EXECUTIVE SUMMARY

A "perfect storm" is forming, due to the combination of the projected growth in the State's population needing long-term care and a shortage of direct-care workers (DCWs). Without interventions to better recruit and retain these workers, the quality of life for thousands of Mainers, as well as our state's economic future, will be adversely affected.

Health insurance coverage is a critical component in recruiting and retaining DCWs -- even more important, perhaps, than wages in increasing the supply of workers and hours worked.[1]

DCWs face many barriers in obtaining health insurance. The cost of coverage affects nearly all DCWs, as most earn less than $10 per hour. Accessibility barriers affect certain workers more than others; home- and community-based workers are less likely to be offered coverage by their employers than their facility-based counterparts, in part due to the State's reimbursement structure. Also, the unpredictable schedule of home-care services results in many DCWs being classified as temporary or part-time employees, who therefore do not qualify for job-based coverage.

Given the significant barriers to health coverage, the critical function of DCWs, and concerns about a workforce shortage, Maine's policymakers have made multiple efforts to increase DCW access to health insurance. In 2008, the Joint Standing Committee on Insurance and Financial Services asked the Superintendent of the Bureau of Insurance to convene a group of stakeholders to consider whether the Insurance Code provides options to expand coverage to more DCWs. The resulting Direct-Care Workforce Health Coverage Working Group held seven meetings to examine existing options in the Insurance Code, as well as publicly funded initiatives and programs, and other possibilities.

- ***Insurance Code options*** – private purchasing alliances, trustee groups, association groups, labor union groups, multiple employer welfare arrangements (MEWAs), and modification of the small group plan participation rate – would not significantly impact affordability and accessibility barriers, and are therefore not likely to expand coverage for this workforce (absent significant increases in wages).

- ***Creating a "bare bones" insurance product*** for DCWs has tradeoffs. While premiums would be less expensive than those associated with more comprehensive coverage, the out-of-pocket costs for a DCW in need of medical care not covered, or caps on coverage (such as a cap of $5000 on hospital care), could mean no access to needed medical services, financial hardship for the DCW, and cost-shifting to other patients or to the State. Such limited coverage would not result in broad access to necessary medical care or the financial security that suitable health insurance provides.

[1] Health Care for Health Care Workers, *Fact Sheet* (October 2007).

- ***Including DCWs in the State Employee Health Plan*** is also not likely to increase coverage. Without a significant subsidy, premiums for the State Employee Health Plan would be out-of-reach for the vast majority of DCWs.

- ***Expanding public insurance options to DCWs***, given the low income level of such workers, would result in the majority of DCWs having access to affordable and suitable health coverage. Publicly funded options include DirigoChoice, MaineCare, and/or enhanced State reimbursements earmarked for health coverage. *Policymakers should consider these options*. If policymakers determine that public insurance would be an appropriate way to cover DCWs, given the current budgetary forecasts, immediate expansion efforts are unlikely without new federal financial support.

Absent immediate solutions, one pilot project could be tried on a limited basis. Limited funding would be necessary. In this project, two or three large home- and community-based direct-care service providers would receive an enhanced State reimbursement to pay for coverage within DirigoChoice. The Dirigo Health Agency would open large group enrollment strictly to these providers. Provider participation would be voluntary. The pilot would provide an opportunity to examine the extent to which employees take up coverage, the level of benefits and premium best suited to the DCW workforce, and the impact providing coverage has on workforce retention.

Although there are no easy solutions given budgetary constraints, it is certain that without effective interventions to expand health coverage, the need for DCWs will soon outpace the supply in Maine.

PURPOSE OF THE REPORT

In a letter dated April 4, 2008 (Attachment A), the Joint Standing Committee on Insurance and Financial Services asked the Superintendent of Insurance to:

> "convene a working group of stakeholders to review the State's health insurance laws and consider whether there are provisions under current law that provide an opportunity for group purchasing for direct care workers and their employers. In conducting the review, [the Committee] also ask[s] that the working group identify any potential statutory changes or other public policy options to increase access to private health insurance coverage for direct care workers."[2]

The letter requested that the Bureau submit its findings and recommendations to the Committee. This report details the process and results of this project.

[2] Letter to Mila Kofman, Superintendent of Insurance, from Sen. Nancy B. Sullivan and Rep. John R. Brautigam, Chairs, Joint Standing Committee on Insurance and Financial Services, April 4, 2008.

WHO ARE MAINE'S DIRECT-CARE WORKERS?

In 2005, more than 22,300 Maine direct-care workers (DCWs) served older adults and people with disabilities or chronic health conditions.[3] The Maine Department of Labor includes five types of occupations in its definition of DCWs:

- Nursing aides, orderlies and attendants;
- Home health aides;
- Psychiatric aides;
- Personal and home-care aides; and
- Psychiatric technicians.[4]

DCWs work directly for consumers, small providers, or large agencies. They work in institutional settings and in people's homes. Their work accounts for eight out of every ten hours of paid care received by consumers of long-term care.[5]

A survey of more than 800 DCWs employed by 26 Maine home-care agencies, conducted by the University of Southern Maine's Muskie School of Public Service, made the following findings/observations:

- *Gender*: 96% are women;
- *Age*: Average age is 47 years, ranging from 16 to 78 years old, with 41% between 50 and 64 years old;
- *Income*: One in two are primary wage earners for their household, 78% earn less than $10/hour, 35% report annual household incomes of less than $20,000;
- *Work hours*: 73% work part-time or in temporary positions, 30% work more than one job (half of these are second direct-care jobs).[6]

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[3] Maine Department of Health and Human Services, *Study of Maine's Direct Care Workforce: Wages, Health Coverage, and a Worker Registry*, Report to the 123rd Maine Legislature (March 2007).

[4] Maine Department of Labor (Matthew Kruk, Economic Research Analyst, lead author), *Special Report: 2006 Healthcare Occupations Report*.

[5] Lisa Pohlmann, "A New State Study on the Direct Care Workforce", *Choices: Ideas for Shared Prosperity*, Maine Center for Economic Policy (April 25, 2007), Volume XIII, Number 3.

[6] Elise Scala and Lisa Morris, (2007) *Internal Report with Research Findings for the Grant Demonstration Project, Providing Health Coverage and Other Services to Recruit and Retain Direct Service Community Workers*, funded by the federal Centers for Medicare and Medicaid Services Grant # 11-P-92187/1-01. Full report is located at: http://www mainerealchoices.org/workforce_workdemo.htm (go to bottom of the page,

The survey also found:

- 26% have no health insurance coverage;
- 63% do not have access to employer-sponsored coverage;
- 68% of those who have access to employer-sponsored coverage report they do not participate mostly because they cannot afford their share of the premium; and
- 41% of those who are insured obtain their insurance through public/government programs, mostly MaineCare.[7]

to Workforce Demonstration Grant Final Report and click link to Final Report) or contact Elise Scala at: scala@usm maine.edu.

[7] Ibid.

URGENT NEED TO FIND COVERAGE OPTIONS FOR DIRECT-CARE WORKERS

Why Policymakers Should Closely Examine These Uninsured Workers

DCWs are critical to Maine's future economic viability, as well as to the quality of life for a growing number of seniors and their family members. Both the Legislature and other policymakers (including the architects of *Maine's 2008-2009 State Health Plan*) have placed an urgent priority on ensuring that long-term care services are available and affordable in Maine:

- The 123rd Legislature passed Resolve 2007, ch. 209, creating the Blue Ribbon Commission to Study the Future of Home-based and Community-based Care. More than two-thirds of the Legislature voted in favor of passing this bill on an emergency basis, noting, "…work to study the unmet needs and financing options of long-term home-based and community-based care must begin before the end of the legislative session because the State has an increasingly elderly population and *there is a shortage of long-term home-based and community-based care workers*…." (italics added).[8] This Commission was to report its recommendations to the Legislature by November, 2008.

- *Maine's 2008-2009 State Health Plan* includes six goals related to "finding the right place of care for the elderly and disabled in need of assistance." One goal is to "identify/implement strategies to support the direct-care work force."[9] The Office of Elder Services within the Department of Health and Human Services was required to develop initiatives to support direct-care workers. These initiatives include gathering and comparing information about rate structures across various types of long-term care services to determine what components are included that directly benefit DCWs (e.g., wages, compensation, training).

These necessary long-term care services will <u>not</u> be available without an adequate DCW workforce. The role of DCWs has been identified by stakeholders as critical support in every aspect of independent living, and the challenges in recruiting and retaining people in this work has been and continues to be a major concern.[10]

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[8] Resolve 2007, ch. 209, *Resolve, To Create the Blue Ribbon Commission to Study the Future of Home-based and Community-based Care*, www.mainelegislature.org/legis/bills/chapters/RESOLVE209.asp

[9] Governor's Office of Health Policy and Finance with the Advisory Council on Health Systems Development, *Maine's 2008-2009 State Health Plan* (April 2008).

