs, this does not offer any meaningful aid. The major problem for DCWs is in affording coverage even though they are employed.

Policy Option 5: Federal Tax Credits and Health Savings Accounts

A strategy for a federal tax credit approach to reducing health care costs is getting increasing attention. The premise for this health insurance option is that it opens the door wider to those for whom a tax savings would offset part of the costs to families or individuals. This proposal aims to increase affordability while retaining personal choice. It further aims to promote continuity in care by ensuring that individuals can maintain coverage regardless of work or work status.

Agenda 2003 Health Care: Helping the Uninsured. The Heritage Foundation

Newt Gingrich's Center for Health Transformation can take a great deal of credit for the surging interest in Health Savings Accounts (HSA) which came into being in January 2004. Quite simply, employers buy high-deductible health insurance policies for employees, saving an average of 44% on premiums. Employees set up HSAs (which they own). Before-tax dollars are deposited into the account by the employee to pay for ordinary medical expenses they accrue before meeting the deductible (in the neighborhood of $3,000 per year). Many employers are contributing part of the savings on the insurance policy into employees' HSAs. The result is a mix of employer-employee payment for health care, with federal support in the form of vouchers to buy the high-deductible plan and to fund the HSA.

Center for Health Transformation: Projects: Health, October 2004, Healthtransformation.net.

Advantages. The plan is designed to help reduce the rising costs of health care, by cutting costs to employers, by creating tax breaks to individual spending on health care, and by introducing greater consumer control on ordinary medical expenses. Those who participate will realize a tax savings on the amount of their contribution to the account. Employers will reduce their employee benefit costs, by switching to a high-deductible plan. The account is portable, and won't be lost due to a change of jobs or temporary unemployment. Unused dollars roll over year to year, which helps individuals save up for co-pays which would accompany major medical events (10% to 20%). A final advantage of this approach is the characterization of "low-income household," as a family of four making $25,000 or less.

Disadvantages. It is too early to judge the effectiveness of the HSAs and that is a big disadvantage. There is just very little data from which to draw sound conclusions. While some Iowa firms have embraced this option, some have resisted, fearing their workforces would not be competent to make proper medical choices for themselves.

Cost is another concern. Individual health plans, for those who can afford them, are of course, an option. Wellmark Blue Cross and Blue Shield of Iowa offers two possibilities for individual coverage. The first is a Health Savings Account/High Deductible policy option. To participate, monthly contributions are made that will total no more than the amount of the deductible on the accompanying policy. If a single, non-smoking female, age 45-49, purchases a policy with a

deductible amount of $1,550, her monthly policy premium will be $188.20 per month. Total HSA contributions of no more than $1,550 will be in addition to that.

The second option is the purchase of one of Wellmark's regular products. Monthly premiums for a typical health plan for a single, female non-smoker, age 48, with a $1,500 deductible will come to $159.80 per month.

Both the HSA/High Deductible plan and the typical health plan offer DCWs good coverage. As both options are not linked to employment, they are portable, an advantage to those who move from one employer to another, or have a gap in employment. However, costs in both situations would likely be prohibitive for many DCWs.

Information provided by Angela Feig, Janet Griffin and Sue Brownlee of Wellmark Blue Cross and Blue Shield, November 2004.

Beyond cost is concern about self-selection into consumer-directed plans. A Commonwealth Fund report references uncited studies showing healthier, wealthier adults opt for the consumer-directed option leaving sicker, poorer adults in traditional health insurance plans. That leads to higher rates. We found no studies, however, that document whether this self-selection is taking place in employer-sponsored plans.

Karen Davis, Ph.D., The Commonwealth Fund, "Will Consumer-Directed Health Care Improve System Performance?," August 2004.

Edwin Park and Robert Greenstein, Center on Budget and Policy Priorities, "Initial Data on Individual Market Enrollment Fail to Dispel Concerns about Health Savings Acccounts," September 13, 2004.

Outlook. In its current incarnation, this is an option of little use to DCWs, many of whom simply do not have the discretionary income to make the outlays necessary to build the account. However, Gingrich's Center for Health Transformation admits some government assistance may be required for HSAs to truly have an impact on the uninsured. In an op-ed published in *USA Today* October 25, 2004, Gingrich said: "Low-income Americans who do not qualify for Medicaid will receive direct help with a $2,000 tax credit to purchase a policy, and a $1,000 contribution to their HSAs. Families that do not adopt a HSA-plan will receive a $3,000 tax credit to buy insurance."

