

Key Facts

- Coverage won through collective bargaining, and funded by the state of Washington and participating private employers
- Benefits administered by SEIU 775 Multi-Employer Health Benefits Trust (a labor/management Taft-Hartley Fund) and the state's Basic Health Plan
- Workers contribute \$17 monthly to premium cost
- Comprehensive benefits, including prescription drugs and mental health services
- Low eligibility requirements: workers must average 86 hours per month after 3-month waiting period

Direct-care workers provide essential support and personal care to vulnerable elders and others living with disabilities and long-term conditions, yet more than a third have no health insurance for themselves or their families. **Health Care for Healthcare Workers**, an initiative of the Paraprofessional Healthcare Institute, seeks to address this problem through public education, research and analysis, and state-based campaigns.

This case study is part of a series designed to offer interested stakeholders and policymakers models to draw from as they seek to expand health coverage for direct care workers.

This, and related publications, are available online at the Health Care for Health Care Workers website (www.coverageiscritical.org), or by calling the national campaign office at 718-928-2066.



Comprehensive Health Coverage for Consumer-Directed Home Care Workers

Introduction

In Washington, approximately 23,500 home care workers known as individual providers (IPs) serve Medicaid and other state-subsidized long-term care consumers who direct their own care. A significant number of these workers are family members of the clients they serve. Until recently, none of these workers had access to health insurance through their jobs. While some of these workers earned so little that they qualified for state-subsidized insurance, none had guaranteed coverage as a condition of employment and many were completely uninsured.

In November 2001 voters approved Initiative 775, a ballot measure that created a new state agency, the Home Care Quality Authority (HCQA), and established this agency as the employer of record for the IP workforce for the sole purpose of collective bargaining.

The following year, the Service Employees International Union (SEIU) won representation rights. Subsequently, IP home care workers successfully bargained for significant wage increases¹ and an array of new benefits, including health insurance.

This case study describes the establishment a Taft-Hartley multi-employer trust as the administrative structure for providing health benefits to the home care workforce.² It outlines the eligibility requirements, benefits, and costs of this coverage and then explores why enrollment rates for IP home care workers are far lower than predicted. While changes must be made to increase enrollment rates, Health Care for Health Care Workers concludes that the multi-employer trust in Washington is a successful effort that meets nearly all of the key design features necessary for quality coverage.

Creating a Multi-Employer Health Benefits Trust

When SEIU won representation rights for the IP workforce, it formed a new local union, SEIU 775, named after the successful initiative. This local union represents IP home care workers in addition to direct-care workers employed by home care agencies and nursing homes.³ Early on, SEIU 775 and the HCQA agreed on the importance of including health benefits for the IP workforce in their first contract. The challenge then became how to create an administrative structure to purchase health benefits and how to convince the Washington State legislature to approve the funding.⁴

One obvious option was to create a “carve out” that would make all IP workers, regardless of their income level, eligible for the Basic Health Plan (BHP), a state plan for residents who meet income eligibility requirements. This solution would have built on a previous policy that allowed categorical eligibility for home care workers employed by state-contracted home care agencies. This proposal, however, was problematic because it came at the same time that Washington was experiencing cuts to the public benefits available through the BHP.

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Subsequently, the parties went back to the bargaining table and began exploring the feasibility of establishing a Taft-Hartley multi-employer benefit fund, an arrangement common in other industry sectors. Multi-employer benefit funds are labor-management partnerships that cover employees of multiple private employers, usually in the same industry, who have signed a collective bargaining agreement (CBA) with the same the same local, national, or international union.

