



HEALTH CARE AND HUMAN SERVICES POLICY, RESEARCH, AND CONSULTING—WITH REAL-WORLD PERSPECTIVE.

Final **Report Summary** Costs and Options for Insuring Minnesota's Long-Term Care Workforce

Prepared for:
Minnesota Department of Human Services (DHS)

Submitted by:
The Lewin Group

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Report Summary

This Report Summary summarizes the key points from each chapter of the report. Please see the full report for additional technical details on the analysis and further discussion of findings and recommendations.

A) Background and Study Purpose

“Long-term care” includes a wide range of services to help older persons and people with physical disabilities, intellectual and developmental disabilities, and mental health/substance abuse issues live fulfilling, independent, and self-directed lives. Long-term care services are provided in an array of settings including individuals’ homes, group homes, nursing homes, job sites, and schools.

Thousands of Minnesotans of all ages rely on long-term care services because of illness, cognitive impairment, or disability. These individuals count on a consistent, well-qualified workforce to provide support and services in a wide range of settings.

In Minnesota, and in other states nationwide, low wages and lack of health insurance make it difficult to recruit and retain long-term care workers to meet the growing demand for services. As the population of older persons and people with disabilities rapidly increases, the situation will likely worsen in the future. Frequent worker turnover can harm the quality of life of people receiving services, as well as reduce quality of services. High turnover is also expensive, in terms of direct and indirect costs for providers and public long-term care financing programs.¹

Recent economic and political trends compound the problem of access to health insurance for workers. As health insurance costs continue to escalate, businesses nationwide increase costs for coverage and/or reduce coverage for workers. Meanwhile, budget pressures have resulted in cuts to the public insurance safety net for Minnesotans without access to affordable employer coverage.

Given the growing demand for long-term care services and supports – particularly services provided in homes and the community – states must address the barriers to people choosing direct service as a long-term career

¹ Dorie Seavey, *The Cost of Frontline Turnover in Long-Term Care*, Better Jobs Better Care, October 2004. <http://www.bjbc.org/content/docs/TOCostReport.pdf>

path. A growing number of studies indicate that health coverage plays a powerful role in recruitment and retention of direct service workers.²

To address these issues, in 2008, as part of Minnesota health reform legislation, the Minnesota state legislature directed the Department of Human Services (DHS) to conduct a study including “recommendations for a rate increase to long-term care employers dedicated to the purchase of employee health insurance in the private market.”³ The legislation specified that the study include all employees of long-term care providers, not just those who directly provide care services. For example, dietary, maintenance, and housekeeping staff were also included.

DHS contracted with The Lewin Group (Lewin) and its sub-contractors Ingenix Consulting and PHI to conduct the legislatively mandated research.

B) Study Methodology

The study projected participation rates and costs for a rate increase for long-term care employers designated for the purchase of health and dental insurance for their employees and their families. This involved three key study activities:

- ▶ Gather needed actuarial data and other employment-related information from surveys of providers and workers.
 - To gain needed actuarial data for the actuarial analysis, the Lewin team gathered information on the number and characteristics of long-term care workers, current health insurance coverage and costs, and other results from surveys of long-term care employers and employees. The surveys also provided an opportunity for workers and employers to comment on the proposed initiative. We also compared key findings with the available data from other studies on long-term care worker health insurance. In addition, we analyzed data from other sources, including PHI and Lewin analysis of data from the Current Population Survey (CPS) from the Bureau of Labor Statistics (BLS).

- ▶ Analyze actuarial data and develop cost and participation estimates.
 - Ingenix Consulting (IC) projected coverage impacts and costs for six levels of coverage: 1) MinnesotaCare Basic+2 (parents); 2)

² Health Care for Health Care Workers, “Health Insurance Vital to Job Retention,” Fact Sheet, October 2007. <http://www.directcareclearinghouse.org/download/RetentionFactSheet.pdf>

³ Law of Minnesota for 2008, Chapter 358–S.F.No. 3780, Sec. 13. Long-Term Care Worker Health Coverage Study. <https://www.revisor.leg.state.mn.us/laws/?year=2008&type=0&doctype=Chapter&id=358>

MinnesotaCare Basic+1 (non-parents); 3) a plan like MinnesotaCare+1 but without the \$10,000 in-patient hospital limit; 4) the benefits provided by the state employees' health plan (Minnesota Advantage); 5) a sample low deductible (\$100) commercial plan; and 6) a higher (\$500) deductible commercial plan. Finally, IC projected three approaches for how employers obtain the insurance: 1) through the commercial market; 2) through a new risk pool; and 3) directly through MinnesotaCare. IC also projected dental insurance participation rates and costs for a sample commercial and MinnesotaCare dental plan, for both stand-alone (dental can be chosen separately from medical) and dental coverage tied to medical coverage. The study team then projected total program participation and costs for the various plan design/funding approach combinations.

- ▶ Develop implementation options and recommendations.
 - Finally, Lewin and PHI developed recommendations and presented implementation options for implementing a rate increase for health insurance in Minnesota, based on the findings from all components of the study, as well as a review of the experiences of other states.

C) Survey Findings

A total of 910 long-term care workers and 772 providers completed at least some portion of the surveys.

Key findings from the worker survey include:

- ▶ Many long-term care workers in Minnesota do not have private health insurance, primarily because they cannot afford it or they do not work enough hours.
- ▶ 25 percent of all long-term care workers (34% of direct service workers) have been uninsured within the past 12 months.
- ▶ 46 percent of all workers have unpaid medical bills.
- ▶ Coverage rates vary by employment setting and job type:
 - All facility based and all home and community based (HCBS) workers reported little difference in the percent uninsured – 18 percent of facility based and 20 percent of HCBS workers.
 - Different job settings within these categories showed larger disparities. Notably, a related study by Lewin found exceptionally

- high rates of uninsurance among workers in the Minnesota Personal Care Assistance program.⁴
- Disparities also emerged among workers in different occupations. Direct care / direct service workers (DSWs) (home health aides, personal care attendants, certified nursing assistants, direct support professionals, etc.) had the highest uninsurance rates. Compared with “professionals” (e.g., social workers, nurses, physical therapists, psychologists, and administrative staff) and other long-term care employees (e.g., maintenance, dietary, and laundry staff), DSWs also were more likely to work part-time, were more likely to hold more than one long-term care job, had the least longevity on the job, had the lowest incomes, and were more likely to lack private health insurance. At the same time, many of the other employees, particularly those in dietary, housekeeping, maintenance, and similar low-wage jobs, also reported a lack of insurance, low pay, and other challenges.
 - ▶ Many workers – especially in home care – do not qualify for employee benefits because they work less than full-time.
 - Two thirds of workers (66%) work 32 hours or more for the employer who gave them the survey, the amount needed to qualify for coverage under the Minnesota proposal. The remaining third work less than this amount. One approach for expanding coverage to these part-time workers would be to offer full-time work: Of workers without private health coverage, 33 percent said they would try to work 32+ hours a week so they could get health insurance (47 percent said they already work 32+ hours a week). Another possible approach would be to offer coverage to those who work full-time in the long-term care field through more than one job: of workers surveyed with more than one long-term care job, 15 percent said they work 32+ hours through more than one part-time long-term care job.
 - ▶ Many workers spoke of serious problems related to lack of affordable coverage and expressed support for a state initiative to address the issue.