In follow-up e-mails, Vince Haley, of the Center for Health Transformation, said the $3,000 would be refundable and further agreed with the logic that the credit would have to be issued in the form of a voucher to buy the insurance and to pay into the HSA at the start, rather than ask the individual to wait 18 months for reimbursement.

Haley-Selzer e-mail, October 25-26.

While these details have not been worked through with authorizing legislation, this approach offers some hope for DCWs by helping them buy their own high-deductible health insurance plan and subsidizing pre-deductible expenses. A remaining issue is whether the $166 per month subsidy will buy a 50-year-old woman a health insurance policy—even with a high deductible.

Policy Option 6: Help Employers to Offer Health Insurance

The reality of health insurance for uninsured DCWs is that not only is a policy unaffordable to the workers themselves, but also to their employers. They are paid by the same Medicaid pool of funds that are provided to individuals. In short, DCWs are largely a tax-funded workforce and many efforts are made to keep costs to a minimum.

This policy option provides subsidies directly to employers through a refundable state tax credit to employers who are not currently providing coverage. The subsidies would set the amount of a tax credit equal to a percentage of the employer's expenditures for employee health benefits. This approach would have particular impact on small firms. Eligibility would be restricted to firms that have not provided coverage for at least 12 months, and to firms with an average payroll below the average for small firms in the state.

The plan would also be restricted to firms with 25 and fewer employees. The credit would reimburse a 25% of employers' expenses for health insurance.

Advantages. These approaches are designed to decrease the uninsured by creating more employer-sponsored plans. In Iowa, 80% of the uninsured hold at least one job.
IA SPG 2000 p.138.

The refundable tax credit could be made available to for-profit and non-profit firms alike in that they all pay employer taxes.

Disadvantages. Tax credits, whether to businesses or individuals, often fail to deliver the help they promise. A small service-based business may not pay much in taxes. In order to offer any relief, the tax credit would have to be refundable. In addition, small businesses have the same cash-flow problems as individuals. Waiting for a tax credit/refund for 18 months may make the program unworkable for those businesses not currently offering health insurance. In addition, a tax credit must be large enough to act as an incentive in order to have an impact. Jo Ann Lamphere of the Lewin Group says it takes a credit of 60% to see a real increase in health insurance coverage. And, a March 12, 2002 report from the Urban Institute entitled *Health Care Crisis of the Uninsured: What are the Solutions?* concluded, "If the goal is to reduce the number of people without health insurance, spending money on tax credits is a huge gamble, paid for with taxpayer funds."

Outlook. In addition to a nagging question of affordability, DCWs' eligibility remains an issue under these approaches. With waiting periods for new coverage combined with high turnover, many DCWs in need of insurance may not qualify for a company plan. In addition, most employers do not allow participation by part-time employees.

Realistically, in a time of dramatically rising health insurance costs, few firms are likely to jump in the game. From 2000, employers in Iowa have seen double-digit percentage increases, meaning their premiums double in four years.
2003 Iowa Employers Benefit Study by David P. Lind & Associates, L.L.C.

The Iowa Department of Public Health's recent Survey of Iowa Business notes that 89% of Iowa businesses that do not currently offer health insurance are even considering it. A tax credit of 25% alone is unlikely to change that sentiment.
Iowa SPG Survey of Iowa Businesses, 2004

Policy Option 7: Pooling Small Businesses

Group purchasing arrangements bring together different employers, groups or individuals for the purpose of purchasing health insurance or negotiating provider discounts for members. Purchasing pools are created to maximize buying power. They also aim to increase small group coverage by reducing

premiums; reduce administrative costs through a common administrative mechanism; and provide employees with a choice of alternative health plans.

One prominent example is Maine's Dirigo Health Reform Act, a comprehensive law enacted in 2003 and based on pooling small businesses, the self-employed and all individuals into a large group to bargain as effectively as possible for good prices. The state sought bids from insurers for administration of the Plan. If no bids meet the requirements, the state will seek legislative authority for self-administration. Individuals and families with annual household incomes below 300% FPL are eligible for discounts on monthly costs, payments and deductibles, and out of pocket costs, on a sliding scale based on income and family size. A family of two, for example, with an annual income of $24,980 or less, is eligible for a coverage plan that has no deductible amount, no out-of-pocket maximum, provides 100% of preventive care, 100% of hospital costs, and requires payment of $2.50 co-pay for drugs and $3 co-pay for a physician office visit.

Dirigo Health Reform Act: Addressing Health Care Costs, Quality, and Access in Maine. Jill Rosenthal, Cynthia Pernice. National Academy for State Health Policy, June 2004.

