



Subsidizing Health Insurance Coverage for the Home Care Workforce in Two Wisconsin Counties:

An Analysis of Options

Prepared for:

The Wisconsin Regional Training Partnership

By the:

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Health Care for Health Care Workers Initiative

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Health Care for Health Care Workers, a campaign to expand access to affordable health insurance coverage for the direct-care workforce, is an initiative of the **Paraprofessional Healthcare Institute** (PHI). The nonprofit PHI works to strengthen the direct-care workforce within our nation's long-term care system. PHI's program activities include developing innovative approaches to recruitment, training, and supervision; client-centered caregiving practices; and effective public policy. Our premise is that creating quality jobs for direct-care workers is essential to providing high-quality, cost-effective services to long-term care consumers.

Wisconsin Regional Training Partnership (WRTP) is a non-profit membership organization that is dedicated to family-sustaining jobs in Wisconsin. It develops programs that help employers and union members expand employment and advancement opportunities. Through WRTP employers are able to upgrade the skills of current employees and recruit and retain qualified job candidates. WRTP's programs prepare low-income, unemployed, and young workers for careers in a wide range of targeted industries. WRTP created TRIADA, a nonprofit professional employer organization or PEO. It contracts with employers, for a set fee, to help improve recruitment, training, and retention of a quality direct-care workforce. TRIADA, as a co-employer of employees, can take responsibility for many personnel matters such as health benefits (see www.wrtp.org).

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Introduction

The high cost of health insurance is a serious issue in Wisconsin. Two groups that have particular difficulties in obtaining affordable coverage are home care providers (e.g., small businesses) and their employees (e.g., low-wage service workers). As small businesses, home care agencies find it particularly difficult to purchase employer-sponsored insurance (ESI) for their employees, and when offered, many employees are unable to participate given the high cost of premiums, significant out-of-pocket costs, and eligibility status. Yet providing health insurance for direct-care workers may play a stronger role in reducing turnover and increasing retention than increasing wages alone. As Wisconsin works towards identifying strategies to meet the increasing demand for direct-care workers,¹ supporting access to affordable health insurance will prove beneficial to employers, workers, and consumers alike.

The purpose of this paper is to identify possible options for subsidizing health insurance for the home care workforce in Milwaukee and Dane counties under an innovative purchasing arrangement—a union-sponsored Professional Employer Organization (PEO)—created by the Wisconsin Regional Training Partnership (WRTP), the nonprofit training organization affiliated with the Wisconsin AFL-CIO. One of the objectives in creating the PEO was to offer affordable health coverage to home care workers beginning July 2006. The WRTP PEO, TRIADA, is unique from other PEOs because it will work in partnership with the Service Employees International Union (SEIU) to provide health insurance through SEIU's national Health Care Access Trust.

To provide a context for understanding the various options for subsidizing worker and employer health care premiums, this paper is divided into four parts:

- Background on the home care workforce and the availability of health insurance coverage for these workers;
- Description of the TRIADA PEO;
- Analysis of potential sources of funding to subsidize employee and employer premium costs; and
- Recommended options for the WRTP to consider in making health insurance affordable for this market.

The Home Care Workforce and Health Insurance Status

Home Care Workers in Wisconsin

Home care work is one of the fastest-growing jobs in America. The most recent data from the U.S. Bureau of Labor Statistics (BLS) indicate that there are 12,990 home health aides and 19,150 personal and home care aides in Wisconsin.² However, because this data only includes home care workers employed by agencies and does not count those who are independent providers employed directly by consumers, the total workforce is estimated to be much larger.³

Home care work is primarily low wage and part-time. The average wage of personal and home care aides in Wisconsin is \$9.17, with a mean annual income of \$19,080. Home care workers average fewer weeks of employment and fewer hours per week compared to direct-care workers in hospitals or nursing facilities. Nationally only one-third of home care workers are employed full-time, year round.