[10] Stuart Bratesman, *Direct Care Workforce Challenges: Improving the Recruitment and Retention of Workers who Provide Direct Support to Persons with Disabilities*, University of Southern Maine, Muskie School of Public Service (December 28, 2000).

A "Perfect Storm" Is Brewing

A "perfect storm" is being created by the projected growth in Maine's population needing care, the projected shortage of DCWs, and continued economic pressures. Absent appropriate interventions, thousands of Mainers who need services and care from DCWs may find few (if any) options for care. Family members of elderly and incapacitated Mainers, who are now able to participate in the general workforce, may need to stay at home to provide care, possibly further weakening the State's economy.

The number of Mainers needing direct-care services is large and growing. In 2006, at least 14,465 Mainers used direct-care services: 6,446 were in nursing homes (all payors), 3,851 were in residential care facilities (all payors), and 4,168 were served in their homes (MaineCare and General Fund clients).[11] The population needing these services is expected to grow significantly during the next 10-20 years. In 2006, 15% of Maine's population was over age 65; by 2030, Mainers over age 65 will account for 27% of the population, making Maine second highest (after Florida) in the percentage of residents 65+ in the United States.[12] Demand for home-care workers is expected to grow faster than for workers in institutional settings. Using the category of "personal and home health aides" as a proxy for home-care workers, and "nursing aides, orderlies, and attendants" as a proxy for institutional workers, the Maine Department of Labor predicts that demand for personal and home health aides will grow 28% between 2006 and 2016, while simultaneous demand for nursing aides is projected to grow 7.7%.[13]

Demand is also influenced by Federal and State policymakers' recognition that it is less expensive and better for patients to receive care in least restrictive settings – their homes and communities. The Federal Centers for Medicare and Medicaid Services expects states to reduce facility-based care and provide support services to enable older adults and people with disabilities to live in home and community settings.[14] In Maine, since enactment of long-term care reforms in 1993, the number of Medicaid-funded nursing home residents declined from 9,502 in 1995 to 8,812 in 2006, while the number of persons receiving Medicaid or state-funded home-care increased from 7,623 to 12,955.[15]

A shortage of direct-care workers already exists and is expected to become much worse. There are indicators that fewer people are becoming DCWs and staying in the field; one

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[11] Julie Fralich, Stuart Bratesman, Catherine McGuire, Louise Olsen, Jasper Ziller, and Karen Mauney, *Assessment of Maine's Long-term Care Needs; Baseline Report: Demographics and Use of Long-term Care Services in Maine*, Prepared by the Muskie School of Public Service for the Office of Elder Services, Maine Department of Health and Human Services (December 20, 2007).

[12] U.S. Census Bureau, *Interim State Projections of Population by Single Year of Age: July 1, 2004 to 2030*, Washington, DC (2005), www.census.gov.

[13] Maine Department of Labor, Labor Market Information Services, http://maine.gov/labor/labor_stats/index.html.

[14] Brian Burwell, Kate Sredl, and Steve Eiken, *Medicaid Long Term Care Expenditures FY 2007*, http://www hcbs.org/moreInfo.php/nb/doc/2374/.

[15] Maine Department of Health and Human Services, *State Profile Tool 2007 Real Choices Systems Change*, (2007).

such indicator is a 44% decline in the number of people completing CNA training from 2002-2004.[16] Nationally, by 2030, the number of older adults is estimated to increase by 104%, but the number of women age 25-44 (the age of most DCWs entering the workforce) is estimated to grow only by 7%.[17] In other words, the demand for care is estimated to greatly outpace supply.

A number of factors contribute to the DCW labor shortage. Direct-care providers rely primarily on State programs. Reimbursements through MaineCare and the General Fund are relatively low given budget constraints. Therefore, the median wages in direct-care occupations are just above the poverty line and have not kept pace with inflation.[18] The average DCW earns $6.67 per hour less than the average Maine worker.[19] Personal and home-care aides have the lowest wages.[20] Other sectors with high demand for an entry-level workforce, such as retail sales or food service, compete for these workers. Jobs in those sectors are not generally as physically and psychologically challenging as direct-care work, nor do they typically have similar pressures brought on by understaffing. Additionally, some offer better benefits.

Non-competitive wages and benefits contribute to high turnover within the direct-care industry in Maine: 26% of DCWs leave within six months; 33% leave within one year; 44% leave within two years; and 51% leave within three years.[21]

Labor shortages and high turnover rates have adverse implications. Approximately $2,500 is spent each time a DCW position is vacated and must be re-filled.[22] Shortages make it more stressful on the workers who stay,[23] possibly leading to burnout. Perhaps most significantly, quality of care, from the perspective of the persons receiving services, cannot be maintained with inconsistent staffing, as consumers must deal with constantly changing workers performing very intimate tasks. Surveys of consumers find that stable relationships with frontline staff are a key component of their satisfaction.[24]

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[16] Lisa Pohlmann, *Meeting Maine's Need for Frontline Workers in Long-term Care and Service Options*, prepared for the Blaine House Conference on Aging (September 2006).

[17] Paraprofessional Healthcare Institute, *Women Caring for Women: Coverage Is Critical to Care*, Fact Sheet (September 2008).

[18] Maine Department of Health and Human Services, *Study of Maine's Direct Care Workforce: Wages, Health Coverage, and a Worker Registry*, Report to the 123rd Maine Legislature (March 2007).

[19] Lisa Pohlmann, *Many of Maine's Direct Care Workers Do Not Have Health Insurance*, produced with Maine's Direct Care Worker Coalition for the Paraprofessional Healthcare Institute (2005), www hchcw.org.

[20] Maine Department of Labor, Labor Market Information Services, http://maine.gov/labor/labor_stats/index.html.

[21] Elise Scala and Lisa Morris (2007).

[22] Dorie Seavey, *The Cost of Frontline Turnover in Long-term Care*, Better Jobs Better Care (2004).

[23] Lisa Pohlmann (2005).

[24] Ibid.

In addition to high demand for DCWs and a labor shortage, other factors exist for policymakers to consider, including:

- Nationally, direct-care work has the third highest rate of on-the-job injury. Nurse aides, orderlies and attendants – 41% of whom work in nursing homes – have a higher incidence of injuries and illnesses requiring more days away from work than any other job in the country.[25]

- DCWs in home-care settings – the fastest growing segment of the direct-care workforce -- generally do not have access to health insurance coverage compared to DCWs in institutional settings. Personal and home-care aides have the most limited access to employer-sponsored benefits.[26]

- A survey of Maine DCWs conducted by the Maine Center for Economic Policy found that one in five home-care workers said their health was only fair while closer to one in ten in residential settings said their health was only fair.[27]

Health coverage is a critical component in recruiting/retaining DCWs and in maintaining quality of care. Health insurance may be even more important than wages in increasing the supply of health workers and hours worked.[28]

Missed days of work not only impact the workers themselves, but also the consumers they serve, who are forced to scramble for substitute care, which may or may not be available. An injured DCW returning to work before healing may be unable to complete necessary tasks, such as physically assisting a client, and takes the risk of re-injury or delaying the healing process. Yet one-third of low-income women report that lack of health coverage influences their access to needed healthcare services, a rate 2.5 times higher than for women with higher incomes.[29] Health coverage could allow a sick or injured DCW to get the treatment needed to speed recovery, helping both the worker and the client.

Finding a way to improve recruitment and retention of DCWs, as well as to keep them healthy, will help with the current shortage of DCWs and is paramount in addressing and planning for predicted future needs of Mainers. Providing access to adequate and affordable health coverage is a critical part of the solution.

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[25] U.S. Department of Labor, Bureau of Labor Statistics, *Survey of Occupational Injuries and Illnesses,* www.bls.gov/iif/oshwc/osh/case/osch0034.pdf.

[26] Maine Department of Labor, Labor Market Information Services, http://maine.gov/labor/labor_stats/index.html.

[27] Maine Department of Health and Humans Services (2007).

[28] Health Care for Health Care Workers, *Fact Sheet* (October 2007).

[29] Ibid.

One Working Group participant said the following (in part) in 2008 testimony before the Joint Standing Committee on Insurance and Financial Services:

I have been working at my home-care job for five years. I help keep elderly folk living in their homes. I help them with grocery shopping, taking them to medical appointments, to the bank, getting errands done. I help them keep their homes clean and tidy. I also help them with personal care like bathing and dressing. They look forward to my visits every week. I look forward to seeing them too. I enjoy their company and I enjoy this job.

I do not make tons of money; I am not getting rich at it. There's no paid sick time, paid vacations, paid holidays and most important, no health insurance. When I took this job, I had coverage through my husband. Circumstances changed and we now buy our own catastrophic coverage. It doesn't pay much and is very expensive, $300 per month with a $10,000 annual deductible per family member. The way I see it, we won't lose our home if one of us should become very sick. We won't have to file bankruptcy to pay our medical bills.

I've lived with the threat of cancer all my life. I am now 42, the age my mom was when she died of breast cancer. Since November 2007, I have had my yearly mammogram and an abdominal ultrasound, screenings to detect cancer early. The cost of these screenings plus the doctors' consultations and visits is almost $2000. All of this is out of pocket cost to me.