Taft-Hartley benefit funds operate as a single risk pool covering all of the eligible employees of all of the

contributing employers. Such funds purchase insurance for the group through one or more private carriers. Generally, the CBA will require the employers to make either a “cents per hour” or monthly premium contribution on behalf of each employee based on the number of hours the employee has worked for that employer during the reporting period (i.e., month, quarter, etc.) Under the Taft-Hartley Act,⁵ a multi-employer benefit fund must be governed by a joint board of trustees on which labor and management each have equal representation

Obstacles to Forming a Taft-Hartley Benefits Fund

To make this model work for the IP workforce, the bargaining team had to address several obstacles. First, to meet the criteria, they had to broaden the risk pool to include multiple employers. SEIU invited other home-care employers with which they held CBAs to participate. One of these employers, Addus Health Care, a state-contracted home care agency, agreed to fill the management seats on the Board of Trustees (with SEIU filling the labor seats). While IPs still make up the vast majority of the risk pool, this participation of private sector employers was essential because multi-employer funds cannot be established exclusively for public sector workers.⁶

IPs are statutorily public sector workers, though they are not state employees. While they are paid by the state, IPs are hired, managed, and fired directly by consumers. Initially, HCQA represented the state in bargaining. Today, the union bargains directly with the governor’s office, while the HCQA and the state Medicaid agency (Department of Social and Health Services, DSHS) play an advisory role. According to the state, they do not have a seat on the board of the trust because they are the employer solely for the purposes of collective bargaining. They do, however, provide an official “public liaison” to the trust for consultation purposes.

The second obstacle faced by the bargaining team concerned workers’ compensation insurance. Health insurance carriers would not want to be held liable for high claims for workplace injuries that would normally be covered by workers’ compensation insurance. But traditionally, IP home care workers were not covered by such policies.

To obtain affordable workers’ compensation coverage, the parties agreed to phase in a four-hour safety training

for all new IP workers. In addition, the state provided funding for a contracted Third Party Administrator (TPA) to provide claims management and risk mitigation for this new workers' compensation program. This was especially important given the unique employment relationships and atypical issues of management and supervision of this workforce.

The final obstacle was getting the legislature to approve both the mechanism and the substantial cost of covering health benefits for the IP workforce. The bargaining team presented the legislature with a contract that included a nearly \$500 per member per month contribution⁷ for health coverage. They predicted that if established, as many as 9,000 IPs would be eligible to enroll in the trust fund's insurance plans.

Mobilizing its grassroots power, SEIU made nearly 50,000 contacts between workers and legislators. This advocacy campaign had the desired effect: in spring 2004, the legislature quickly approved the contract which included funding to provide the health coverage for thousands of direct-care workers in Washington State.

Eligibility, Benefits & Cost

The SEIU 775 Multi-Employer Health Benefits Trust (hereafter referred to as the Union Trust) currently enrolls all eligible IPs and other home care agency workers whose CBAs include participation in the trust, in addition to a small number of workers who belong to another home care industry union.

Eligible home care workers have the option of enrolling in health plans administered through the Union Trust or in plans administered by Washington's Basic Health Plan (BHP). By design, the eligibility requirements, benefits, and cost structures of the Union Trust plans and the BHP plan options available to categorically eligible home care workers are similar. The key differences are:

- Only the Trust Plan includes dental and vision coverage
- Only the BHP has family income eligibility requirements
- Only the BHP is open to family coverage (at the worker's own expense)

To be eligible for coverage, workers must have completed three consecutive months of employment and must

maintain 86 hours of work per month.⁸ Workers cannot enroll in the Union Trust if they are eligible for other family or employment-based coverage, and they cannot enroll in the BHP if they are eligible for Medicare. For the BHP, workers must also meet family income eligibility requirements and must be a resident of Washington State.

The cost structure of the benefit is designed to encourage as much participation as possible by keeping out-of-pocket costs for workers low.

Both the Union Trust plan and the BHP offer a comprehensive benefits package including hospitalization, prescription drugs, preventive care, and mental health services. The following private insurance carriers administer these plans:

- **Union Trust carriers for independent providers:** Premera and Kaiser for health and vision, and Standard Insurance for dental.
- **Union Trust carriers for agency workers:** Premera, Kaiser, or Group Health Cooperative
- **BHP carriers:** Kaiser and other regional providers

The cost structure of the health benefit is designed to encourage as much participation as possible by keeping out-of-pocket costs for workers low. Home care workers who enroll in either plan make a \$17 per month premium co-payment as well as other modest co-pays for specific services. This premium level is strikingly low compared to the average monthly premium contribution by U.S. workers (\$52 per month in 2006).⁹ The BHP plan requires enrollees to cover a modest \$150 deductible, while Union Trust has no deductible.