Key findings from the employer survey include:

⁴ The Lewin Group, *Recommendations for Minnesota's Personal Care Assistance Program*, Report for Minnesota Department of Human Services, Disability Services Division, Draft July 2009.

- ▶ 72 percent of providers surveyed offer health insurance and 59 percent offer dental insurance.
- ▶ 81 percent of employers rated lack of health insurance as a “high” or “medium” challenge in retaining workers, second only to low pay (96 percent).
- ▶ Providers generally supported the proposed rate increase for health insurance. Over half (56%) of providers said they support or strongly support the initiative, 21 percent neither oppose nor support it, 17 percent were unaware of it, and 8 percent opposed it.

To build on these findings, PHI and Lewin reviewed 30 previous surveys of long-term care employers or employees about health insurance. The literature supports our key findings, including that many long-term care workers decline health insurance because they cannot afford it, that many do not qualify for coverage because they work less than full-time, and that health insurance benefits is an important factor affecting long-term care employee retention.

D) Actuarial Analysis of Projected Participation and Costs

Actuarial staff from Ingenix Consulting (IC) projected participation and costs for several plan designs and approaches for how employers obtain insurance. The process consisted of six steps: 1) Specify the model insurance plans; 2) Determine funding sources; 3) Describe current employee contribution to plan costs and project change in employee contributions; 4) Describe current participation rates and project increased participation; 5) Project monthly premium rates; and 6) Calculate total projected statewide participation and costs for the various plan design/funding source combinations.

i) Specify the Model Insurance Plans

The legislation specified that the study consider three plan designs, providing the benefit levels of: 1) the MinnesotaCare program for low-income Minnesotans; 2) the state employees' health plan, Minnesota Advantage; and 3) a sample commercial plan but with a deductible limited to \$100.

The actuarial staff of Ingenix Consulting (IC) simulated participation rates and costs for six specific model health insurance benefit plan designs. Because MinnesotaCare includes a number of different plans, IC projected outcomes for three model MinnesotaCare plans. The higher deductible commercial plan, although not consistent with the legislative proposal, was included for comparison purposes and because this design is more typical of plans available in the commercial market.

- Plan 1: MinnesotaCare Basic Plus Two (parents) benefit package (a model commercial plan with the same deductibles, co-pays, benefits, and other elements as the MinnesotaCare Basic Plus 2 plan)
- Plan 2: MinnesotaCare Basic Plus One (non-parents) (\$10,000 annual inpatient max.) benefit package
- Plan 3: MinnesotaCare Basic Plus One (same as Plan 2, but with unlimited inpatient maximum) benefit package
- Plan 4: Minnesota Advantage (the plan for state employees) benefit package
- Plan 5: A sample low deductible commercial plan
- Plan 6: A sample higher deductible commercial plan

Highlights of the six model plans are described in *Table RS.1*, below:

**Table RS.1
Comparison of Insurance Plan Benefits**

	MinnesotaCare + 2		MinnesotaCare + 1, \$10,000 In Patient Maximum	MinnesotaCare + 1, No In Patient Maximum		Minnesota Advantage	Commercial, \$100 Deductible		Commercial, \$500 Deductible	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	\$0		\$0	\$0		See table RS.2	\$100	\$400	\$500	\$1,000
Coinsurance	0%		10% In Patient Only	10% In Patient Only		See table RS.2	20%	40%	20%	40%
Out-of-pocket max [1]	None		None	None		See table RS.2	\$2,000	\$4,000	\$2,500	\$4,500
Copayments										
ER	\$6 Copay for Non Emergency Visits		\$6 Copay for Non Emergency Visits	\$6 Copay for Non Emergency Visits		See table RS.2	\$150	Deductible/coinsurance	Deductible/Coinsurance	Deductible/coinsurance
Primary care	\$3/Copay non-preventative visits		\$3/Copay non-preventative visits	\$3/Copay non-preventative visits		See table RS.2	\$15 [2]	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance
Specialist	\$3/Copay		\$3/Copay	\$3/Copay		See table RS.2	\$30 [2]	Deductible/coinsurance	Deductible/Coinsurance	Deductible/Coinsurance
Preventive	100% covered		100% covered	100% covered		See table RS.2	100% covered	Not covered	100% covered	Not covered
Eye exam	\$3/Copay		\$3/Copay	\$3/Copay		See table RS.2	No	No	No	No
Rx copays										
Generic	\$3		\$3	\$3		See table RS.2	\$10		\$10	
Brand-Preferred	\$3		\$3	\$3		See table RS.2	\$25		\$35	
Brand-Non-preferred	\$3		\$3	\$3		See table RS.2	40% with \$40 minimum		40% with \$50 minimum	

[1] Includes deductible and office visit copays (not Rx copays).

[2] Surgical procedures, laboratory, radiology, etc performed during an office visit are subject to the deductible and coinsurance.

[3] Minnesota Advantage Plans vary by provider level

Table RS.2 Minnesota Advantage Plan Summary of Key Benefit Features Out-of-Pocket Expense				
	Provider Level			
	1	2	3	4
Deductible [1]	\$50	\$140	\$350	\$600
Office Visit Copay [2]	\$17	\$22	\$27	\$37
ER Copay	\$75	\$75	\$75	25%
Inpatient Hospital Copay	\$85	\$180	\$450	25%
Outpatient Surgery Copay	\$55	\$110	\$220	30%
DME	20%	20%	20%	30%
Preventative Services	\$0	\$0	\$0	\$0
Hospice & Skilled Nursing Facility	\$0	\$0	\$0	\$0
Lab, Pathology, Radiology	5%	5%	10%	30%
Other	5%	5%	10%	30%
Rx	← ← ←\$10/\$16/\$30 for all levels → → →			
Out-of-Pocket Max: Non-Rx [1]	\$1,100	\$1,100	\$1,100	\$1,100
Out-of-Pocket Max: Rx [1]	\$800	\$800	\$800	\$800

[1] 2 times for family. Deductible applies prior to all copays & coinsurance

[2] Office visit copay is \$5 more if employer does not complete health assessment and does not agree to a follow-up call from a health coach. Convenience clinics: \$10 copay all levels, and deductible does not apply.