I am very healthy and grateful that I'm so far cancer free. If one of my doctors should tell me that I have cancer, I will have to leave this job at Home Care for Maine in search of a job with health insurance. That would mean that the three consumers I have would be out of a worker until another worker could be found if one would be found at all (shortened from the original).

(Testimony of Helen Hanson, February 5, 2008, before the Joint Standing Committee on Insurance and Financial Services in support of LD 1687, *An Act to Increase Health Insurance Coverage for Front-line Direct Care Workers Providing Long-term Care.)*

Past Efforts to Help Direct-care Workers Access Health Insurance

Multiple efforts to increase health coverage for this workforce have been made by the State and others during the past several years.

Maine was one of 10 states awarded a grant by the federal Centers for Medicare and Medicaid Services (CMS) between 2003 and 2007 to provide health coverage and other services to recruit and retain DCWs. Among other activities, the project offered support to participating home health agencies and employees to evaluate and enroll in a comprehensive health insurance benefit program and/or to support their employees in locating affordable options for coverage. This effort was initiated concurrent with the start of DirigoChoice; the cost of coverage was identified as one barrier to enrollment in DirigoChoice or other products on the market by participating home-care employers and their DCWs.[30]

In 2006, the 122nd Legislature enacted two resolves (Resolve 2006, ch. 194 and 199) and a budgetary provision (Chapter 519, Sec. EEEE-1) requiring the Department of Health and Human Services, in conjunction with the Department of Labor, to conduct a study of DCWs in programs funded by MaineCare or the General Fund. The Legislature directed the Departments to include recommended options for extending MaineCare or other health insurance coverage to DCWs. The resulting *Study of Maine's Direct Care Workforce* was submitted to the 123rd Legislature by the Maine Department of Health and Human Services in March 2007.

In 2008, the Joint Standing Committee on Insurance and Financial Services considered LD 1687, *An Act to Increase Health Insurance Coverage for Front-line Direct Care Workers Providing Long-term Care* (Attachment B). This bill proposed actions based on the DHHS report recommendations. If passed, LD 1687 (as originally presented) would have: allowed direct-care providers with over 50 employees to participate in DirigoChoice; allowed DCWs working an average of at least 10 hours per week to participate in DirigoChoice; directed the Dirigo Health Agency to develop a marketing and outreach program targeting DCWs; directed the Dirigo Health Agency to develop a plan to allow multiple direct-care employers to contribute to the premiums of DCWs enrolled in DirigoChoice as individuals; and directed the Department of Health and Human Services to establish a demonstration project offering financial assistance for direct-care providers who make health insurance coverage available to their workers.

While LD 1687 was voted "Ought Not to Pass," the Committee sent a letter to the Bureau of Insurance seeking additional guidance. As the Committee Chairs explained in their April 4th letter:

> "While members of the Committee support the goal of providing access to health coverage for direct-care workers, the Committee could not support an expansion to the DirigoChoice program at this time …. Although LD 1687 was voted

[30] Elise Scala and Lisa Morris (2007).

> 'Ought Not to Pass' by the Committee, we believe increased options for health insurance coverage are needed to support the recruitment and retention of direct-care workers who provide home-care and long-term care for Maine's elderly and persons with disabilities."[31]

The Committee asked the Bureau to convene a working group to report on other coverage options for this workforce.

2008: Direct-Care Workforce Health Coverage Working Group

In the spring of 2008, Superintendent of Insurance Mila Kofman spoke with a wide range of key stakeholders and invited all interested parties to participate in the Direct-Care Workforce Health Coverage Working Group. Stakeholders included:

- Members of the Joint Standing Committee on Insurance and Financial Services;
- Legislators who had sponsored LD 1687;
- Legislative leadership of both political parties;
- Direct care workers;
- Direct-care providers/agencies/employers;
- Consumer groups;
- Health insurance plans;
- Private payers;
- Organized labor;
- State agencies, including the Governor's Office of Health Policy and Finance, the Dirigo Health Agency, the Employee Health Commission, MaineCare/DHHS, and the Department of Labor.

Of the 60 people invited, 36 participated in the Working Group (Attachment C).

The Working Group held seven meetings between June 18 and August 27, 2008. Superintendent Kofman directed the first meeting and appointed Deputy Superintendent Judith Shaw to facilitate future sessions. Appendix D lists topics covered at each meeting. Meeting summaries are available from the Bureau of Insurance upon request.

[31] Letter to Mila Kofman, Superintendent of Insurance, from Sen. Nancy B. Sullivan and Rep. John R. Brautigam, Chairs, Joint Standing Committee on Insurance and Financial Services, April 4, 2008.

BARRIERS TO ACCESS

The Working Group first examined the barriers faced by direct-care workers in obtaining health insurance. Some of these – such as affordability – affect nearly all DCWs. Other issues, including eligibility for employer-sponsored coverage, affect certain segments of the direct-care workforce more than others. Barriers to coverage helped inform discussions of possible coverage options.

Affordability

DCWs and their employers, like other Maine employers and workers, struggle to afford health insurance coverage. The monthly premium for an employee in a small group plan can range from a little more than $400 for a PPO plan to in excess of $1,100 for an indemnity plan. The monthly premium to also cover that employee's spouse and children can range from approximately $1,250 (for a PPO plan) to nearly $3,400 (for an indemnity plan).[32] Monthly premiums for comparable benefits in the individual market run even higher.

Premium costs are high because the costs of providing medical care are high. In 2007, Maine's HMOs spent $0.85 of every premium dollar on medical claims.[33] In 2004, Maine's per person spending on healthcare was the second highest in the U.S. (behind Massachusetts)[34] Maine's cost crisis reflects both national and regional trends – the U.S. spends almost twice as much per person on healthcare as other industrialized nations, and New England states spend more than the U.S. average.[35] The Governor's Office of Health Policy and Finance and the Advisory Council on Health Systems Development are spearheading efforts to deal with this cost crisis; these efforts are discussed in detail in *Maine's 2008-2009 State Health Plan.*[36]

Employers

Given budget constraints and competing needs, State reimbursement levels are too low for many direct-care providers to offer insurance to their employees. Those that offer coverage to their workers often cannot make dependent care available due to the cost.

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[32] Maine Bureau of Insurance, *A Consumer's Guide to Small Employers Health Insurance* (Last updated: September 2, 2008).

[33] Maine Bureau of Insurance, summary of 2007 Rule Chapter 945 filings, http://www maine.gov/pfr/insurance/hmo/aggregate/2007_qtr4 htm.

[34] Governor's Office of Health Policy and Finance, *ACHSD Data Book: Investigating Maine's Health Care Cost Drivers* (October 29, 2007).

[35] Ibid.

[36] Governor's Office of Health Policy and Finance with the Advisory Council on Health Systems Development (April 2008), http://www.maine.gov/governor/baldacci/cabinet/health_policy.html.

- MaineCare and the General Fund account for more than two-thirds of funding for nursing homes and long-term care facilities, and nearly all of the funding for direct-care services provided in people's homes.[37]

- Nursing homes report that cost increases in areas such as food, power and heat have far outpaced recent State reimbursement rate adjustments. The shortfall in their costs measured against reimbursements nearly tripled from 2004-2005 (from $10 million to $27 million).[38]

- In 2006, home-based care agencies received $14.98 from MaineCare for a home visit (a reduction from 2003-2004 levels) to cover wages and other costs of doing business, such as workers compensation and mileage. The reduction in MaineCare reimbursement resulted in cutting workers' hours, freezing salaries, and reducing consumers' services, especially in geographically isolated areas with high travel costs.[39]

Here is what one DCW participating in the Working Group had to say:

As to low income and all the discussion that DCWs are below the FPL, I was starting to think of myself as poor! Yes, I don't make much money, but with me and my husband working, we are able to pay our bills, have a roof over our heads, have food on the table and have oil. I realize that many DCWs are not in the same situation I am.

I thought about this some last week as I was with a consumer. My thoughts went to the discussion on our (DCWs) low income. I thought that the folks around the table in the workgroup meetings really can't say what a worker would say if offered the chance to get health insurance through their work.

The way it is now, many workers don't even have a choice when it comes to health insurance. Our employers don't offer it or offer paid time off. Where is the choice in that? The choice is to completely get out of direct care work if you want health insurance or other benefits.

(Helen Hanson, email, September 15, 2008)

Workers

Low wages and the high price of coverage are significant barriers for DCWs in obtaining health insurance coverage:

[37] Department of Health and Human Services (2007).

[38] Lisa Pohlmann, (September 2006).

[39] Ibid.

- In Maine, 78% of DCWs earn less than $10/hour, and 35% report household incomes of less than $20,000.[40]

- Recent national data on personal and home-care aides found that in 2006 the median hourly wage was $8.86; when adjusted for inflation, that figure becomes $9.62 in 2008 dollars.[41]

When employers offer health insurance coverage, many DCWs cannot afford their premium contributions. When not offered employer-sponsored coverage, individual policies are typically completely unaffordable for DCWs; individual policy premiums are higher than group premiums and there is no employer contribution to help pay the premium.