An in-depth, statewide picture of the home care workforce in Wisconsin is not available. However, a study of direct-care workers from 11 agencies across long-term care sectors (including residential care) in Milwaukee found the following:⁴

- Over one-third of direct-care workers surveyed (37.5 percent) received coverage from their employer; more than one-quarter were uninsured (27.5 percent); and 12.3 percent were covered by Medicaid.
- Of those surveyed, 26 percent reported annual incomes under \$15,000, and 35 percent reported annual incomes between \$15,000 and \$25,000.
- Half of those surveyed had a child under the age of 18; nearly half said they were single (45 percent); and 29 percent identified themselves as married.
- The average age of home care workers who answered the survey was 52 years.
- Home care workers reported working on average less than 31 hours/week.

Health Insurance Availability

Wisconsin has one of the lowest rates of uninsured residents (11 percent) in the country, in part because of the high rate of employer-sponsored health coverage.⁵ A study by state of Wisconsin found that 40 percent of the uninsured population in the state is childless adults, most with incomes less than 200 percent of the federal poverty level (FPL).⁶ Many of these workers are employed by small businesses, which have difficulty accessing affordable health plans. As childless adults, they also do not qualify for Medicaid coverage (see page 7).

As the Milwaukee study cited above suggests, direct-care workers in Wisconsin are uninsured at a rate that is more than twice that of the overall uninsured population (27.5 percent vs. 11 percent)—and the rate for home care workers is likely even higher. Despite their low incomes, only 12 percent of direct-care workers in the Milwaukee study were covered by Medicaid, possibly because many do not have children under age 19 and therefore are ineligible. Certainly, a major reason for this high rate of uninsurance among direct-care workers is that they are employed by small businesses that, like other small businesses, increasingly cannot afford to offer coverage to their employees.

Small businesses face particular challenges in obtaining affordable health insurance coverage. Barriers for small employers include the size and characteristics of the company’s workforce and the administrative and claim costs associated with providing health insurance. For small businesses, premium costs generally end up being slightly higher than for large employers.⁷ Wisconsin does not regulate insurance for the small group market—for example, through community rating, guaranteed issue, and/or guaranteed renewability—though this kind of government regulation has been shown to improve access to affordable coverage. As a result, less than half (46 percent) of small employers provide health insurance, as compared to 98 percent of large employers.

Home care workers are at a disadvantage for another reason as well. For workers employed by firms with a majority of employees earning less than \$10/hour, premium costs for employees are much higher than average, as shown in Table 1. However, even with employees picking up a larger share of the premium, small home care employers whose revenue primarily comes from Medicaid reimbursement simply cannot afford their share of rapidly rising health care premiums.

Table 1
Average Premium Costs for Workers in Low-Wage Establishments: Wisconsin 2004⁸

	All private-sector establishments		Private-sector establishments at which a majority of workers earn less than \$10 per hour	
	Total Premium	Worker’s Share	Total Premium	Worker’s Share
Single Coverage	\$3,927	\$795	\$3,779	\$1,037
Worker plus One	\$7,491	\$1,712	\$6,537	\$2,085
Family Coverage	\$10,146	\$2,193	\$10,712	\$3,140

To address the need for affordable coverage for home care employers and their workers, the Wisconsin Regional Training Partnership (WRTP) created TRIADA, a professional employer organization (PEO) that will offer insurance to both home care and child care providers. TRIADA will be able to lower the cost of health insurance options for this segment of the market through group purchasing. A purchasing pool alone, however, is not necessarily capable of sufficiently lowering costs to make health coverage affordable to these small businesses and their employees. By pairing the pool with a subsidy that lowers the cost of insurance to home care agencies and low-income workers, TRIADA may be able to further stimulate demand, increase market share, and lower administrative costs.^{9, 10}

TRIADA: WRTP's Professional Employer Organization (PEO)

The WRTP is a nonprofit membership organization of employers, unions, and associations that develops programs to help union members expand employment and advancement opportunities and upgrade their skills, and helps employers recruit and retain qualified job candidates. The WRTP has three main goals: to preserve quality jobs in the community; to improve access to jobs in targeted sectors of the regional economy; and to operate a PEO to provide health benefits and other human resource services to human services agencies.