IC also projected costs for two dental insurance benefit plan designs: a model dental benefit that provides the benefits of MinnesotaCare dental insurance, and a typical commercial PPO dental plan. The dental plans were modeled for both stand-alone (dental can be chosen separately from medical) and dental insurance tied to medical coverage.

ii) Determine Funding Sources

The legislation specified that the study develop estimates assuming the insurance would be purchased in the commercial market. For comparison purposes and at the request of DHS, IC developed cost projections for two additional purchasing mechanisms: a dedicated risk pool and the plan as part of MinnesotaCare. The main difference between the three options was the proportion of premium devoted to expenses other than benefits, referred to in this study as “non-benefit costs.” In addition, health care provider reimbursement under MinnesotaCare would be at MinnesotaCare levels, which is similar to Medical Assistance reimbursement levels.

For a comparison of non-benefit costs see *Table RS.3*.

Table RS.3: Non-Benefit Costs for Model Plans		
	Percent of Premium for Non-Benefit Costs	Types of Non-Benefit Costs Included
Funding Source A - Commercial Market	For health insurance: 22.5% for small group 17.0% for large group	Administrative costs Broker commission Premium tax Assessment for MCHA
	For dental insurance tied to medical: 20% for small group 14.5% for large group	
	For stand-alone dental: 29% for small group 22% for large group	
Funding Source B - Risk Pool	10.25% for all plans	Administrative costs Catastrophic claim reinsurance costs Start-up costs Costs to build up stabilization reserve
Funding Source C - Minnesota Care	9% for all plans	Administrative costs

iii) Describe Current Employee Contribution to Plan Costs and Project Change in Employee Contributions

Based on the results of the employer survey, the current plans offered by long-term care providers require relatively high average employee contributions.

Table RS.4: Current Employee Contribution Levels Based on Employer Survey				
	Small Group (50 or fewer eligible employees)		Large Group (51+ eligible employees)	
	Single EE	Family	Single EE	Family
Medical Coverage				
Average employee monthly contributions	\$144.38	\$483.95	\$109.06	\$503.77
as % of total plan cost	27.3%	48.2%	22.8%	39.7%
Dental Coverage				
Average employee monthly contributions	\$23.66	\$70.57	\$16.43	\$54.94
as % of total plan cost	43.7%	55.7%	41.2%	54.1%

These figures are very similar to the findings from the Minnesota Department of Health’s 2002 study, which reported average employee contributions of 24 percent for individual coverage and 45 percent for family coverage. In other studies examining long-term care employee health insurance, employee contributions for individual coverage have ranged from 23.5 percent to 65 percent, or between \$50 and \$193.

The proposed plan requires that employee contributions be no higher than these ranges for state employees. Therefore, IC modeled, for all plans, the impact of these monthly employee contributions on employee participation.

Table RS.5: Proposed Monthly Employee Contribution Rates ⁵				
	Small Group (50 or fewer eligible employees)		Large Group (51+ eligible employees)	
	Single Employee	Family	Single Employee	Family
Medical	\$0.00	\$130.20	\$0.00	\$130.20
Dental	\$5.00	\$34.16	\$5.00	\$34.16

⁵ While the employee contribution amount is the same for all proposed plans, the employer contribution, and hence the percentage contributions, vary by plan type.

iv) Describe Current Participation Rates and Project Increased Participation

Based on the employer survey, the **current participation rates in medical and dental plans**, expressed as percentage of employees eligible for coverage, are approximately:

- ▶ Small group (50 or fewer eligible employees): 50% for single coverage; 18% for family coverage
- ▶ Large group (51 or more eligible employees): 53% for single coverage; 28% for family coverage

Based on the employee survey, a significant number of these employees are covered by plans other than the one offered by the surveyed employer. A commercial carrier underwriting a group would consider these employees to have “other valid coverage” and not count them in the minimum participation requirement. IC therefore adjusted the current medical plan participation levels to reflect only those employees without other valid coverage. This adjustment increased the participation rate for small group single coverage from 50 percent of eligible employees to 73 percent of eligible employees without other valid coverage. The remaining **adjusted current medical participation rates** are shown below:

- ▶ Small group: 73% for single coverage; 26% for family coverage
- ▶ Large group: 77% for single coverage; 41% for family coverage

For dental plans, the current participation rates are approximately:

- ▶ Small group: 67% for single coverage; 20% for family coverage
- ▶ Large group: 71% for single coverage; 34% for family coverage

Other dental coverage is probably less common. Individual dental coverage is rare, and COBRA dental is unlikely given its cost. Therefore, it was not necessary to adjust dental participation rates to take into account other valid coverage.

Table RS.6 displays projected participation rates for each of the plans for the Metro region. While participation rates vary by region, the patterns are similar across regions. The proposed single employee contribution is \$0. Because this is non-contributory coverage, **the projected participation rate for individual coverage is always 100 percent.**

The employee survey indicates a very high level of price sensitivity among these workers. **Only 41 percent of surveyed employees said that they are**

willing to pay \$100 per month or more for family medical coverage. The family coverage participation rates vary as shown above in *Table RS.5*. As one would expect, the highest projected participation rates are with the two MinnesotaCare benefit package Plans 1 and 3, the plans with the best benefits and highest total plan costs (and hence highest plan “values”), but at the same employee contribution amount as the lesser plans. Projected participation is higher for large groups, because the base current plans’ participation rates, from which IC projected the new plans’ participation, are higher to begin with.

Table RS.6: Projected Increased Employee Participation Rates - Medical*				
Metro	Small Group (<51 eligible employees)		Large Group (51+ eligible employees)	
	Single Employee	Family	Single Employee	Family
MinnesotaCare Basic+2	100.0%	47.5%	100.0%	58.7%
MinnesotaCare Basic+1, \$10K in-patient limit	100.0%	35.8%	100.0%	46.9%
MinnesotaCare Basic+1, no in-patient limit	100.0%	48.2%	100.0%	59.3%
Minnesota Advantage	100.0%	41.6%	100.0%	52.7%
Commercial Plan, \$100 ded	100.0%	41.6%	100.0%	52.7%
Commercial Plan, \$500 ded	100.0%	40.6%	100.0%	51.7%

Because the proposed dental plan has an employee contribution for single coverage, the projected single participation level is less than 100 percent. For this group of employees with generally modest incomes, even the proposed low \$5 monthly contribution for single coverage may be enough to dissuade many employees from taking dental coverage.