Even for people with insurance, out-of-pocket costs are significant barriers to accessing needed medical services.

Out-of-pocket costs, such as copays and deductibles, can create further financial hardships and discourage people from seeking needed care. For example, a Commonwealth Fund study found that 44% of adults with insurance deductibles of $1,000 or more reported one of four access problems: did not fill a prescription; did not see a specialist when needed; skipped a recommended test, treatment or follow-up; or had a medical problem but did not see a doctor. Approximately 25% of adults with deductibles under $500 cited similar access problems.[42]

The growing economic crisis exacerbates this problem. One-quarter of the 2,000 respondents to a survey conducted this past summer by the Rockefeller Foundation and Time magazine said they had decided not to see a doctor because of cost, up from 18% the year before, and 10% said they did not take a child to the doctor for the same reason.[43]

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[40] Elise Scala and Lisa Morris (2007).

[41] Paraprofessional Healthcare Institute, *State Chart Book on Wages for Personal and Home Care Aides, 1999-2006*, prepared for the Center for Personal Assistance Services, University of California San Francisco (July 2008). Calculations use median hourly data from the Occupational Employment Statistics of the U.S. Department of Labor, Bureau of Labor Statistics, and regional Consumer Price Indices for urban wage earners and clerical workers (1982-84=100), also from the Bureau of Labor Statistics, USDOL.

[42] Sara R. Collins, Jennifer L. Kriss, Karen Davis, Michelle M. Doty, Alyssa L. Holmgren, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-being of American Families*, The Commonwealth Fund (September 2006).

[43] Ceci Connolly and Kendra Marr, "As Budgets Tighten, More People Decide Medical Care Can Wait," *Washington Post* (October 16, 2008), Page A01.

Accessibility/Eligibility

Home- and community-based workers are less likely to be offered coverage by their employers than their facility-based counterparts.[44] This is due, in part, to the State's reimbursement structures.

- About 75% of all direct care in Maine is funded through MaineCare.[45] The State's General Fund pays for additional care. The reimbursement system used to pay employers for services to state-funded clients is based on client-approved hours paid on a fee-for-service basis, creating a system of per diem workers without guaranteed hours and a rate structure that does not include payments toward benefits.

- Nursing homes and residential facilities, by contrast, are reimbursed on a cost-basis within specified ceilings, and boarding homes for people with developmental disabilities are reimbursed through a negotiated rate system based on individual needs for services with designated allowable costs.[46]

Also, the unpredictable schedule of home-care services results in many direct-care providers classifying their DCWs as temporary or part-time. Small group direct-care providers, which offer health insurance coverage to full-time employees working at least 30 hours per week, may choose not to cover part-time employees working between 10 and 30 hours per week. DCWs who work less than 10 hours per week are not eligible for coverage at all. [47] Large group direct-care providers do not have these same parameters on coverage of part-time and temporary workers, but must negotiate with an insurance company over who would be eligible for coverage, based on time worked.

Some direct-care employers also note that the requirement many carriers have for a 75% participation rate among eligible employees is a barrier to access in the small group market. State law prohibits insurers from requiring a higher than a 75% employee participation rate. Many carriers use the 75% participation rate requirement to avoid adverse selection, which occurs if only employees with health issues enroll in the plan.

Making informed purchasing decisions

The Working Group also examined barriers that make it more difficult to make informed decisions about coverage options, including adequacy of coverage. Many small businesses lack the time and specific knowledge to research and understand the various

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[44] Paraprofessional Healthcare Institute, *The Invisible Care Gap: Caregivers without Health Coverage, Ten Key Facts*, (May 2008).
[45] Lisa Pohlmann (2005).
[46] Lisa Pohlmann, "A New State Study on the Direct Care Workforce," *Choices: Ideas for Shared Prosperity*, Maine Center for Economic Policy, Volume XIII, No. 3 (April 25, 2007).
[47] Title 24-A, M.R.S.A. §2808-B(1)(C).

insurance products available. This is also the case for DCWs working in home settings searching for the best insurance choices for themselves and their families.

Safety/Wellness

The Working Group also noted that safety and wellness issues are critically important to this workforce. Direct-care work has the third highest rate of on-the-job injury.[48] Nurse aides, orderlies and attendants' injuries and illnesses require more days away from work than any other job in the country.[49] For some DCWs a lack of paid sick time means returning to work before being fully healed.

Additionally, the lack of access to wellness programs is also a challenge for this workforce. Employers across the country are establishing wellness programs as part of their long-term strategies to address rising healthcare costs. These employers believe that keeping their workforces healthy will reduce medical utilization, thereby slowing cost increases in premiums.[50] Given the independent nature of home- and community-based services, DCWs lack access to the types of programs available in other industries.

[48] Bureau of Labor Statistics, U.S. Department of Labor, www.bls.gov/iif/oshwc/osh/case/osch0034.pdf.

[49] Ibid.

[50] Debra A. Draper, Ann Tynan, and Jon B. Christianson, *Health and Wellness: The Shift from Managing Illness to Promoting Health*, Center for Studying Health System Change Issue Brief No. 121 (June 2008).

OPTIONS TO IMPROVE ACCESS TO COVERAGE

The Working Group considered many different alternatives including existing options in the Insurance Code, publicly funded initiatives, and projects modeled after programs in other states.

Insurance Code Options

The Joint Standing Committee on Insurance and Financial Services directed the Bureau of Insurance to "convene a working group of stakeholders to review the State's health insurance laws and consider whether there are provisions under current law that provide an opportunity for group purchasing for direct care workers and their employers."[51] In keeping with this charge, the Working Group identified all possible coverage options currently within the Insurance Code and explored the advantages and disadvantages of each. None of these options require statutory changes. All options include the following consumer protections applicable to all fully insured plans in Maine:

- Guaranteed issue and renewability, regardless of a person's health status or claims history;
- Coverage for pre-existing conditions as long as no break in coverage lasts longer than 90 days;
- Adjusted community rating, allowing premium variation for age, geographic area, group size, and smoking status, but not for gender, health status, claims experience, or policy duration;
- Geographic access limits of 30-minute drive time from a person's home for primary care, and 60-minute drive time from a person's home for specialty and hospital care[52];
- Benefits mandated by statute; and
- The right to appeal a claim denial by an insurance company.

[51] Letter to Mila Kofman, Superintendent of Insurance, from Sen. Nancy B. Sullivan and Rep. John R. Brautigam, Chairs, Joint Standing Committee on Insurance and Financial Services, April 4, 2008.

[52] One exception exists to the geographic access standards. PL 2007, c. 278 codified as 24-A M.R.S.A. §6603(9) permits Multiple Employer Welfare Arrangements, or MEWAs, to offer managed care plans on a pilot basis which do not adhere to geographic access requirements. The exception is in effect from January 1, 2008 until repealed on January 1, 2011, unless extended by the Legislature.

Private Purchasing Alliance
Pursuant to 24-A M.R.S.A. § 2804-A, a private purchasing alliance (PPA) is a corporation created and maintained to provide health insurance to its members through a licensed insurer. To establish a PPA, a separate non-profit corporation must be created; the PPA is policyholder.

One example is the Maine State Chamber Purchasing Alliance, established by the Maine State Chamber of Commerce in 2007.[53] The Alliance offers different coverage options to employers with less than 50 workers, including sole proprietors, who are members of either a local or regional chamber of commerce or the Maine State Chamber of Commerce. The Alliance contracts with Anthem Blue Cross and Blue Shield to offer seven plans in Chamber BlueOptions (eight plans will be offered for 2009). Each worker of member employers can select among all the plans available, which range in deductibles and premiums. Premium rates are comparable to rates available to small businesses directly from Anthem. A 2% wellness discount has recently been made available to businesses with 25-50 employees at renewal.

Considerations:

- A separate corporation must be created and maintained, involving start-up and ongoing costs. The State Chamber advanced approximately $25,000-$30,000 to start the Purchasing Alliance, a stand-alone nonprofit organization. Current operational costs run approximately $75,000 annually. To cover these costs, participating employers pay an annual $50 fee directly to the Purchasing Alliance (in addition to their annual dues to either their local chamber or to the State Chamber).

- The separate corporation must find an insurance carrier to offer health insurance benefits through the PPA.

- Given the experience of the Chamber and what is known about DCWs' health needs and risks, it is unlikely that an alliance created for DCWs would be able to obtain health insurance at lower rates for comparable coverage than the market currently offers.

Trustee Group/Association Group/Labor Union Group
Health insurance benefits can be offered through three types of groups. A person who is a member of the group or whose employer is a member would qualify for the group's health insurance.

[53] Presentation by Dana Connors, Maine State Chamber of Commerce, to the Direct-Care Workforce Health Coverage Working Group, July 30, 2008.