Along with broadening access, the Act includes equal emphasis on maximizing quality of care and minimizing costs. A number of state boards and commissions have administrative responsibility. Funding comes from a combination of premiums paid by participating employers and plan participants, $53 million in one-time federal funds, and additional Medicaid matching funds. In conjunction with the Dirigo plan, the state moved limits for the state's Medicaid program to 125% of FPL for adults without children to 200% for adults with children.

Dirigo Health Reform Act: Addressing Health Care Costs, Quality, and Access in Maine. Jill Rosenthal, Cynthia Pernice. National Academy for State Health Policy, June 2004.

California's PacAdvantage is one more example and is the country's largest nonprofit small employer health insurance purchasing pool. In 2002 it covered 147,000 state employees and 11,000 small employer groups in the state.

Building a Pathway to Universal Coverage, The Flood Tide Forum III, National Academy for State Health Policy, Nov.2002.

One other option is to pool small businesses into the state employee pool, leveraging a large workforce's buying power to assist small business.

Advantages. A pooling arrangement that includes individuals and small businesses would likely open health insurance opportunities, depending on the pools' size, composition, eligibility requirements and cost to participants. Pooling proposals and plans vary widely in their design and breadth of eligibility. Some plans are community-rated, reducing cost. The Dirigo plan appears to have promise for low-income people, as the eligibility and cost requirements above demonstrate. Preventive care is a central feature, and expenses incurred should pay off over time with healthier participants. As the plan only recently went into effect, the fulfillment of its promise remains to be seen.

Pooling business with state government would seem a potentially dramatic way to save cost at little incremental expense to the state by way of bureaucracy. Companies would pay the group rate for individuals which would include administrative costs.

Disadvantages. Such arrangements need to be legally recognized by the state or federal government because under traditional insurance regulation, multiple employers and individuals are prohibited from forming a group solely for the purpose of buying group insurance.

Fundamental to the success of a pooling arrangement is creating a group sizable enough to effectively bargain for lower costs, make best use of administrative resources, and to spread the risk broadly. Also necessary: a competitive market. The Iowa SPG report notes that since much of the state is rural, with long distances between providers and that most urban areas are small with limited provider options, there is little opportunity for expanding coverage through pools in Iowa. Pools often end up with problems of risk selection. Healthy groups in the pool end up subsidizing the less healthy groups, and end up leaving the pool.

In Iowa, association-based benefit plans are illegal, due to past experience with unscrupulous associations that left the plans bankrupt. According to Susan Voss, Deputy Director of the Iowa Insurance Division, consumer protections are needed for these plans to become viable. In their heyday in the 1970s, these plans looked too good to be true, and in fact they were. In the beginning, the associations are collecting premiums and have few claims. But as the members start having health problems or accidents, the claims mount. Without proper pricing—and wise investment of the collected monies—these plans quickly fail. They left a trail of debt with physicians and hospitals when they went bankrupt. Because of this bad experience, Iowa is likely to be cautious in permitting such plans to start again.

Interview with Susan Voss, November 2004

Outlook. Generally, pools have not been found to decrease cost or increase coverage, according to the Lewin Group. The only successful model is California, a highly competitive environment quite unlike Iowa.

Iowa SPG, p. 140.

The Lewin Group's analysis shows that the cost savings to employers would average $15 per employee per month, but would result in a cost of $15 per month for each state employee in the pool.

Iowa SPG, p. 141

More specifically, a pooling option may not be viable for many DCWs who work part time, or change jobs frequently. Even if eligibility barriers were resolved in favor DCWs, for many, the cost of employee contributions, deductibles or co-pays may be prohibitive.

There is little promise in any proposal to leverage the size of the state employee health plan to cover more lives. The State of Iowa Personnel Department, which controls the plan, was approached with an idea to offer new businesses the opportunity to buy into the state employees' plan—as an enticement to bring new business to Iowa. Initial reaction was muted by concern for protecting the fiscal risk of the current pool. Even though it could be argued that new businesses coming to Iowa are likely bringing younger rather than older employees, department officials were not eager to explore this as a policy option. Reaction to the idea of allowing small business to buy in is likely to be less warmly received. Personnel Department officials might reasonably conclude that only small businesses with high costs associated with health risks among their staff would exercise this option. That adds cost to the state employee pool, which is what they want to avoid. The demographics of DCWs make it as a workforce an even less likely candidate for inclusion in any pool, so long as there is choice among those who join.