Table RS.7: Employee Projected Increased Participation Rates - Dental				
Metro	Small Group (<51 eligible employees)		Large Group (51+ eligible employees)	
	Single Employee	Family	Single Employee	Family
Tied to Medical Coverage				
MinnesotaCare Plan	82.4%	35.7%	84.6%	48.5%
Commercial Plan	80.5%	30.2%	82.6%	42.6%
Stand-alone				
MinnesotaCare Plan	82.9%	37.3%	85.1%	50.0%
Commercial Plan	81.4%	32.8%	83.5%	45.1%

v) Project Monthly Premiums Rates

IC actuarial staff projected the premium rates for each model health and dental plan/funding source combination. The table below shows the **projected monthly premium** for each model health plan for the year 7/1/2009 through 6/30/2010, for all regions averaged together, with the projected increased employee participation levels. The projected rates are based on an IC model that incorporated provider reimbursement levels, network utilization, regional variations in costs, survey findings on employee demographics, and selection factors. This is the total premium (i.e., employer plus employee portions of cost).

Table RS.8: 2010 Total Projected Monthly Premiums for Health Insurance for LTC Workers: Weighted Average of All Regions With Projected Increased Employee Participation Levels				
Funding Source & Benefit Plan	Small Group (<51 eligible employees)		Large Group (51+ eligible employees)	
	Single Employee	Family	Single Employee	Family
A. Coverage from market				
MinnesotaCare Basic+2	\$443.89	\$1,539.09	\$414.70	\$1,328.42
MinnesotaCare Basic+1, \$10K IP limit	369.94	1,454.31	345.61	1,197.31
MinnesotaCare Basic+1, no IP limit	440.14	1,526.08	411.19	1,317.18
Minnesota Advantage	390.81	1,415.11	365.10	1,212.62
Commercial Plan, \$100 ded	381.38	1,380.99	356.30	1,183.39
Commercial Plan, \$500 ded	363.80	1,348.95	339.88	1,128.83
B. Coverage from dedicated risk pool				
MinnesotaCare Basic+2	\$383.30	\$1,327.91	\$383.30	\$1,227.85
MinnesotaCare Basic+1, \$10K IP limit	319.44	1,254.74	319.44	1,106.67
MinnesotaCare Basic+1, no IP limit	380.06	1,316.68	380.06	1,217.47
Minnesota Advantage	337.46	1,220.92	337.46	1,120.82
Commercial Plan, \$100 ded	329.33	1,191.48	329.33	1,093.80
Commercial Plan, \$500 ded	314.15	1,163.86	314.15	1,043.37
C. Coverage directly from MinnesotaCare				
MinnesotaCare Basic+2	\$210.51	\$729.27	\$210.51	\$674.32
MinnesotaCare Basic+1, \$10K IP limit	189.53	744.45	189.53	656.60
MinnesotaCare Basic+1, no IP limit	208.14	721.06	208.14	666.73

The highest cost health plans are the MinnesotaCare Basic+2 and Basic+1 with no in-patient limit purchased in the commercial market. The lowest cost plan in the commercial market is the \$500 deductible commercial plan. Providing insurance through a new dedicated risk pool resulted in

significantly lower costs. The availability and funding scenario in which the plan is actually part of MinnesotaCare produces lower costs than insurance obtained in the commercial market, due to the low provider reimbursement rates and lower non-benefit costs of MinnesotaCare.

Table RS.9 shows model rates for the dental plans. The commercial dental plan – with coinsurance and a deductible applied to basic and major procedure costs and a \$2,000 annual benefit – has a total cost (employer plus employee contributions) that is 44 percent less expensive than the MinnesotaCare model plan that provides 100 percent coverage without a deductible and a high, \$5,000, benefit maximum.

Table RS.9: 2010 Projected Premiums for Dental Insurance for LTC Workers: Weighted Average for All Regions				
Funding Scenario & Benefit Plan	Small Group (<51 eligible employees)		Large Group (51+ eligible employees)	
	Single Employee	Family	Single Employee	Family
A. Coverage from market				
Tied to Medical Coverage				
MinnesotaCare Plan	\$ 69.84	\$ 173.83	\$ 65.38	\$ 159.65
Commercial Plan	40.31	102.11	37.74	93.94
Stand-alone				
MinnesotaCare Plan	89.81	223.53	81.75	199.13
Commercial Plan	50.91	128.98	46.34	113.92
B. Coverage from dedicated risk pool				
Tied to Medical Coverage				
MinnesotaCare Plan	\$ 62.25	\$ 154.95	\$ 62.25	\$ 152.01
Commercial Plan	35.94	91.02	35.94	89.44
Stand-alone				
MinnesotaCare Plan	71.05	176.84	71.05	173.06
Commercial Plan	40.28	102.04	40.28	99.01
C. Coverage directly from MinnesotaCare				
Tied to Medical Coverage				
MinnesotaCare Plan	\$ 30.70	\$ 76.41	\$ 30.70	\$ 74.96
Stand-alone				
MinnesotaCare Plan	35.04	87.20	35.04	85.34

vi) Calculate Total Projected Statewide Participation and Costs

Based on the above analysis, the study team projected the total number of participants in each plan/funding source combination to develop an estimate of the cost to cover all participating long-term care workers and their families.

The **total number of LTC employees** was derived from low and high estimates of the number of long-term care workers in the state (77,000 and 181,000), taken from a report from the Minnesota Department of Health in 2002 entitled *Employer-Sponsored Health Insurance in the Minnesota Long-Term Care Industry: Status of Coverage and Policy Options*. A medium estimate was added based on the average of the two figures (129,000). Based on the employee survey, we estimated 66 percent of employees work enough hours to be eligible for benefits.

The statewide figures combine projections for single employees and employees with families, small group (50 or fewer) and large group (51 or more) employers, and for each combination of medical plans, dental plans, and funding sources.

Table RS.10 shows the **projected numbers of participants in health insurance** for each funding approach.

To estimate total participation, we added together: 1) the projected number of employees without families who enroll in individual coverage (100 percent for all plans because there is no cost to employees to enroll); 2) the number of employees with families who purchase family coverage (varies by plan depending on the richness of the plan); and 3) the number of employees with families who enroll in individual coverage (i.e., all employees with families who do not purchase family coverage).