Trustee group - A trust formed pursuant to 24-A M.R.S.A. § 2806 may be established by two or more employers or by one or more labor unions or employee organizations. To be eligible for coverage, a person must either be an employee of a workplace participating in the trust or a member of a participating union or employee organization.

Association group - 24-A M.R.S.A. §2805-A allows a group of at least 50 people to be insured under one policy issued to an association. The association must have been organized in good faith for a purpose other than obtaining insurance and must have been in active existence for at least two years before offering insurance. To be eligible for coverage, one must be either an individual or employer member of the association.

Labor union group - 24-A M.R.S.A. § 2805 allows a group of people to be insured under a policy issued to a labor union or similar employee organization. Only members of the union or employee organization are eligible for insurance. The labor union is the policyholder.

The Working Group received detailed information on the creation and operation of an association group and a labor union group:

- The Maine State Bar Association Group began several decades ago. Initially insuring about 1,000 people, it now insures 200. Large law firms have left the Association and now negotiate with insurers directly. Rates for those in the Association are similar to market rates.[54]

- The SEIU Voluntary Health Care Access Trust Plans, provided through Aetna, offer fully-insured limited benefits coverage to union members who do not have a collective bargaining agreement in place.[55] In 2005, SEIU conducted focus groups around the country; these included DCWs. The benefit packages were designed within the confines of what was considered affordable. These products are available in Virginia, Illinois and California and may become available in other states in 2009.

Considerations:

- A trust or association must be created and maintained, involving start-up and ongoing costs. A trust or association must have sufficient resources to dedicate toward negotiation of the terms of health insurance coverage to be offered to members.

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[54] Presentation by Don Antonucci, Anthem Blue Cross and Blue Shield of Maine, to the Direct-Care Workforce Health Coverage Working Group, July 30, 2008. Additional information provided by Julie Rowe, Maine Bar Association, in phone interview.

[55] Presentation by Mary Anne Turowski (MSEA-SEIU), Mike Sylvester (MSEA-SEIU) and Louise Milone (SEIU Health Care Access Trusts, Washington, DC) to the Direct-Care Workforce Health Coverage Working Group, August 11, 2008.

- An association must be maintained, for purposes other than obtaining insurance, for two years prior to offering insurance for its members. While it could be legally possible for the Maine Personal Assistance Service Association (Maine PASA) – a nonprofit member association for DCWs – to serve as the association for obtaining coverage, some Working Group members noted that it does not have the expertise or resources to serve in this role and that not all DCWs belong to the Association.

- If a large group chooses to leave a trust or an association, it can change the insurance experience for the entire group and result in higher premiums.

- Given the experience of the Bar Association, it is unlikely that premiums would be lower than in the small group market.

Multiple Employer Welfare Arrangement (MEWA)

Maine law (24-A M.R.S.A. §§ 6601-6616) allows MEWAs of at least two employers to pool their risk and collectively self-insure. The nonprofit arrangement must be established by a trade organization, industry association or professional employer association for at least one year, for purposes other than providing insurance, before actively offering insurance. MEWAs determine their own benefit packages and administer the plans themselves or through a third-party administrator. Coverage is only available to workers employed by participating employers.

Examples of such arrangements are the Maine Automobile Dealers Association, the Maine Bankers Association and the Maine Municipal Association. The Working Group decided, based on the requirement of joint and several liability discussed in more detail below, not to investigate this option, and therefore not to meet with representatives of any of these MEWAs.

Considerations:

- The liability of each employer for the obligations of the MEWA is joint and several, which means that if the MEWA is unable to pay its obligations, participating employers are required to pay an assessment. If any of the participating employers do not have sufficient funds to pay an equal share of the assessment, the other employers must make up the difference.

- A nonprofit arrangement must be created and maintained, involving start-up and ongoing costs. Reserves for payment of claims and other capital required, exceeds that needed for any of the other Insurance Code options.

Lowering the Small Group Plan Participation Rate

Pursuant to 24-A M.R.S.A. § 2808-B (4), insurance carriers cannot require more than 75% of eligible employees to participate in an employer's small group health insurance

plan. The law allows, however, a carrier to have a lower participation rate if the carrier chooses to do so.

For example, in developing its private purchasing alliance, the Maine State Chamber of Commerce Purchasing Alliance negotiated with Anthem Blue Cross and Blue Shield for a 60% participation requirement. This was viewed as a "pilot project"[56] by the Bureau of Insurance and stakeholders. Since 2007 (the first year the Alliance was in operation), 23 groups -- less than 5% of the total 482 groups enrolled -- have utilized the lower minimum participation rate.[57] In a 2008 report to the Joint Standing Committee on Insurance and Financial Services, the Bureau of Insurance noted that insufficient data was available to determine whether the groups with participation rates between 60-75% had different claims experience than other groups.[58]

Considerations:

- Carriers view the participation requirement as an important tool to guard against adverse selection in the small group market. Other tools, like a minimum contribution requirement, are prohibited by statute.

- Given the risk factors for DCWs (injury rates, health status), the adverse selection concerns would be difficult for a carrier to overcome. If, however, an employer contributes a significant portion to premiums, the risk of adverse selection may be minimized.

- This option does not address affordability concerns.

Creating a "Bare Bones" Insurance Product Specifically for Direct-care Workers
Some Working Group members noted that a limited insurance policy – with preventive benefits but no hospitalization coverage – might be the only product DCWs could afford.

SEIU presented information on a policy with limited benefits currently offered in several states.[59] SEIU's Voluntary Health Care Access Trust Plans provide preventive and office visit benefits but only limited coverage for other services. Plan A has an annual benefit maximum of $2,000; Plan B's annual maximum is $10,000; Plan C (the richest plan) has an annual maximum of $20,000. Each plan has inside limits for hospital care, diagnostic and outpatient services, and wellness care benefits (preventive care) for each family

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[56] Testimony of Eric A. Cioppa, Acting Superintendent of Insurance, in opposition to L.D. 1102, "An Act to Lower Mandatory Group Participation Rates to 60%" before the Joint Standing Committee on Insurance and Financial Services, March 27, 2007.

[57] Presentation by Dana Connors, July 30, 2008.

[58] Letter from Eric A. Cioppa, Acting Superintendent of Insurance to the Joint Standing Committee on Insurance and Financial Services, RE: Participation Requirements for Small Group Health Insurance, March 4, 2008.

[59] Presentation by Mary Anne Turowski (MSEA-SEIU), Mike Sylvester (MSEA-SEIU) and Louise Milone (SEIU Health Care Access Trusts, Washington, DC) to the Direct-Care Workforce Health Coverage Working Group, August 11, 2008.

member covered. None of the plans covers prescription drugs. SEIU acknowledged the drawbacks of limiting the benefit package – lack of adequate insurance to cover a person who becomes sick. Premium rates are set nationally. With the idea that "something is better than nothing," SEIU designed products within the confines of what was considered affordable by childcare workers and DCWs -- information gleaned from SEIU's focus groups around the country.

Considerations:

- Being underinsured would not accomplish the goal of helping DCWs access necessary medical care and realize some sense of financial security. A recent study found a sharp increase in the number of underinsured adults between 2003 and 2007. That population now totals approximately 14% of the U.S. nonelderly population.[60] Underinsured people reported spending 10% or more of their incomes on out-of-pocket medical expenses.[61]

- People with inadequate coverage report problems accessing medical care, as well as keeping up with basic necessities. In 2007, more than half of the underinsured went without needed care—including not seeing a doctor when sick, not filling prescriptions, and not following up on recommended tests or treatment.[62]

- About 60% of underinsured adults reported problems paying their medical bills or paying off medical debt.[63] Adults who experienced medical bill problems faced dire financial problems: 29% were unable to pay for basic necessities like food, heat, or rent because of their bill; 39% used their savings to pay bills; and 30% took on credit card debt.[64]

- In the United States, it is also reported that illness is the leading cause of personal bankruptcy. Significantly, a majority of filers had health insurance at the time of the bankruptcy.[65]

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[60] Cathy Schoen, Sara R Collins, Jennifer L Kriss, Michelle M. Doty, *How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007*, The Commonwealth Fund (June 10, 2008).
[61] Ibid.
[62] Ibid.
[63] Sara R. Collins, Jennifer L. Kriss, Michelle M. Doty, and Sheila D. Rustgi, *Losing Ground: How the Loss of Adequate Health Insurance Is Burdening Working Families*, The Commonwealth Fund (August 20, 2008).
[64] Ibid.
[65] Himmelstein, David U., Warren, Elizabeth, Thorne, Deborah, and Woolhandler, Steffie. "Marketwatch: Illness and Injury as Contributor to Bankruptcy." Health Affairs – Web Exclusive. 2005 Project HOPE – The People-to-People Health Foundation, Inc.