According to the collective bargaining agreement, employers currently pay the Union Trust approximately \$500 per month for each eligible participating worker. This covers the cost of administering the trust and purchasing insurance from the private carriers. Sustaining this level of contribution from the employer (in the case of IP workers, the state on behalf of the Medicaid clients served) is possible because the workers and their union continue to have a strong political presence in the state capitol.

Enrollment Patterns

Though the Union Trust offers a comprehensive health plan with minimal cost-sharing, enrollment levels are far lower than the 9,000 IP participants originally predicted. To date, enrollment hovers closer to 4,500 IPs. As of April 2006, 4,091 IPs were enrolled in the Union Trust plans, and an additional 550 in the BHP, less than 20 percent of the total IP workforce.

Polling data suggests that it is not for lack of need that such a low percentage of workers are enrolling. In a survey of IP workers conducted by Lake Research Associates in October 2005, 41 percent of those interviewed said they wanted health care coverage but did not have it. In a separate telephone survey of new IPs entering the field within the last six months, workers cited the following as the most common reasons for not taking advantage of the availability of health insurance: 1) about half (48 percent) had other sources of health insurance, 2) almost one-quarter (22 percent) were not eligible; and 3) 13 percent were not aware that health insurance was available.¹⁰

Of those workers who have enrolled, the Union Trust is the more popular choice. There are many possible explanations for this. First, the Union Trust does not require participants to meet income eligibility requirements and, in turn, does not carry the stigma of being a public benefit. In addition, it includes dental and vision coverage and is easy to enroll in through a simple one-page application. Nonetheless, overall enrollment is half of what was projected.

Actual vs. Projected Enrollment

Total Number of IPs	23,500
Projected Enrollment (based on number of hours worked)	9,000
Actual Enrollment (as of April 2006*)	4,591

* 4,091 were enrolled in the Union Trust; 500 in the BHP

Barriers to Coverage

There appear to be two major obstacles to enrollment in the Union Trust. First, as illustrated in the table below, part-time status makes the majority of the workforce ineligible for benefits. According to an October 2006 census, 57 percent of the total IP workforce is ineligible because they work fewer than 86 hours per month. Yet barriers also exist for those who meet eligibility requirements. Approximately 22 percent of IP workers are eligible but have not enrolled. For these workers, it appears that the major barrier is learning about the benefit and how to enroll.

Part-Time Status

For the IP workforce in Washington, securing more than 86 hours is a challenge, a struggle shared by home care workers nationwide. Many IPs are family members or friends of the clients they serve. While a provider in this

Eligibility & Enrollment Patterns

	Number	Percentage
Total IP Pool in Census	23,545	
Not Eligible based on hours worked (< 86)	13,436	57%
Eligible but not Enrolled	5,189	22%
Eligible, Qualified and Enrolled	4,415	19%
Not Eligible Based on hours worked and qualifying months (< 86, < 3 months employed)	505	2%

Source: Union Trust demographic reporting and data from the state and SEIU 775 used in interest arbitration. Note: this chart does not reflect an additional 1,500 enrollees who are home care workers employed by state contracted agencies.

category, such as an adult daughter taking care of her own mother, may voluntarily provide more hours of care than those for which her mother is eligible, the daughter cannot qualify for benefits based on these unpaid hours. Securing a minimum of 86 hours of work per month is challenging for non-family members as well. It is difficult to coordinate the part time needs of multiple clients and hours tend to fluctuate as clients move in and out of institutional care or die.