Table RS.10: Total Projected Participation in Medical Insurance (Combined Metro & Non-Metro, Small and Large Group)					
Medical Plan		Percent of Eligible Employees Participating	Low Estimate	Med Estimate	Hi Estimate
MinnesotaCare Basic +2	Individual Coverage	100% of eligible employees not enrolled in family coverage -- <u>for all plans</u>	28,336	47,471	66,607
	Family Coverage	47.5% small group, 58.7% large group	22,484	37,669	52,853
	Total Enrolled	100% of eligible employees -- <u>for all plans</u>	50,820	85,140	119,460
MinnesotaCare Basic +1 \$10k In-Patient Limit	Individual Coverage		33,031	55,338	77,645
	Family Coverage	35.8% small group, 46.9% large group	17,789	29,802	41,815
	Total Enrolled		50,820	85,140	119,460
MinnesotaCare Basic +1 No In-Patient Limit	Individual Coverage		28,093	47,065	66,037
	Family Coverage	48.2% small group, 59.3% large group	22,727	38,075	53,423
	Total Enrolled		50,820	85,140	119,460
Minnesota Advantage	Individual Coverage		30,729	51,481	72,233
	Family Coverage	41.6% small group, 52.7% large group	20,091	33,659	47,227
	Total Enrolled		50,820	85,140	119,460
Commercial \$100	Individual Coverage		30,741	51,500	72,260
	Family Coverage	41.6% small group, 52.7% large group	20,079	33,640	47,200
	Total Enrolled		50,820	85,140	119,460
Commercial \$500	Individual Coverage		31,137	52,164	73,191
	Family Coverage	40.6% small group, 51.7% large group	19,683	32,976	46,269
	Total Enrolled		50,820	85,140	119,460

The total projected participation in dental insurance is summarized in the *Table RS.11*:

Table RS.11: Total Projected Participation in Dental Insurance (Combined Metro & Non-Metro, Small and Large Group)					
Dental Plan		Percent of Eligible Employees Participating	Low Estimate	Med Estimate	Hi Estimate
Minnesota Care - Tied to Medical	Individual Coverage	82.4% Small Group 84.6% Large Group	27,585	46,215	64,844
	Family Coverage	35.7% Small Group 48.5% Large Group	17,883	29,960	42,037
	Total Enrolled		45,469	76,175	106,881
Minnesota Care - Stand Alone	Individual Coverage	82.9% Small Group 85.1% Large Group	27,184	45,541	63,899
	Family Coverage	37.3% Small Group 50.0% Large Group	18,602	31,165	43,728
	Total Enrolled		45,786	76,706	107,627
Commercial - Tied to Medical	Individual Coverage	80.5% Small Group 82.6% Large Group	28,949	48,500	68,050
	Family Coverage	30.2% Small Group 42.6% Large Group	15,318	25,662	36,006
	Total Enrolled		44,267	74,161	104,056
Commercial - Stand Alone	Individual Coverage	81.4% Small Group 83.5% Large Group	28,350	47,496	66,642
	Family Coverage	32.8% Small Group 45.1% Large Group	16,475	27,601	38,726
	Total Enrolled		44,825	75,096	105,368

The projections of **total costs** for the plans are the costs of the health and dental plan combination, based on IC's projections for increased participation. Total costs for the employer portion of the premium varied widely, depending on the plan design and funding approach selected, from an average of \$340 to \$879 per insured worker per month, or a total of \$17.3 million to \$105.1 million a month depending on the number of workers and the model plan and funding source selected by the state (*Table RS.12*). For the mid-range estimate of the number of workers, total monthly costs ranged from \$28.9 million to \$74.9 million. The total costs include the employer plus employee share. The employer share would be paid through a combination of Federal Medical Assistance match, state funds, and any required employer

contributions. The employee share could be paid by the employee, or by a subsidy provided by the employer or the state.

A mid-cost option is a plan modeled after Minnesota Advantage, with commercial dental insurance tied to medical insurance. This plan would cost \$698 per insured worker per month, or \$59.5 million a month to cover all participating workers and their families, using the medium estimate for the number of workers in the commercial market. A new dedicated risk pool could lower costs to an estimated \$634 per insured worker per month, or \$54.1 million total monthly costs.

The lowest costs were for the option in which the plan is actually part of MinnesotaCare itself, with a cost per insured worker from \$340 to \$396. This is because the average provider reimbursement in MinnesotaCare is assumed to be at the Medical Assistance level, which is far less than provider reimbursement under commercial plans. Also, MinnesotaCare has much lower non-benefit, or administrative, costs than typical commercial plans.

For the options where insurance is purchased commercially, the lowest cost plan was the \$500 deductible commercial plan, purchased through a new dedicated risk pool, with dental tied to medical (\$586 per member per month). The \$100 deductible plan cost somewhat more, at \$618 per member per month if purchased through a dedicated risk pool. The medical plans with the benefits of MinnesotaCare, purchased through the market, were the most expensive options (\$673 to \$877 per member per month). The projected total costs for each scenario are included in *Table RS.11*, below:

Medical Plan & Dental Plan	Funding Source	Dental Plan Type	Average Cost per Insured Worker per Month	Estimated Total Monthly Cost (In Millions)		
				Low Estimate # of workers	Med Estimate # of workers	Hi Estimate # of workers
MinnesotaCare +2 / MinnesotaCare Dental	Market	Tied to Medical	\$854	\$43.4	\$72.8	\$102.1
		Stand Alone	879	44.7	74.9	105.1
	Dedicated Risk Pool	Tied to Medical	777	39.5	66.2	92.9
		Stand Alone	791	40.2	67.4	94.6
	MinnesotaCare	Tied to Medical	389	19.8	33.2	46.6
		Stand Alone	396	20.1	33.7	47.3
MinnesotaCare Basic +1 10k IP with MinnesotaCare Dental	Market	Tied to Medical	\$673	\$34.2	\$57.3	\$80.4
		Stand Alone	716	36.4	60.9	85.5
	Dedicated Risk Pool	Tied to Medical	629	31.9	53.5	75.1
		Stand Alone	642	32.6	54.7	76.7

Table RS.12: Combined Monthly Medical and Dental Insurance Monthly Costs Excluding Employee Contributions						
Medical Plan & Dental Plan	Funding Source	Dental Plan Type	Average Cost per Insured Worker per Month	Estimated Total Monthly Cost (In Millions)		
				Low Estimate # of workers	Med Estimate # of workers	Hi Estimate # of workers
	MinnesotaCare	Tied to Medical	340	17.3	28.9	40.6
		Stand Alone	346	17.6	29.5	41.4
MinnesotaCare Basic +1, No IP with MinnesotaCare Dental	Market	Tied to Medical	\$834	\$42.4	\$71.0	\$99.6
		Stand Alone	877	44.6	74.7	104.7
	Dedicated Risk Pool	Tied to Medical	775	39.4	66.0	92.6
		Stand Alone	789	40.1	67.1	94.2
	MinnesotaCare	Tied to Medical	387	19.6	32.9	46.2
		Stand Alone	393	20.0	33.5	47.0
Commercial Plan, \$100 Ded with Commercial Dental	Market	Tied to Medical	\$670	\$34.1	\$57.2	\$80.2
		Stand Alone	693	35.3	59.1	83.0
	Dedicated Risk Pool	Tied to Medical	618	31.5	52.7	74.0
		Stand Alone	625	31.8	53.3	74.8
Commercial Plan, \$500 Ded with Commercial Dental	Market	Tied to Medical	\$634	\$32.3	\$54.1	\$75.9
		Stand Alone	658	33.5	56.1	78.7
	Dedicated Risk Pool	Tied to Medical	586	29.8	49.9	70.1
		Stand Alone	592	30.1	50.5	70.8
MinnesotaAdvantage with Commercial Dental	Market	Tied to Medical	\$698	\$35.5	\$59.5	\$83.5
		Stand Alone	711	36.2	60.6	85.0
	Dedicated Risk Pool	Tied to Medical	634	32.3	54.1	75.9
		Stand Alone	641	32.6	54.6	76.7