Insurance Code Options

Option	Defining characteristic(s)	Who could be covered?	Considerations
Private purchasing alliance	Separate corporation created and maintained to provide insurance to members through a licensed insurer.	All size employers, individuals (depending on set-up)	• Rates unlikely to be lower than small group rates • Costs to run separate corporation
Trustee group	2 or more employers, labor unions or employee organizations create a trust to insure participants	All size employers, individuals (depending on set-up)	• Rates unlikely to be lower than small group rates
Association group	An association must have been created and maintained for 2 years for purposes other than insurance.	All size employers, individuals (depending on set-up)	• Rates unlikely to be lower than small group rates
Labor union group	The union/labor organization is the policyholder.	Individual union members or groups (depending on the set-up)	• Rates unlikely to be lower than small group rates
Multiple Employer Welfare Arrangement (MEWA)	Self-insured group with joint and several liability.	All size employers,	• Member employer is liable for the MEWA's financial obligations • Operations costs higher than other options (reserves and other required capital)
Modification of the small group plan participation rate	Decrease the minimum participation rate to below 75% of eligible employees	Small businesses	• Does not address cost of coverage
Limited benefit plans	Benefit package is not comprehensive, possibly excluding first-dollar coverage, hospitalizations, drugs, etc.	All size employers, individuals	• Underinsurance would not ensure access necessary medical care and provide financial security

As the chart above illustrates, considering both price of insurance and ability to pay for what insurance does not cover -- including deductibles, co-insurance, care not covered, and other out-of-pocket financial obligations -- private insurance options are not likely to result in a significant coverage expansion for this workforce (absent significant increases in wages or financial help).

Other Options

Expand the State Employee Health Plan[66]
In addition to employees of Maine State Government, the State Employee Health Plan also allows quasi-governmental employers, such as the Maine Community College System, the Maine Turnpike Authority, the Maine Public Employees Retirement System, and the Maine Maritime Academy to participate. Eligibility has also been extended to two non-governmental groups of individuals: blind persons operating a vending facility under the direction of the Department of Labor's Division for the Blind and Visually Impaired, and licensed foster parents caring for children in the foster parents' residence and reimbursed through the Department of Health and Human Services.

Eligibility for licensed foster parents was extended in part because these individuals rely on public funding and the State Employee Health Plan would offer a better alternative to the individual market. The same public policy consideration would support including DCWs in the State Employee Health Plan. Extending eligibility to DCWs would require amendments to the statute.

Funding would be necessary, however, to make the coverage more affordable. The premium price for the State Employee Health Plan reflects comprehensive benefits with broad access to providers; modest out-of-pocket expenses from enrollees; and a significant retiree population which consumes a disproportionate share of medical and pharmacy expenses. Only two individuals have enrolled under the provision for foster parents in any single year. No one has enrolled under the provision for the visually impaired. The price for coverage has proven to be cost-prohibitive as these individuals must assume the full premium cost – both the employer and employee share.

Considerations:

- The premium costs are high (approximately $7,800 per year for an individual and $19,300 for a family).

- The Plan is a frequent target of proposed legislative cuts affecting benefit design. Most recently, funding was reduced by $3.5 million as part of balancing the FY2009 budget.

- In the absence of claims data it is not known what, if any, impact adding the DCWs would have on the experience of the Plan.

[66] All data on the State Employee Health plan provided by Frank Johnson, Employee Health Commission, September 2008.

- Individuals enrolled in this Plan may not be able to enroll their children in SCHIP because of federal prohibitions.[67]

Provide Injury Prevention Training

Training to help prevent injuries would benefit this workforce. All state-funded consumer-directed care in Maine goes through Alpha One (which was created to act as a fiscal intermediary for consumer-directed care) or through another agency (e.g., Home Care for Maine has a small consumer-directed program). These "employers of record" pay workers compensation insurance, so no DCW working directly for a consumer goes without workers compensation. This is notable because private health insurance policies typically exclude job-related injuries.[68] It is also important because it gives DCWs working in home settings access to Maine Department of Labor's SafetyWorks! Program, a voluntary program designed to reduce job-related injuries.[69] SafetyWorks! services - including training, consultation and information - are available to employers such as Alpha One by request and free of charge.

The Workers' Compensation program for State employees under the Office of Employee Health & Benefits may be another good resource. The injury prevention training programs have demonstrated success in settings such as residential behavioral health facilities.

These programs could provide needed training for DCWs to reduce and prevent work-related injuries and to facilitate an appropriate return to work following an injury consistent with what some large employers are able to offer through their own safety programs.

Publicly Funded Options

The publicly funded options discussed below would require funding and statutory changes.

DirigoChoice

DirigoChoice was designed, in part, to fill a gap for workers and families falling through the cracks – not poor enough to qualify for public insurance (MaineCare) and not making enough to afford private health insurance. DCWs are the type of population that DirigoChoice was intended to assist because of their low-income status and high rate of uninsured. Most DCWs without access to employer-sponsored coverage have household

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[67] Department of Health and Human Services, *Chapter 332: MaineCare Eligibility Manual*, Section 9000.02(II)(D) states, "II. Children Excluded from Coverage: (D) A child who is eligible for coverage under the State Employee Health Insurance program through a relative with whom they are residing."

[68] Although health policies do not ultimately pay for job-related injuries, Title 24-A, §§ 2723-A and 2844 require that private health insurers coordinate benefits with other insurers, including workers compensation insurers, so that consumers can receive medical care as quickly as necessary.

[69] More information on SafetyWorks! can be found at http://maine.gov/labor/workplace_safety/index html.

incomes of less than 150% of the federal poverty level, and would be eligible for a subsidy on the DirigoChoice monthly premium.

The Board of Trustees of the Dirigo Health Agency has discretion to allow employers with more than 50 employees to participate.

If contractual enrollment caps on individuals were lifted and appropriate financing was available, this option would likely achieve the goal of affordable and adequate coverage for DCWs.

Considerations:

- Due to funding constraints, DirigoChoice is currently closed to new enrollment of members requiring subsidies.

- The current contract between Dirigo and Harvard Pilgrim Health Care includes a 50% cap on individual enrollment. DirigoChoice has been at the enrollment cap since July 2007 and over 1,300 individuals are currently on a waiting list.[70]

Create a State-sponsored Discounted Program for Direct-care Workers

Other states have created subsidized programs for specific segments of the workforce:

- Rhode Island created a program specifically for childcare workers and their dependents. Workers rendering at least $7,800 worth of childcare, whose household incomes are between 250-350% FPL, are eligible for sliding-scale State subsidized premiums at one of three private managed care plans. The premium cost to the worker is $61-130/month. There are no copayments. The program costs the state $333 per member per month. Approximately 300 people are covered.[71]

- Legislation passed in Iowa in 2008 established a premium assistance state subsidy pilot program to enable DCWs to purchase health coverage through their employers. This program is to be implemented by December 2009. It is estimated to benefit 250 workers and their dependents.[72]

A variation of either program in Maine could achieve the goal of expanding coverage specifically to DCWs. Such a program could be folded into the Dirigo Health Agency, where an infrastructure has already been developed. Funding would be needed.

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[70] Karynlee Harrington, Dirigo Health Agency, during discussion at the August 11, 2008 meeting of the Direct-Care Workforce Health Coverage Working Group.

[71] Health Care for Health Care Workers (An initiative of PHI). *Coverage Models from the States: Strategies for Expanding Health Coverage to the Direct-care Workforce*, Paraprofessional Healthcare Institute (2007).

[72] Iowa State Assembly Bill Book, *House File 2539 – Enrolled*, http://coolice.legis.state.ia.us/Cool-ICE/default.asp?Category=billinfo&Service=Billbook&menu=false&hbill=HF2539.

Considerations:

- A subsidized program for DCWs would help large direct-care employers as well as smaller businesses and individual DCWs.

- Eligibility requirements could reflect the nature of the work – such as working for multiple employers.

- As with other options, there would be a need for sufficient funding.

Expand MaineCare Eligibility[73]

Another option would entail an eligibility expansion of Maine's Section 1115 waiver (the noncategorical waiver). This currently provides coverage for nondisabled adults under age 65 with incomes below 100% of the Federal Poverty Level (FPL) – approximately $10,400/year for an individual[74] -- who do not have minor children in their custody. To be eligible, individuals must also fall below the $2000 asset limit (after exclusions), and prove citizenship/identity.[75]

To increase noncategorical eligibility to a higher FPL, the state would need to seek to amend the waiver. Waivers of Section 1115 of the Social Security Act are granted by the Centers for Medicare and Medicaid Services (CMS) to allow states to demonstrate policies that have not been implemented on a widespread basis.

The Dirigo Health Reform Act included language that allowed the State to expand eligibility to 125% FPL. This language was repealed. Statutory language would be required to increase the FPL.

Considerations:

- If an amendment to Maine's Section 1115 waiver is obtained, federal Medicaid matching money would be available. So for every dollar paid for MaineCare's expansion for DCWs, the federal government would pay $0.63, and Maine would pay $0.37.[76]

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[73] An expansion of the State Children's Health Insurance Program (SCHIP), an option not discussed by the Working Group, may also be part of the solution. This would require a SCHIP State Plan Amendment.