Policy Option 8: Combined Strategies to Cover All

Minnesota is closest among states to reaching universal coverage. Some 95% of Minnesotans are covered by health insurance plans. This may be as high as the rate can go, under a voluntary system. "Minnesota

seems to have hit on a combination of public and private programs that has yielded one of the highest rates of health insurance coverage in the nation."

Tools & Innovations: Approaching Universal Coverage: Minnesota's Health Insurance programs. The Commonwealth Fund, August, 2004

Coverage is made possible for approximately 11% of Minnesota residents through a combination of five state programs to reach those who cannot qualify for, or afford, employer-sponsored or individual plans.

Program	Eligibility	Provisions
Medical Assistance	Medicaid program for low-income children and families, the elderly and persons with disabilities. Highest income eligibility limits under federal law.	Covers children under age two with family incomes up to 280% FPL; children 2-18 with family incomes to 275% FPL. Also parents, the aged, blind and disabled, and children ages 19-20 to 100% FPL.
MinnesotaCare (state funded)	Health insurance program for families and adults with modest incomes without access to employer-sponsored insurance.	Coverage for families with children at or below 275% of FPL, though parents not eligible if income greater than $50,000. Subsidizes coverage for childless adults with incomes of up to 175% of FPL who are not eligible for Medical Assistance. Coverage for those with incomes between 76% and 175% FPL limited to $10,0000 for inpatient hospital care per year and $5,000 for physician care, drugs, lab and diagnostic services. Monthly premiums based on family size and income.
General Assistance Medical Care (GMAC)	Designed for those not eligible for other state or federal program (such as those whose assets exceed Medical Assistance or Minnesota Care guidelines)	Similar to Medical Assistance, covers a full benefits package for adults without children with incomes below 75% FPL. Also provides catastrophic hospitalization coverage with $1,000 deductible per admission to those with incomes between 76% and 175% FPL.
Minnesota Comprehensive Health Association (MCHA)	Assistance for individuals who cannot obtain individual coverage due to pre-existing condition. Includes those 65+ who are ineligible for Medicare Covered approximately 33,000 Minnesotans as of Aug. 2003.	High-risk pool for medically uninsurable individuals. Premiums capped at 125% of standard rates, among lowest in country.
Public Employee Insurance Program.	Open to town and county governments and school districts.	Small group purchasing pool for employees in public sector.

State Options for Expanding Health Care Access, Barbara Youndorf, Laura Tobler and Leah Oliver. National Conference of State Legislatures, March, 2004.

As noted earlier, the Iowa SPG Report concluded its review of options for expanding health coverage with an outline of combined strategies. Basic elements are these:

Strategy	Eligibility	Provisions	Funding
Expand eligibility for Medicaid and SCHIP	All adults living below 200% of the FPL, including parents of children on Medicaid/hawk-I and non-custodial adults	Wellmark PPO benefits package.	Small premium contribution for adults above 150% FPL
Short-term insurance	Unemployed receiving unemployment compensation	Benefits package modeled on Wellmark package for state employees, limited to duration of unemployment compensation. No premium payment for individuals and families while unemployed	Increases in state unemployment insurance taxes
Refundable tax credits for amount paid by employer for coverage	For employers of low-wage workers in small firms: 25 or fewer workers, no coverage for at least 12 months; average payroll below the average for small firms in state.	Extended to employers not currently providing coverage to help them offer coverage to workers.	State subsidy
Insurance purchasing pool	Pool to be comprised of state employees and employers with 25 or fewer workers.	Benefits modeled on Wellmark package for state employees, and thus extended to employers of small operations. Effectively a subsidy to small business that would reduce the cost of coverage for small groups resulting in increase in coverage.	State subsidy

Advantages. Combining approaches is a strategy aimed at reaching the special circumstances of the widest possible arrange of an uninsured population with varying needs and circumstances. Minnesota can point to a high degree of success in that effort.

Disadvantages. The problem with systems that require such large outlays of public monies and administrative resources is whether they are sustainable. These plans depend on the public fisc which is subject of the vagaries of the economy. In tough times, entitlement programs begin to look like luxuries.

Outlook. DCWs would find a means for coverage under one of the plans, making it the most efficacious methods for meeting DCWs' needs. However, the Bush administration is not headed in the direction of greater government involvement in health care. Quite the opposite. The cost was estimated by the Lewin Group to be $358 million. A state could, conceivably, do it on its own, but in Iowa this is not likely, given a Republican-dominated statehouse.