Low Estimate: Assumes 77,000 employees; 50,820 eligible for coverage
 Med Estimate: Assumes 129,000 employees; 85,140 eligible for coverage
 Hi Estimate: Assumes 181,000 employees; 119,460 eligible for coverage

E) Conclusions, Recommendations, and Implementation Options

The surveys document that low wages, part-time and fluctuating hours, and eroding employer benefits leave many long-term care employees without access to affordable coverage. At the same time, small size, rising insurance costs, and heavy reliance on public funding make it difficult for many long-term care employers to offer affordable coverage to their employees. This section presents recommendations and implementation considerations for a rate increase to expand coverage for this workforce, based on findings from all components of the study, as well as examples and lessons learned from other states.

i) Recommendations for Benefit Plan Design and Funding Options

The legislation mandated that this study develop estimates of a rate increase for insurance assuming the insurance would be obtained in the commercial market.

1. The plan modeled after Minnesota Advantage, with the commercial dental plan tied to medical, provides the most cost effective plan with reasonable coverage for this workforce.

Because individual premiums are \$0 for all plans, the main areas where the plans differ are in projected costs and projected enrollment in family coverage:

- ▶ The MinnesotaCare+2 plan and the model plan of MinnesotaCare+1 without the \$10,000 in-patient limit are the most expensive plans (*Table RS.12*), but also result in higher enrollment in family coverage, due to the better benefits. These may not be the most advantageous plans for covering all eligible long-term care employees because of the very high cost.
- ▶ We recommend the plan modeled after Minnesota Advantage. This plan has a total cost that is about 2.5 percent higher than the \$100 deductible plan, but has a better chance of controlling future cost increases due to its tiering structure. Our recommendation assumes that a commercial carrier or third party administrator (TPA) – usually a claims processor⁶ – can develop a tiered provider network for the plan.
- ▶ We do not recommend the \$500 sample commercial plan or the MinnesotaCare+1 plan with the \$10,000 in-patient limit, because these plans would not provide adequate coverage for this workforce.

For a dental plan, we recommend the commercial plan tied to medical coverage. As with medical coverage, the MinnesotaCare dental plan is very costly. Tying dental coverage to medical coverage can increase participation in the initiative. One of the stated goals is to reduce the number of employees and their families who are now in public plans. If stand-alone dental coverage is offered, some employees may stay in the public medical plan but take the separate dental plan. This would result in employees and their dependents remaining in the more costly public medical plans, and dental costs being higher due to anti-selection by employees choosing just the dental insurance.

⁶ A TPA is essentially an entity that doesn't take insurance risk but just pays claims, arranges the provider network, and performs disease management, and similar functions.

2. Montana provides an example of the feasibility of a rate increase to cover health insurance.

Although several states (including Minnesota) have enacted rate increases designated for wages (called wage pass-throughs), Montana is the first and to date only state to establish a health insurance pass-through. Montana's plan was launched in January 2009 for employers delivering Medicaid-funded personal assistance or private duty nursing services. The coverage is for individuals only. Employers may choose their own plan as long as it meets the state's "benchmark" criteria for an insurance plan, which stipulates a maximum \$1,000 individual and \$3,000 family deductible, 70 percent co-insurance, individual premium no greater than \$25/month, and other plan design requirements.⁷

The program is voluntary and was expected to cover about 1,000 uninsured workers. As of April 2009, the plan covers 900 personal assistance services workers and private duty nurses.⁸ Across the state, approximately 4,000 caregivers provide personal assistance services. In the first round of funding for the Montana program, 20 of the 28 Medicaid personal assistance service agencies (71%) participated in the rate increase for insurance.⁹ Seven of the 20 Medicaid private duty nursing (PDN) agencies participated, and these 7 agencies provide approximately 71 percent of the total PDN services in Montana. Montana's health insurance program is more limited in scope in several respects than the plan under consideration in Minnesota (*Table RS.13*).

⁷ Montana Department of Public Health and Human Services, "Department's Benchmark Standards," <http://www.dphhs.mt.gov/sltc/services/communityservices/HCWorkers/Index.shtml>

⁸ Conference call with staff at Montana Department of Health and Human Services, Senior Long-Term Care Division, April 2009.

⁹ Montana Department of Public Health and Human Services, "Health Care for Direct Care Workers Application 1 Report." <http://www.dphhs.mt.gov/sltc/services/communityservices/HCWorkers/Index.shtml>

Table RS.13: Montana and Minnesota Health Insurance Initiative Designs		
	Montana Health Insurance Rate Increase	Minnesota Proposed Rate Increase
Employees covered	Direct care workers in Medicaid-funded personal assistance and private duty nursing service providers only. The state is studying how the program would work for nursing homes and developmental disability service providers.	All long-term care employees
Coverage type	Individual coverage only; dental is optional if employer funding allows	Individual and family coverage; medical and dental
Key features of plan design	Max \$1,000 individual and \$3,000 family deductible 70% co-insurance Individual premium no greater than \$25/month	\$100 deductible for model commercial plan Co-pays vary by model plan design Individual premium \$0

Although the Montana plan differs in scope from the Minnesota proposal, most closely resembling the \$500 sample commercial deductible plan, we recommend that Minnesota keep abreast of developments in Montana for potential ideas and lessons learned.¹⁰

3. Creating a dedicated risk pool could significantly reduce costs.

Sharing the risk is essential for lowering insurance premiums. That is why it is easier for large companies with multiple facilities that share a single health plan to make insurance affordable. In the employer survey, several employers commented that their small size made it difficult for them to obtain affordable health insurance benefits for their employees.

In Ingenix Consulting’s (IC) actuarial analysis, projected costs for commercially purchased insurance were significantly lower when purchased through a new dedicated risk pool. This is primarily due to the lower administrative and other non-benefit costs of a risk pool.