Washington has implemented a referral registry that is intended to help match workers and clients. Public authorities in California and elsewhere illustrate that referral registries can be a successful tool in this regard, while also helping workers increase their paid hours. Washington's statewide registry, however, is new and does not yet have a track record.¹¹ Generally, workers who want to take on multiple clients and move towards full-time work are still relying solely on their own networks to expand the number of clients they serve. Another strategy to qualify for benefits is to work part time for a home care agency, while also serving a consumer-directed client.

A Large, Isolated & Dispersed Workforce: Difficult to Reach

Another barrier to insuring the IP workforce is its nontraditional structure. Agencies such as Addus see their employees regularly when they come into the office to get assignments or pick up their checks. Supervisors are also in close contact with employees, often notifying them personally when they become eligible for benefits. IP home care workers, by contrast, do not have this type of regular connection with a worksite or formal supervisor, thus posing obstacles to outreach about availability and eligibility requirements for health coverage.

While written material about the health benefits is distributed to each new IP worker from multiple sources (SEIU 775, the state, and the Trust Plans own direct marketing), enrollment patterns and polling indicate that many workers, including those who meet all eligibility requirements, are not getting the information and support they need to enroll.

When IPs begin employment, they sign a contract between the State Department of Social and Health Services (DSHS), the consumer, and the IP. Typically this happens at the Area Agency on Aging office or a Developmental Disabilities regional office. The consumer's case manager oversees this process and later plays many of the traditional roles of a manager—for example, acting as a point of contact on issues such as scheduling time off.

Case managers, however, do not see it as their responsibility to inform IPs about their potential eligibility for health coverage.

In their orientation, new IP workers receive an overview of benefits available under their collective bargaining agreement, including a brief explanation of the health benefit. However, this orientation is typically very early in their tenure, and three months later, when workers may actually be eligible for benefits, they are working in the isolation of their client's homes. Clients act as supervisors in the sense of directing the IPs on how to provide them needed assistance, but they do not issue their paycheck or advise the IPs about benefits or assist them in applying for benefits.

This communication gap is exacerbated by the diversity of these workers and their dispersion across a large state with vast rural areas. New immigrants, clustered in the urban and agricultural regions, and native Americans in

The absence of a traditional workplace, in addition to cultural and geographical barriers, are key barriers to accessing insurance coverage.

the tribal areas are not always familiar with or comfortable accessing benefits available to them and may not speak English well enough to understand the written materials they receive. While no data is available on the cultural background and languages spoken by the home care workforce, the state makes interpreters available for entry-level training in 14 languages and a recent survey of more than 20,000 aging home care clients identified that they spoke 36 distinct languages. The absence of a traditional workplace, in addition to these cultural and geographical barriers, are key barriers to accessing insurance coverage.

Conclusion

Home care workers in Washington State have enjoyed health insurance coverage through the Union Trust since 2004. Over time, as word spreads about the availability of health benefits, enrollment rates are likely to increase. In the meanwhile, SEIU 775 and its partners are exploring strategies to increase enrollment and expand access to coverage. SEIU is looking at options for providing limited health care coverage for part-time home care workers and, at the same time, advocating for policy changes to assist

The \$17 premium and limited out-of-pocket costs makes coverage affordable and accessible to direct-care workers who earn modest wages.

IPs in securing the additional hours or clients they need to achieve full-time work. The Home Care Quality Authority is working with the state and SEIU to educate consumers, providers, case managers, and stakeholders about health care and other benefits for which IPs are eligible. These parties are also working together to streamline processes and provide consistency in communications, including distribution of written materials.