Iowa SPG 2000, p. 122

Policy Option 9: State Funded Plans

Single-payer coverage plans aim to provide uniformity of access and quality, and a means of negotiating for lower costs. Single payer coverage is a health care system in which a government entity finances most health care as the "single payer" for most health care services. Typically, the government takes in taxes for health care purposes. The government then pays health care providers, such as hospitals and physicians, to provide care to those enrolled in the government health care plan. An example is the Canadian health system, which incidentally was started in Saskatchewan, the Iowa of the Great White North.

Closer to home, the state of Washington's Basic Health Plan (BHP) is entirely funded and controlled by the state, though it does not aim for universal coverage. With no federal oversight, state officials have broad freedom to manage and restructure the program. It covers uninsured workers and their dependents with incomes up to 200% FPL, whether or not children are present in the home. BHP provides private HMO coverage with benefits and point of service cost sharing modeled after employer-sponsored coverage, with limits on drugs and mental health services. Typically, consumers pay a minimum of $10 per month with additional amounts required depending on income, choice of health plan and age. The plan has several key provisions:

- It is not an entitlement program, so provides more control over caseload and costs;
- Enrollment is capped;
- It requires enrollees to help pay for their insurance and med care;
- It uses private insurance and strictly managed care through HMOs; and
- It provides benefits resembling typical employer-based coverage.

California is one of a number of states exploring the possibilities of single-payer coverage. Unlike Washington's plan, the California proposal aims for universal coverage. In 2002, the California Health and Human Services Agency contracted with a private firm to analyze nine proposals to expand health insurance coverage in the state, including three single-payer proposals. The report concluded that a single-payer system would result in coverage for all California residents, including undocumented people and a net reduction in total spending in the state. Medical services would be provided by the existing private health-care delivery system, and there would be free choice of doctors and hospitals. The proposition was on the 2004 general election ballot.

Advantages. In Washington, broad eligibility reaches out to low-income individuals as well as families. While plans like these can be complex in design and administration, they create stakeholders invested in the success of the programs. Compromise and concessions are shared.

In California, proponents claim this is the best way to cover virtually everyone, that it is more efficient as the current administrative structure would be eliminated; and that costs would be control costs through negotiating prices with doctors, hospitals, drug companies and other health care providers.

"California Can Lead on Medical Care Reform." Spyros Andreopoulos, www.sfgate.com. Sept. 22, 2004.

Disadvantages. In Washington, caps on enrollment, based on available funding, make accessibility uncertain.

In California, opponents claim it is a radical change, creating too great a role for government, diminishing choices and reducing competition. They also claim the private sector can more

efficiently administer health care. There is likely to be strong political opposition to a single payer system.

Health Care Coverage in America: Understanding the Issues and Proposed Solutions. Cover the Uninsured Alliance for Health Reform, 2004,

Outlook. This proposal is going ahead incrementally. The initiative on the November ballot lost by a very narrow margin—49.1 to 50.9. With the success of stem-cell funding, this may come back. Other states may follow California's lead to address their own problems with their own methods with less reliance on the federal government.

Conclusion

Most approaches to covering low-income workers do not address the needs of Iowa DCWs. Change will require a great deal of fortitude in overcoming economic and political barriers. Here are a few key facts to take away:

Medicaid. Because these individuals are working at jobs that pay more than the minimum wage, they are not qualified for Medicaid, unless there are children in the home. With this aging workforce, children are typically not present. Certainly, fewer individuals will be eligible in the future as their older children leave home.

Individual purchase. In a climate of rapidly rising rates, a 50-year-old worker cannot afford her own policy in a traditional plan unless she has income from sources other than her job as a DCW.

Employer-sponsored plans. Health care facilities that do not currently offer health insurance are unlikely to start, given the characteristics of the employee pool (older and female in jobs that expose them to disease and injury). Among Iowa businesses who do not currently offer health insurance, the vast majority (89%) are not even considering it. This is not a climate in which employers want to jump into the health insurance game.

New government programs. With the outcome of the November 2004 election, the country is farther away from creating of any new federal program to provide universal coverage.

Refundable tax credits and vouchers. The Newt Gingrich approach may hold the most promise for low-income Americans without health insurance. It allows them to purchase their own policies (with government assistance) and offers help with ordinary medical expenses. The remaining question is whether this can be done affordably for Iowa's DCWs.

In the next section, we offer ideas on how the Iowa Better Jobs Better care Coalition and the Iowa CareGivers Association can use this information for greatest impact.