¹⁰ For more information, contact Mike Hanshew, Montana Health Solutions, LLS mikeh@consumerdirectonline.net, PHI, *Coverage Models from the States*, 2007. . See also the Montana Department of Health and Human Services’ Health Care for Health Care Workers web page at <http://www.dphhs.mt.gov/sltc/services/communityservices/HCWorkers/Index.shtml>.

We recommend coverage be obtained from carriers in the commercial market for the first five years of the program. After the first five years of operation, the plan would have enough experience on which to base premiums and to build a dedicated risk pool. This is ultimately the better approach, provided that all long-term care employers that accept the rate increase from the state would have to get their benefit plan from the dedicated risk pool.

A few states have considered health insurance risk pools for long-term care employers. Montana has an insurance pool for small businesses (2 to 9 employees) called "Insure Montana," which is not specific to healthcare workers.¹¹ However, this strategy has had limited impact on long-term care workers, because most home care agencies have more than 10 employees. The Wisconsin Regional Training Partnership, the nonprofit training organization affiliated with the Wisconsin AFL-CIO, established an innovative purchasing arrangement – a union-sponsored Professional Employer Organization (PEO).¹² A PEO is a co-employment strategy in which participating employers share a human resources service to reduce costs. Although the risk pool helped reduce costs, a subsidy was also needed to make insurance affordable to employers.

4. Providing insurance directly through MinnesotaCare would be a less expensive approach, but low provider reimbursement rates could present a challenge.

For comparison purposes, the study also projected participation and costs for the approach where insurance was actually part of MinnesotaCare. This funding option yielded significantly lower projected costs due to the much lower provider reimbursement rates and non-benefit costs of MinnesotaCare compared with the typical commercial plan. However, this approach may be unrealistic because providers would have to accept very low reimbursement for private employer plans. The result could be that many providers, particularly outside the Twin Cities, would refuse to accept the plan's reimbursement, and members would be left with a very limited provider network.

In addition, this approach would not leverage as much in federal funds. For a Medical Assistance rate increase, the state could capture the 60.19 percent temporary enhanced Federal Medical Assistance match for reimbursements for services provided by the American Recovery and Reinvestment Act

¹¹ PHI Health Care for Health Care Workers, Case Study: Montana, "Healthcare for Montanans Who Provide Healthcare," http://www.dswresourcecenter.org/tiki-download_file.php?fileId=27

¹² PHI, *Subsidizing Health Insurance Coverage for the Home Care Workforce in Two Wisconsin Counties: An Analysis of Options*, February 2007, <http://www.directcareclearinghouse.org/download/HealthInsCovWIreport.pdf>

(ARRA). The match reverts back to 50 percent in January 2011. By comparison, the federal match for MinnesotaCare (31 percent in 2007)¹³ is much lower, because there is no federal match for adults without children in MinnesotaCare.

ii) Implementation Recommendations, Options, and State Examples

Several criteria are critical to ensuring the success of the proposed Minnesota long-term care workforce health insurance initiative. The 2008 Minnesota health reform legislation identified two key criteria that the proposal should meet:

- ▶ Ensures equitable treatment between employers that currently offer insurance and those who do not, and those with differing insurance costs and plans,
- ▶ Ensures the requirement that the rate increase be expended for the intended purpose.

In addition, a 2007 PHI report about the experiences of the CMS DSW Demonstration grantees identified five key design elements for this workforce:¹⁴

- ▶ Accessible to all long-term care workers,
- ▶ Affordable for workers and employers,
- ▶ Adequate benefit plan,
- ▶ Simple, easy to understand and enroll in, and
- ▶ Sustainable over time.

This chapter provides recommendations for how the Minnesota initiative can meet these goals, based on the results of the surveys, actuarial analysis, and review of other states' experiences.

1. To ensure equitable treatment of providers, make participation voluntary and do not base eligibility on previous expenditures for health insurance.

Some employers in Minnesota have emphasized health coverage, while others have offered better wages.¹⁵ Hence, the Minnesota Health Care for

¹³ Minnesota House of Representatives, December 2008, "MinnesotaCare," <http://www.house.leg.state.mn.us/hrd/pubs/mncare.pdf>

¹⁴ PHI, Emerging Strategies for Providing Health Coverage to the Frontline Workforce in Long-Term Care.

¹⁵ The Minnesota Legislative Commission on Health Care Access, Health Care for Long-Term Care Workers working group, 2007.

Long-Term Care Workers working group recommended that the state address fair treatment of providers regardless of prior decisions on the issue of better health insurance benefits versus better wages. This issue was also identified in the legislation mandating this study.

Montana's initiative provides an example of how to meet this goal, as the amount of the rate increase is based on the percentage of revenue a provider receives from Medicaid, and not on previous expenditures for health insurance or wages. If an agency's current plan meets the benchmarks, the agency can use the enhanced rate to offer the current plan to their uninsured workers.¹⁶ If the agency's plan does not meet the benchmarks, they will need to enroll in a different plan to obtain the enhanced rate. The difference in reimbursement must go to pay insurance premiums.

2. Consider impacts of the initiative on equity across long-term care workers.

The legislation directed the study examine a rate increase for insurance for the entire long-term care workforce. However, given limited state funds, beginning with one sector of the workforce with the highest rates of uninsurance and expanding to other sectors – as is the Montana plan – may be a viable strategy for Minnesota. Montana is beginning with home care and private duty nursing workers and studying how the rate increase would work in other settings. Most other states have also targeted their health insurance initiatives for workers in specific sectors, particularly individual providers, home care workers, and workers supporting people with intellectual/developmental disabilities. If this option is considered, funding should be targeted to sectors with the greatest need, to improve parity in compensation for workers in similar jobs across provider types.

Although the survey found small differences between workers in institutional and home and community based settings, our findings indicate much larger differences by workplace setting *within* home and community based or institutional settings, with lower paid direct service staff at the greatest disadvantage. A related study by Lewin on Minnesota's Personal Care Assistance program also found exceptionally high uninsurance rates among PCAs.¹⁷ Minnesota should consider giving priority to workers in the specific provider types with greatest need.

¹⁶ "Health Insurance for Health Care Workers: Frequently Asked Questions," <http://www.dphhs.mt.gov/sltc/services/communityservices/HCWorkers/Index.shtml>

¹⁷ The Lewin Group, *Recommendations for Minnesota's Personal Care Assistance Program*, Report for Minnesota Department of Human Services, Disability Services Division, Draft July 2009.