These improvements will enhance an already strong program that meets many of the key design features that the HCHCW campaign recommends, including the following:

- **Affordable for workers**
Nationwide, many direct care workers are eligible for health benefits but cannot afford to accept coverage because the premiums and out-of-pocket costs are too high. The \$17 premium and limited out-of-pocket costs associated with both the Union Trust and the BHP make them affordable and accessible to direct-care workers who earn modest wages.
- **Affordable for employers**
Many small employers have difficulty finding affordable plans on the private market because brokers consider them to be high risk. The Union Trust has the advantage of a

very large pool of eligible workers, which enables them to spread the risk and bargain for lower premiums. In addition, unlike other employer association purchasing pools, Taft-Hartley benefit funds enjoy labor and management oversight and a joint commitment to both cost and quality and member/enrollee satisfaction. According to the state, “The Trust’s cost history thus far has been less expensive than anticipated during its first two years of existence. Over time, it is likely that this could have a positive effect on rates.”¹²

- **Comprehensive coverage**
Direct-care workers are sometimes offered plans with very limited benefits because that is all their employers can afford. In contrast, IP home care workers are offered a full range of benefits through the BHP and the Union Trust, including dental and vision coverage for those enrolled in the Union Trust. These benefits are crucial for older workers and those with chronic diseases.
- **Easy to understand and enroll in**
As discussed in this case study, IP home care workers are hard to reach. Nonetheless, when they do receive information, it is simple, easy to understand and available in multiple languages. Both the Union Trust and the BHP have simple application forms (one page for Union Trust, seven pages for BHP because of need to determine income eligibility).
- **Sustainable over time**
The IP home care workforce, through their union, is well organized to defend, protect, and expand their health benefits. They engage in constant and continuous legislative advocacy to ensure their contracts are improved and their members’ interests are addressed. This advocacy ensures a stable funding base over time for the Union Trust. Without this level of organization, it is unlikely that home care workers would have access to employer-sponsored health coverage today.

Advocacy ensures a stable funding base over time for the Union Trust.

Endnotes

1. The wage rate for IP workers in 2001 was \$7.18 per hour; today it is \$9.43 per hour. Workers now bargain directly with the state rather than the Home Care Quality Authority.
2. This case study focuses primarily on the expansion of coverage to the Individual Provider home care workforce. However, the Taft-Hartley Act also covers union members who work for state-contracted home care agencies.
3. Home care agencies contract through the state to provide approximately 50% of total state-funded service hours and employ approximately 12,500 workers with over 5,000 represented by SEIU.
4. Under Washington State law, the legislature approves the amount of funding necessary to implement the collective bargaining agreement with an up or down vote.
5. The Taft-Hartley Act is an amendment to the National Labor Relations Act, 29 USC §§141-197, enacted in 1947.
6. The US Department of Labor monitors Trust Fund activities and is responsible for enforcing ERISA.
7. Exact contribution is \$480 per enrolled member per month in FY 2006 and \$532 in FY 2007.
8. It is possible for home care workers who meet income and other eligibility requirements but not the hour's eligibility requirements to qualify for the BHP as a public benefit. In this scenario, however, the BHP plan design that they would be eligible for would include significantly higher premium levels, higher co-payments and higher maximum out-of-pocket costs than the plan design available to categorically eligible home care workers in the Union Trust. In addition, vision and dental would not be included and drug coverage may not be offered.
9. Kaiser Family Foundation and Health Research and Educational Trust, 2006 Employer Health Benefits Survey, pg. 61.
10. Executive Summary, Home Care Quality Authority, Phone Survey of Individual Providers, by Dave Pavelcheck and Candiya Mann, Social & Economic Sciences Research Center, Puget Sound Office, Washington State University, September 2006.
11. As of December 2006, the registry was functioning at 14 regional sites serving the state's 39 counties across the state, but only 4,000 workers had registered. According to SEIU 775, many workers find the process for registering cumbersome and time-consuming.
12. Washington State Department of Social & Health Services, Report to the Legislatures, Draft Report on Homecare Health Options, October 2006.

For more information

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Health Care for Health Care Workers is an initiative of the Paraprofessional HealthCare Institute (PHI). PHI works to improve the lives of people who need home care and nursing home care—and the lives of the workers who provide that care. Our practical workplace and policy expertise helps long-term care consumers, workers and employers improve the quality of care, by creating quality direct-care jobs. Our goal is to ensure caring, stable relationships between consumers and workers, so that both may live with dignity, respect and independence. To learn more, see the PHI website: www.PHInational.org

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