SECTION III: THE ROAD AHEAD

In this section, we shift our focus forward to advocacy positions for the Iowa Better Jobs Better Care Coalition and the Iowa CareGivers Association. While the previous section paints a picture less optimistic than advocates would like, there is still reason for some hope. The 2004 election created a split Senate in the Iowa Legislature, meaning the Democrats and Republicans will share power with each assuming the role of the majority half the time. That may help some bills move out of committee and onto the floor for debate and perhaps passage. With that in mind, here are our recommendations for advocacy with legislators, with employers, and with the public at large.

Position DCWs as a workforce vital to Iowa's future. We are an aging state. Many of us will grow old here and need the care provided by DCWs. If we expect DCWs to be in place, and in good health to care for use as we age, we need to invest now in assuring their wellbeing. That means paying wages sufficient that DCWs can afford health insurance, whether that be the contribution they make to an employer-sponsored plan or the premium for an individual policy.

Learn from unions. Collective bargaining is often an effective way to obtain health care benefits as part of a compensation package. Yet, relatively few Iowa DCWs are union members. The American Federation of State County and Municipal Employees (AFSCME) represents about 1,500 state and county direct care workers in Iowa who are public employees at state and county facilities. These union members work under contracts negotiated by AFSCME, and their hourly wages under the current contract range from $12.52 to $17.50 per hour, considerably higher than the hourly wage measured in the CNA and home care worker surveys. By comparison, the average entry wage for Iowa direct care workers is $8.14; median is $9.56; and for experienced workers, $10.27.

Health care is also part of union contract negotiations, with employers picking up the health care insurance costs. There is no cost to employees, and their family members may be covered at reduced cost. Direct care workers pay union dues of approximately $25 per month.

Interview with Jan Corderman at AFSCME, November 2004.

Clearly, the wages for union direct care workers are significantly higher than their non-union counterparts, and the eligibility for health insurance is an exceptional benefit. As noted, however, these union workers are employed by public institutions. There is little likelihood of expansion to the private sector at this time, under current economic conditions. Further, Iowa's unionized DCWs are facing increasingly heavy workloads, due to staffing reductions that have come about as a result of state and local budget cuts.

Interview with Jan Corderman at AFSCME, November 2004.

While unionizing by itself may not be the answer, teaching DCWs how to negotiate wages and benefits may help some obtain coverage or earn enough to afford a policy. To be effective, the Iowa Better Jobs Better Care Coalition and the Iowa CareGivers Association need to create and implement a public relations policy which explains why the investment in the health care of DCWs is to employers' advantage and to the advantage of Iowans at large. Arguments based on self-interest tend to be the most effective to management. If they see what's in it for them, in terms of cost, especially, they are more likely to opt for change. The question for the Iowa Better Jobs Better Care Coalition and the Iowa CareGivers Association to pose is: What is it costing them to employ uninsured workers? Will they be able to recruit a higher quality workforce and keep them longer? Will they benefit from fewer missed days of work due to illness? If the BJ/BC Coalition can document how health insurance improves the

quality of the workforce in a way that addresses employers' self-interest, such data may open new avenues to employer-sponsored health care.

Educate the workforce on available options. Iowa DCWs demonstrate a lower take-up rate on Medicaid than the national average. In addition to matters of eligibility, this may be due in part to an aversion to the idea of benefiting from government programs. As Anne Kinzel noted, in Iowa, the program is referred to just as often by its authorizing legislation (Title XIX) as by "Medicaid," perhaps indicating a wish not to be associated with the program. DCWs may need to be convinced to overcome their objections in order to get coverage. This may be best accomplished by showing how enrollment is to their advantage. Workers with several children may be eligible for enrollment in an employer-sponsored program—either at their place of employment or through a spouse's job. Education may also reduce the perceived complexity of the enrollment process. Maximizing what is available now is clearly a desired outcome.

Advocate to increase Medicaid eligibility for childless adults. As state revenues increase, the Iowa Better Jobs Better Care Coalition and the Iowa CareGivers Association will be one of many voices lobbying for how new money can be spent. However, the current barriers to Medicaid for working Iowans without children at home make it of no help. The irony is, a non-working adult with very low income gets more of a hand from the government than an Iowan who is working and contributing to the Iowa economy. Just raising the eligibility level to the poverty line may help some DCWs get coverage. Although this is not a policy strategy currently in the debate, it may be wise to suggest that individuals who benefit under higher eligibility guidelines pay into the plan. This may ease the financial burden for state government, and calm policymakers inclined to restrict entitlement programs, not expand them. Sixteen states have made room in their Medicaid plans for parents of children enrolled in Medicaid or SCHIP (the Iowa version is hawk-i). They have effectively made the case that the state has a vested interested in keeping the parents of covered children healthy. Untreated, sick parents can infect their children which will cost the state.