3. Build and maintain accountability systems to ensure that the rate increase is spent for the intended purpose.

Another key issue identified in the legislation is the importance of developing mechanisms to ensure that rate increases are spent for the intended purpose. Minnesota has already developed an accountability system for previously enacted rate increases (COLAs) for long-term care providers earmarked for employee wage increases and benefits. Within six months after the effective date of each rate adjustment, providers must provide a Provider Statement of Assurance letter to the Department of Human Services Commissioner and those counties with which they have a contract. The letter provides assurances that the provider has developed and implemented a compensation plan that estimates the amounts of money that must be used to meet compensation and wage requirements and details the distribution plan for the money.

However, Minnesota officials consulted for this study commented that this has not really worked, as many providers have not returned this statement. In addition, a few survey respondents commented that their employer had not used the COLA for wage increases as required. Research in other states has found that even when accounting mechanisms have been specified, providers have not always passed on rate increases to employees.¹⁸

Hence, Minnesota should also ensure a system is in place to track and monitor outcomes of the rate increase on employee health insurance. For example, in Montana's program, payments are advanced to employers monthly, and every quarter the employer must send in reports attesting to their actual costs.

Research on the experiences of these states suggests several possible approaches to enforcement of a rate increase designated for wages or benefits:¹⁹

- ▶ Surveying providers after the rate increase to determine whether and how they participated;
- ▶ Requiring providers to submit expanded cost reports;
- ▶ Random audits; and

¹⁸ Dorie Seavey and Vera Salter, *Paying for Quality Care: State and Local Strategies for Improving Wages and Benefits for Personal Care Assistants*, Washington, DC: AARP Public Policy Institute, 2006, http://www.aarp.org/research/longtermcare/quality/2006_18_care.html

¹⁹ PHI and IFAS, *State Wage Pass-Through Legislation: An Analysis*, Workforce Strategies No. 1 April 2003. <http://www.directcareclearinghouse.org/download/WorkforceStrategies1.pdf>.

- ▶ Tracking employer deductions for health insurance on business tax returns.

4. Explore options for making insurance more accessible to part-time workers or ensuring full-time work.

Many long-term care workers, particularly direct service workers, do not qualify for health insurance benefits because they work part-time or irregular hours, particularly those in home care. A third of workers reported working less than 32 or more hours per week. Potential strategies for expanding coverage to part-time workers include:

- ▶ **Ensure full-time work** – Of the 33 percent of workers who indicated they do not have private health insurance, 33 percent said they would try to work at least 32 hours if that would qualify them for coverage. Another 47 percent said they already work 32 or more hours. This suggests that ensuring full-time work could be a promising strategy for Minnesota. For example, Cooperative Home Care Associations (CHCA) in New York has developed a guaranteed hours program that blends regular hours with replacement hours worked and “on-call” hours not actually worked.²⁰ The program guarantees participants 30 hours of paid work a week. In addition, ensuring guaranteed continuous eligibility for 12 months would significantly reduce the administrative burden on the state caused by workers churning in and out of employer and public coverage.²¹
- ▶ **Design the premium structure to ensure part-time workers are eligible for the full employer contribution** – Under the Minnesota Advantage plan, employees receive the full employer contribution to premium if they work more than 30 hours a week, partial contribution (50% or 75%) if they work 20 to 29 hours, and no contribution if they work less than 20 hours.²² Based on the results of the worker survey, few workers would be able to afford premiums of over \$100 a month for insurance, so it is unlikely that many part-time employees would enroll unless the cost of premiums were fully subsidized or very low.

²⁰ PHI, The Guaranteed Hours Program, Workforce Strategies No. 4, <http://www.directcareclearinghouse.org/download/WorkforceStrategiesNo4.pdf>

²¹ This has been a significant issue in New York State. See Berliner, H.S. *Home Care Workers Health Insurance Demonstration Project: Final Evaluation*, June 28, 2004.

²² Email from Beth Arntson, Workforce Planning Consultant, Minnesota Department of Human Services, June 19, 2009.

- ▶ **Create an alternative plan for those workers who are working part-time for multiple employers and not eligible for any single employer** – In the worker survey, 15 percent of respondents indicated they work 32 or more hours a week through more than one part-time job. This suggests that another strategy for Minnesota may be to develop a way to count workers as full-time if they work a total of 32 hours through multiple part-time long-term care jobs.

5. Conduct outreach efforts to increase awareness of the health benefit and encourage participation.

The experiences from Maine and Washington states' CMS grantees,²³ and most recently from New York's Family Health Plus Buy-in,²⁴ stress the need for concerted outreach efforts. It is important to ensure that long-term care workers are aware of the insurance benefit, the benefits of insurance and how it works, and how to enroll. Minnesota might consider mechanisms to gain direct access to workers, either with the permission of their employers or independently through direct service worker associations or labor unions representing the direct service workforce.²⁵ Community organizations where many workers are active are another potential venue for reaching workers.

6. Ensure that the rate increase is adequate to make insurance affordable to employers.

For the initiative to have significant impact, the payment made to employers would need to be of sufficient size to provide an incentive for employers to participate.²⁶ In Montana, several of the providers who did not participate said the reason was because the Medicaid rate increase was insufficient to cover the cost of an insurance plan that meets the state's criteria.²⁷ Maine's experience with a health insurance subsidy for employees also illustrates the difficulty of expanding coverage when the employers have a hard time paying premiums, especially when they are funded primarily with public dollars.

²³ PHI, CMS Direct Service Workforce Demonstration Grants: Overview and Discussion of Health Coverage Interventions, 2006.

²⁴ PHI, Coverage Models from the States, 2007.

²⁵ PHI, Emerging Strategies for Providing Health Coverage to the Frontline Workforce in Long-Term Care: Lessons from the CMS Direct Service Community Workforce Grants, January 2007.

²⁶ Minnesota Department of Health, 2002.

²⁷ Montana Department of Public Health and Human Services, "Health Care for Direct Care Workers Application 1 Report."

<http://www.dphhs.mt.gov/sltc/services/communityservices/HCWorkers/Application1Summary.pdf>

7. To ensure sustainability over time, build in mechanisms to ensure that funding keeps pace with escalating health insurance costs.

Due to lack of a steady financing source, several of the long-term care worker health insurance initiatives undertaken by other states were short-lived demonstration programs that were unsustainable when the grant period ended. In some cases, rising health care costs led employers to increase costs or reduce benefits for employees.

To be sustainable, the Minnesota initiative should build in mechanisms to ensure that funding keeps pace with escalating health insurance costs.

iii) Conclusion

In conclusion, implementing the proposed rate increase for health insurance in Minnesota will require careful planning and investment. However, given the growing need for a strong, stable workforce to support Minnesota's growing population of older persons and people with disabilities, the link between health coverage and retention, and the importance of a stable qualified workforce to quality of care, we believe that the results of undertaking this endeavor will be well worth it.