[74] U.S. Department of Health and Human Services, *The 2008 HHS Poverty Guidelines*, http://aspe hhs.gov/poverty/08Poverty.shtml.

[75] Maine Department of Health and Human Services, *Chapter 332: MaineCare Eligibility Manual*, Section 11000, www maine.gov/sos/cec/rules/10/ch332.htm.

[76] National Conference of State Legislatures, *HHS Releases 2008 FMAP Figures*, www ncsl.org/statefed/health/FY08FMAP htm.

- Because there is already a waiting list, additional funding would be required to raise the eligibility cap over the current 100% FPL for noncategorical MaineCare members.

- Raising the eligibility cap could not be limited to one population or workforce (due to a federal law prohibition), and the expansion could result in the overall addition of approximately 30,000 people to MaineCare.

- Given budget projections and varying policy views on public insurance programs, immediate expansion is unlikely.

Enhance State Reimbursements

Another approach is to pay enhanced MaineCare or General Fund reimbursements specifically earmarked for direct-care employers to provide insurance coverage to their workers (defining minimum coverage requirements to qualify for the enhanced reimbursement). Funding would need to be structured so that there would be no mandatory decrease in DCW hours in order to pay for the reimbursement enhancements.

Other states are implementing or considering similar incentive programs. In 2007, Montana approved legislation, *Healthcare for Montanans Who Provide Healthcare*, which will pay enhanced Medicaid reimbursement rates for home-care providers voluntarily covering their DCWs. Montana is in the process of establishing criteria for coverage standards, including minimum benefits and limits spent by workers on premium share, copays, and out-of-pocket costs.[77] In 2008, Minnesota passed legislation mandating a study of the cost and the percentage increase of reimbursement rates needed to cover direct-care providers' average contributions to employee health insurance. The Minnesota Department of Human Services has contracted with The Lewin Group to complete the study by June 2009.[78]

Considerations:

- Increased MaineCare reimbursements would be partially paid for by federal funding through the Medicaid match.

- The current economic situation and serious budgetary hurdles would make increased reimbursement a challenge to achieve. Available State funds are scarce and competition for these resources is understandably extensive.

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[77] Ingrid J. McDonald and Tameshia Bridges, *Healthcare for Montanans Who Provide Healthcare,* Paraprofessional Healthcare Institute (2008).

[78] Carol Regan, "Study on Health Insurance of Direct Care Workers in Minnesota Underway," *PHI's Health Care for Health Care Workers News* (December 1, 2008), http://hchcw.org/archives/study-on-health-insurance-of-direct-care-workers-in-minnesota-underway.

CONCLUSIONS

Direct-care workers are critical to Maine's future economy, as well as our quality of life. Unfortunately, a "perfect storm" is being created by the projected growth in Maine's population needing long-term care and a shortage of DCWs that is anticipated to grow to crisis levels. Without interventions to better recruit and retain these workers, thousands of Mainers who need long-term care may find few (if any) options. Health coverage is a critical component in the recruitment and retention of DCWs.

Direct-care workers face many barriers in obtaining health insurance. Some of these – such as affordability – affect nearly all DCWs. Others – such as eligibility for employer-sponsored coverage – affect certain segments of the workforce. Home- and community-based workers are less likely to be offered coverage by their employers than their facility-based counterparts, due to the State's reimbursement structure. Finally, with the third highest rate of on-the-job injury in the nation, DCWs could benefit from training to help prevent injuries.

With these barriers in mind, the Working Group considered different alternatives, including existing options in the Insurance Code, publicly funded initiatives and programs, and other options.

- Insurance Code options – including private purchasing alliances, trustee groups, association groups, labor union groups, multiple employer welfare arrangements (MEWAs), modification of the small group plan participation rate, and limited benefit plans – would not provide access to affordable and adequate coverage to DCWs (absent significant increases in wages).

- Other options, including expanding the State Employee Health Plan, would not address the problem of affordability. Without a significant subsidy, the premiums of the State Employee Health Plan would be out-of-reach for the vast majority of DCWs.

- None of the publicly funded options to expand coverage – DirigoChoice, a State-sponsored discount program, expanding MaineCare eligibility, and enhanced State reimbursements earmarked for health coverage – is likely to be viable in the very near term due to the State's budgetary constraints and anticipated cuts to public insurance.

Given the lack of immediate solutions, long-term options should be considered. Given the demographics of DCWs, publicly-funded options would likely best address affordability and access barriers.

Pilot Project

A pilot project could be tried on a limited basis. The pilot project would allow several large home- and community-based direct-care service providers to receive an enhanced

State reimbursement directed toward paying for coverage within DirigoChoice. Specifically:

- The Legislature could direct enhanced General Fund or MaineCare reimbursements specifically to pay solely for coverage through DirigoChoice. Participating employers would be required to demonstrate that the enhanced payments were used in this manner.

- The Dirigo Health Agency would open large group enrollment strictly to the home- and community-based direct-care service providers receiving the enhanced reimbursements.

- Home- and community-based direct-care providers with 50 or more DCWs eligible for coverage could apply to participate in the pilot. Participation would be voluntary. The maximum number of participating firms would be based on the amount of available funding.

- The pilot would provide an opportunity to examine the extent to which employees take up coverage, the level of benefits and premium best suited to the DCW workforce, and the impact providing coverage has on workforce retention.

With the current state of the economy, the lack of funding proves to be the greatest impediment to implementing any pilot or comprehensive solution to the problem of health insurance coverage for DCWs. MaineCare continues to be affected by budget cuts. Any increase in reimbursement rates -- whether in general or specifically for health coverage – would be a challenge at this time.

Considerations:

- DirigoChoice appears to be the most viable publicly-funded option for covering DCWs, as serving this population falls within Dirigo's mission, an infrastructure is in place, and the benefit package is adequate and generally affordable.

- If MaineCare funds are used for the enhanced reimbursements, Maine would receive help from the federal government through a federal match. The additional reimbursement would provide funding to, and a possible incentive for, large direct-care providers to participate in the pilot program.

- The advantage of implementing a pilot is that the take-up rate could be studied to determine the affordability of DirigoChoice to members of this workforce before potentially opening it to all DCWs.

- DirigoChoice is currently not able to enroll new members requiring subsidies, and many DCWs would require these subsidies. Absent a stable and adequate funding source, Dirigo's ability to service a segment of the population for which it was created is limited.

- Several equity issues would require attention. First, perceived inequity could result by the pilot's inclusion of large employers and not individuals. However, this could be offset if the inclusion of larger employers allows the Dirigo Health Agency to increase the number of individuals enrolled. Second, perceived inequity could result by limiting the pilot's inclusion to home- and community-based direct-care providers. However, due to the State's current reimbursement system, home- and community-based DCWs are less likely to be offered employer-sponsored coverage than facility-based DCWs.

Although there are no easy solutions given budgetary constraints and challenges, it is certain that absent effective interventions to provide health coverage to DCWs, the need for DCWs in Maine will outpace the supply.

ATTACHMENTS

A. Letter from the Joint Standing Committee on Insurance and Financial Services

B. LD 1687

C. List of Workgroup Participants

D. List of Meeting Dates and Topics

Attachment A

SENATE

NANCY B. SULLIVAN, DISTRICT 4, CHAIR
PETER B. BOWMAN, DISTRICT 1
LOIS A. SNOWE-MELLO, DISTRICT 15

COLLEEN MCCARTHY REID, LEGISLATIVE ANALYST
JAN CLARK, COMMITTEE CLERK

HOUSE

JOHN R. BRAUTIGAM, FALMOUTH, CHAIR
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CHARLES R. PRIEST, BRUNSWICK
JILL M. CONOVER, OAKLAND
PATSY GARSIDE CROCKETT, AUGUSTA
WESLEY E. RICHARDSON, WARREN
MICHAEL A. VAUGHAN, DURHAM
JONATHAN B. MCKANE, NEWCASTLE
DAVID G. SAVAGE, FALMOUTH

STATE OF MAINE

ONE HUNDRED AND TWENTY-THIRD LEGISLATURE

COMMITTEE ON INSURANCE AND FINANCIAL SERVICES

RECEIVED
APR 07 2008
MAINE BUREAU OF INSURANCE

April 4, 2008

Mila Kofman
Superintendent
Bureau of Insurance
34 State House Station
Augusta, Maine 04333-0034

Dear Superintendent Kofman,

Recently, the Joint Standing Committee on Insurance and Financial Services considered LD 1687, An Act to Increase Health Insurance Coverage for Front-line Direct Care Workers Providing Long-term Care. The legislation proposed to allow providers of long-term care services with more than 50 employees to participate in the DirigoChoice health insurance plan and to allow uninsured direct care workers who work an average of 10 or more hours per week to participate in the DirigoChoice health insurance plan. While members of the committee support the goal of providing access to health coverage for direct care workers, the committee could not support an expansion to the DirigoChoice program at this time.