Advocate for mandated coverage. While it may seem that the 2004 election creates an environment less tolerant of mandates rather than more, in fact there is some reason to think lawmakers may see the advantage. If all Iowans, or all Americans for that matter, were required to carry their own high-deductible health insurance policy, new options for how to pay for ordinary medical expenses open up. While it is tempting to offer up a critique of the health insurance system's progression from real insurance to a mix of real insurance plus pre-paid health expenses, that is beyond the scope of this analysis. However, it is useful to know that some policy strategists are looking for ways to separate these two functions of most health insurance plans. First, the high-deductible plan becomes the "major medical" plan of the mid 20th century. Second, pre-paid expenses can be paid for by individuals and employers through health savings accounts. This approach helps employers cap spending while still providing access to basic health needs of obvious concern to DCWs: Flu shots, mammograms, pap smears, antibiotics, cold remedies, smoking cessation programs, prescription drugs, and so on. These are the kinds of expenses that can make the difference between a worker showing up healthy and a worker who must take sick days. They can also mean diagnosing a high-cost condition or disease in its early stages when it is less costly to treat and when the chances for recovery and re-entry into the workforce are greatest. If they see the benefit, employers may be willing to make contributions to the health savings accounts of their employees, reducing the cost to DCWs.

In the 2004 SPG Study of Iowa Businesses, mandates requiring individuals to buy their own high-deductible plan and employers to pay into a health savings account were not rejected. In fact, a scenario with both mandates in force, including an employer contribution of $3,000 per year for full-time

employees was accepted by a majority of businesses as having advantages over their current situations. Fifty-seven percent (57%) say their business would be better off if these mandates were in place. That includes 62% of those already offering a health insurance plan and 52% of businesses that do not.
SPG Survey of Iowa Businesses, 2004.

In conversations with numerous business leaders, and policy strategists on both sides of the political spectrum, we find concerns about mandates to be dampened by what is an obvious and shared need—to find ways of controlling health care costs—to individuals and to employers. From the National Coalition on Health Care (co-chaired by former Iowa Governor Bob Ray) and the Iowa Association of Business and Industry (led by Jim Aippersbach), the idea that a combination of mandates and individual responsibility makes sense, though all agree the idea needs further study. But in theory, they say, we mandate auto insurance for car owners, so this is not a completely new idea. If every Iowan were required to buy a high-deductible health insurance policy, the cost would average about $100 per month for a family of four, based on analysis by John Schneider, Ph.D., College of Public Health at the University of Iowa. If not saddled with the cost of the insurance policy, employers may be willing to contribute to HSAs.

The Iowa Better Jobs Better Care Coalition and the Iowa CareGivers Association can be an effective advocacy element to show how this approach helps low-income earners—those who make too much money to qualify for Medicaid, but do not make enough to afford health insurance coverage. The idea of the dual mandates addresses the need for cost-containment that the insured want, and offer a very real way to reduce the number of uninsured. This is a scenario where everybody wins.

Professional employer associations (PEOs) may hold some promise. One approach to covering DCWs is for the Iowa CareGivers Association to form a PEO and lease DCWs to their employers, insuring them as a pool at what would be hoped to be a reduced rate. We discussed this option with Susan Voss of the Iowa Insurance Division and with a senior executive at Merit Resources, one of the main PEOs in Des Moines. The problem is that this really doesn't help with cost. The reason to do this would be to create a larger group and so offer a better rate than individuals might get on their own. While the latter might be true, it is unlikely to reduce the rate to a level affordable to most caregivers. In fact, Merit Resources' client employers are individually underwritten, based on the small group risk. They did not start out that way, but they quickly discovered that younger, healthier groups did not join the health insurance plan and older, less healthy groups did. In order to keep the healthier groups, Merit had to offer them a separate rate.

But, even if the Iowa DCWs could rate their entire membership as a group, the demographics indicate the price of a policy would still be high—beyond the range of those who do not currently have health insurance.

Wisconsin, however, is experimenting with a PEO, in a unique partnership between the Service Employees International Union Local #150 and the Wisconsin Regional Training Partnership. The PEO will have a collective bargaining agreement with the union, so that the PEO and its employees will be eligible for health insurance through the union, thus opening the pool to non-union shops. Participating employers will be required to pay 80% of the premium, which is projected to be under $200 for a single person and about $425 for family coverage. These rates are significantly below what businesses have been routinely quoted. Businesses would also pay an administrative fee of .5% of payroll.
"A Healthy Union of Convenience?" Kimberly Weisul, Business Week Online, November 14, 2003.

This is an ambitious partnership with potential to offer a much lower price for health insurance—both to the employer and to the employee. With further investigation, this may be area where the BJ/BC coalition can assume a leadership position.

Work for higher wages; educate on the importance of health insurance. Ultimately, insuring more DCWs is a matter of money. Since most DCWs earn more than the minimum wage, this is not so much a matter of public policy. Rather, it is a matter of salary negotiations. An extra dollar an hour translates into $2,080 per year for a full-time worker. The Iowa DCWs may have the greatest impact by both helping their members negotiate for higher wages. That may include training workers on how to negotiate the salary at the time of hire, or how to ask for a raise. It may also include developing certification levels of skill sets that should be accompanied by increased wages. But just as important is educating DCWs to spend money on health insurance. Tahira Hira, Ph.D., a consumer economist of international reputation (currently serving as Assistant to the President for External Affairs at Iowa State University), notes that helping low-income earners prioritize in a way that puts health insurance first is often challenging. They are managing survival with food, shelter, and clothing, and often are trying to pay off debt. While she firmly believes health insurance to be a fundamental staple of a stable household budget, she also says that realistically, individual policies at today's rates are beyond what many can afford at today's wages.

Lobby for higher reimbursement rates to nursing homes, with a pass-through to DCWs wages and benefits. Unlike Medicare, the state sets reimbursement rates for Medicaid. Though the formulae are complex, several states have succeeded in adjusting rates so that nursing homes are paid more on a per day basis. Iowa's rate is roughly $95 per day and, though it is low compared to the nation, is not the lowest (Louisiana).

By 2002, 21 states had enacted pass-through provisions raising the reimbursement rate with the proviso that the increase would be spent on DCW wages. With the federal government supplying nearly $2 for every $1 Iowa invests in Medicaid, this would seem to be an avenue with some promise. However, a survey of states concluded: "A review of current data does not support the efficacy of wage pass-through programs."

State Wage Pass-Through Legislation: An Analysis, Paraprofessional Healthcare Institute, Workforce Strategies, No. 1. April 2003.

A concern, however, is holding employers accountable for actually spending the new money on increasing wages to DCWs. "The problem is, is that we can ask them to do that and then it's very hard to hold the nursing homes accountable for how that actually gets done. The experience in California and Massachusetts and in other states is that a good chunk of the money does not get passed on to workers."

Arvid Muller, Alliance for Health Reform and the Commonwealth Fund Discussion, December 9, 2002, Washington, D.C.

In spite of concerns, "Many state legislators are embracing wage pass-throughs as one of a series of potential options. As one state legislative leader said, a wage pass-through is a 'down payment'— the first step toward a more comprehensive effort to sustain a competent and stable long-term care workforce."

Senator Mark Montigny, Chair of the Senate, Ways and Means Committee for the Massachusetts, Legislature, in announcing his Nursing Home Quality Initiative for FY 2000. Cited in State Wage Pass-Through Legislation: An Analysis, Paraprofessional Healthcare, Workforce Strategies, No. 1. April 2003.

The Iowa legislature and the governor may be more receptive to this kind of approach than in recent years. The Senate splits evenly between Republicans and Democrats and the Democrats picked up five seats in the House. The governor recently turned down an opportunity to run for chair of the Democratic National Committee and, given he is on the record has having no intention to run for re-election, he may be eyeing his legislative legacy. In addition, the state may see higher revenues next fiscal year. In theory some may be available for raising the Medicaid reimbursement rate. If not, the money must come from somewhere else in the budget, making expansion less likely.

The governor's economic development strategy is geared toward attracting good jobs to the state—in wages and benefits. He might be receptive to an approach that upgrades the quality of jobs already here. Raising Medicaid reimbursement with a pass-through to be used to raise salaries or enhance benefits may be a useful step in insuring uninsured DCWs. The Coalition would need to be prepared to assist in any way it can to ensure that higher wages result in enhanced recruitment and retention and so avoid the pitfalls some other states have met.

As the Iowa Better Jobs Better Care Coalition, the Iowa CareGivers Association, and other advocates help DCWs become better able to afford health insurance, they will also need to help them see the urgency of getting coverage.

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