Although LD 1687 was voted "Ought Not to Pass" by the committee, we believe increased options for health insurance coverage are needed to support the recruitment and retention of direct care workers who provide home care and long-term care for Maine's elderly and persons with disabilities. To that end, we are writing to ask that the Bureau of Insurance convene a working group of stakeholders to review the State's health insurance laws and consider whether there are provisions under current law that provide an opportunity for group purchasing for direct care workers and their employers. In conducting the review, we also ask that the working group identify any potential statutory changes or other public policy options to increase access to private health insurance coverage for direct care workers.

We request that the Bureau submit its findings and any recommendations, including recommendations for legislation, to the committee before October 1, 2008. We also would like you to notify committee members and staff of any working group meetings so

100 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0100 TELEPHONE 207-287-1314

interested members may attend. Please contact us or our legislative analyst, Colleen McCarthy Reid, if you have any questions or would like additional information. Thank you for your consideration of our request.

Sincerely,

Nancy B. Sullivan
Senate Chair

John R. Brautigam
House Chair

cc: Sen. Beth Edmonds
Deborah C. Friedman, Esq., Policy Director, Senate President's Office
Members, Joint Standing Committee on Insurance and Financial Services

Attachment B

123rd MAINE LEGISLATURE

FIRST REGULAR SESSION-2007

Legislative Document **No. 1687**

S.P. 594 March 23, 2007

An Act To Increase Health Insurance Coverage for Front-line Direct Care Workers Providing Long-term Care

Reference to the Committee on Insurance and Financial Services suggested and ordered printed.

JOY J. O'BRIEN
Secretary of the Senate

Presented by President EDMONDS of Cumberland.
Cosponsored by Representative PINGREE of North Haven and Senator: MARRACHÉ of Kennebec, Representatives: BEAUDOIN of Biddeford, CAMPBELL of Newfield, CONNOR of Kennebunk, MILLER of Somerville, PERRY of Calais.

Printed on recycled paper

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 24-A MRSA §6903, sub-§5, as enacted by PL 2003, c. 469, Pt. A, §8, is amended to read:

5. Eligible business. "Eligible business" means a business that employs at least 2 but not more than 50 eligible employees, the majority of whom are employed in the State, including a municipality that has 50 or fewer employees. Notwithstanding this subsection, "eligible business" includes a business with more than 50 employees that provides long-term care services.

After one year of operation of Dirigo Health, the board may, by rule, define "eligible business" to include larger public or private employers.

Sec. 2. 24-A MRSA §6903, sub-§7, ¶B, as enacted by PL 2003, c. 469, Pt. A, §8, is amended to read:

B. An unemployed individual who resides in this State; ~~or~~

Sec. 3. 24-A MRSA §6903, sub-§7, ¶C, as enacted by PL 2003, c. 469, Pt. A, §8, is amended to read:

C. An individual employed in an eligible business that does not offer health insurance~~.~~; or

Sec. 4. 24-A MRSA §6903, sub-§7, ¶D is enacted to read:

D. An individual employed as a direct care worker who works an average of 10 or more hours per week and who is not eligible for MaineCare or employer-sponsored health insurance.

Sec. 5. 24-A MRSA §6908, sub-§2, ¶D, as amended by PL 2005, c. 400, Pt. C, §6, is further amended to read:

D. Develop and implement a program to publicize the existence of Dirigo Health and the Dirigo Health Program and the eligibility requirements and the enrollment procedures for the Dirigo Health Program, including a program targeted at enrolling eligible individuals employed as direct care workers, and to maintain public awareness of Dirigo Health and the Dirigo Health Program;

Sec. 6. Department of Health and Human Services demonstration project for health coverage of direct care workers providing long-term care. By October 1, 2007, the Department of Health and Human Services shall establish a demonstration project to provide financial assistance to providers of long-term care services to increase health insurance coverage among uninsured direct care employees who are not eligible for MaineCare. The department provide financial assistance to eligible providers who provide a health insurance benefit plan to full-time and part-time direct care employees that meets minimum standards as determined by the department taking into consideration the health benefits package provided under the Dirigo Health Program. The department shall establish a cap on the number of providers of long-term care services that receive financial assistance through the demonstration project and must

evaluate the demonstration project for its impact on workforce retention. The department may not expend more than $500,000 to fund the costs of the demonstration project under this section. Rules adopted pursuant to this section are routine technical rules as defined in the Maine Revised Statutes, Title 5, chapter 375, subchapter 2-A.

Sec. 7. Dirigo Health Program health insurance plan for long-term care providers and direct care workers. The Board of Directors of Dirigo Health shall design a targeted DirigoChoice health coverage plan to meet the needs of long-term care employers and their employees who provide direct care services pursuant to Title 24-A, section 6908, subsection 2, paragraph D. The health coverage plan designed by the board pursuant to this section must allow long-term care employers to offer monthly premium assistance to direct care workers eligible for coverage under DirigoChoice as an individual and accommodate contributions for premium assistance from more than one long-term care employer. In designing the plan, the board shall consult with and seek input from long-term care employers and direct care workers. The board may not expend more than $400,000 in subsidy costs for direct care workers eligible for the health coverage plan designed by the board pursuant to this section.

SUMMARY

This bill amends the definition of "eligible business" for the Dirigo Health Program to allow providers of long-term care services with more than 50 employees to participate in the DirigoChoice health insurance plan. The bill also allows uninsured direct care workers who work an average of 10 or more hours per week to participate in the DirigoChoice health insurance plan. The bill directs the Board of Directors of Dirigo Health to develop a marketing and outreach program to enroll those newly eligible direct care workers and to design a targeted DirigoChoice health coverage plan that allows multiple long-term care employers to contribute monthly premium assistance to direct care employees eligible to enroll in Dirigo as an individual. The bill limits the costs to Dirigo Health for subsidies to direct care workers in the targeted DirigoChoice plan to $400,000.

The bill also requires the Department of Health and Human Services to establish a demonstration project for long-term care providers who provide health insurance coverage to their full-time and part-time employees. The bill requires the department to provide financial assistance to allow those providers to start or expand health care coverage for their direct care employees. The bill limits the funding of the demonstration project to no more than $500,000.

Attachment C
Direct-Care Workforce Health Coverage Working Group Participants

Person	Representing
Maine State Legislature	
Sen. Nancy Sullivan	Joint Standing Committee on Insurance and Financial Services
Rep. James Campbell, Sr.	District 138, Cosponsor of LD 1687
Colleen McCarthy-Reid	Joint Standing Committee on Insurance and Financial Services
Direct Care Workers and their Employers	
Mollie Baldwin	Home Care for Maine
Elisabeth Derbach	Kennebec Valley Organization
Mary Lou Dyer	Maine Association for Community Service Providers
Richard Erb	Maine Health Care Association
Joyce Gagnon	Maine Personal Assistance Service Association
Roy Gedat	Direct Care Alliance
Helen Hanson	Local 771, MSEA-SEIU Local 1989
Dan Koehler	Kennebec Valley Organization
Vickie Purgavie	Home Care and Hospice Alliance of Maine
Peter Rice	Disability Rights Center
Eunice Spooner	Kennebec Valley Organization
Joan Donahue Thompson	Hummingbird Home Care
Kurt Wise	Maine Direct Care Worker Coalition
Other Consumer Groups	
Doug Clopp	Consumers for Affordable Health Care
Jack Comart	Maine Equal Justice
Sara Gagne-Holmes	Maine Equal Justice
Other Stakeholders	
Bob Downs	Maine Association of Health Plans
Kristine Ossenfort	Maine State Chamber of Commerce
Elise Scala	University of Southern Maine, Muskie School of Public Service
Mary Anne Turowski	MSEA-SEIU
Maine State Government	
Lloyd Black	Department of Labor
Glenn Griswold	Bureau of Insurance
Karynlee Harrington	Dirigo Health Agency
Frank Johnson	Employee Health Commission
Tony Marple	Department of Health and Human Services - MaineCare
Mila Kofman	Bureau of Insurance
Karma Lombard	Bureau of Insurance
Joanne Rawlings-Sekunda	Bureau of Insurance

Person	Representing
Trish Riley	Governor’s Office on Health Policy and Finance
Judith Shaw	Bureau of Insurance
Norman Stevens	Bureau of Insurance
Pamela Stutch	Bureau of Insurance
Brian Sullivan	Department of Health and Human Services - MaineCare

Attachment D
Meeting Dates and Major Topics Discussed

June 18

- Charge to the Working Group
- Timelines for developing the report
- Demographics of Direct-Care Workers

July 1

- Insurance code analysis

July 14

- Characteristics of Direct-Care Workers and their employers

July 30

- Example of private purchasing alliance (Maine State Chamber Purchasing Alliance)
- Example of association group (Maine Bar Association)
- Other states' approaches

August 11

- Example of labor union plan (SEIU Voluntary Health Care Access Trust Plans)
- Other sample policies
- Discussion of issues/barriers to access
- Discussion of options

August 20

- Further discussion of issues/barriers to access
- Further discussion of options

August 27

- Further discussion of options