A PEO is a business model that many small private sector businesses use to reduce administrative costs. It is a co-employment strategy that allows multiple employers to purchase human resource services from a single entity, reducing the costs for individual agencies. The PEO is more than a human resources provider, however. Direct-care workers employed by participating home care agencies have two employers: the PEO for purposes of payroll, benefits, and other HR services, and the agency for purposes of hiring and daily supervision. Provider agencies still manage all aspects of the day-to-day operations of their agencies; the PEO provides economies of scale in administration.

WRTP's PEO differs from other PEOs in several key ways. First, its mission is to improve human resource services, so costs to providers are kept to a minimum and the PEO's finances are transparent to participating agencies. Second, it will focus on services that improve the jobs of direct-care workers: health insurance and other benefits that are crucial for worker retention. Third, in partnership with employers who already receive public funds to provide services, it is in a position to seek private and public funding to support implementation and services.

In 2004, with health insurance premiums in Milwaukee 55 percent higher than those in other large Midwestern metropolitan areas and premiums for small and midsize employers expected to rise 23 percent,¹¹ WRTP set up a PEO to explore alternatives to insurance available in the small-group market, particularly for human service providers.

The PEO will have a collective bargaining agreement with SEIU, thus allowing employees, as union members, access to the SEIU Health Care Access Trust (HCAT), SEIU's new health plan with United Health Care. The Fund will offer multiple plans with different benefit packages including medical, dental, vision, and prescription drug coverage. Price of the plans will range from \$20 per member per month (pmpm) for family coverage in the discount Lilac plan to \$260 pmpm for medical, dental, vision, and prescription drug coverage for a single adult under the full coverage Violet Plan. United Health Care will handle claims and enrollees will have access to UHC's extensive provider network. Further description of the plan options is available in the **Appendix A** and premium costs for the Violet plans are detailed in **Table 2** (see p. 9).

Potential Sources of Public Funding to Subsidize Insurance Costs

Basically, there are three ways to subsidize health insurance costs:

1. Assist workers in paying the employee share of the health insurance premium;
2. Assist home care agencies through an increase in the Medicaid reimbursement rate targeted specifically to pay for health insurance costs;
3. Provide reinsurance to help lower premium costs by “insuring the insurers.”

The first two options rely on Medicaid funding, the federal–state program that pays health care providers to deliver health and long-term care services to frail elderly, people with disabilities, low-income families with dependent children, and certain other children and pregnant women. Notably, Medicaid is the program that insures low-income families (and many home care workers fit this category) and supplies the primary revenue stream for home care agencies that provide long-term care services. As a state/federal partnership, the state pays 42 percent of Medicaid costs and the federal government pays 58 percent.¹²

Premium Assistance for Workers

Wisconsin’s Medicaid Program for Low-Income Families

Wisconsin’s Medicaid program includes Medical Assistance (standard fee-for-service Medicaid) and BadgerCare, a managed-care program that provides wider eligibility but requires families to pay a monthly premium. As of December 2005, 647,000 low-income Wisconsin residents were enrolled in Medicaid. Another 91,000 low-income, working families were enrolled in BadgerCare.¹³

The Medicaid benefit package, which is the same for Medical Assistance or BadgerCare, is comprehensive, covering a wide range of services including physician and hospital care, diagnostic tests, vision, dental, and prescription drugs¹⁴ (see **Appendix B**). Eligibility requirements for Medicaid are as follows:

- Low-income adults with a disability, as determined by receipt of Supplemental Security Income (SSI) or other factors, are eligible for Medical Assistance.
- Children (up to age 19) and their families with incomes below the federal poverty level (in 2006, the FPL is \$9,800 for an individual and \$3,400 is added for each additional person) are eligible for Medical Assistance.
- Children (up to age 19) and families with incomes below 185 percent of FPL (\$30,710 for a family of three; \$37,000 for a family of four) are eligible for BadgerCare.
- Childless adults without disabilities are not eligible for Medicaid.

Home care workers who meet the categorical and income requirements are eligible for Medicaid coverage. As noted above, in Milwaukee, 12 percent of direct-care workers across all sectors currently obtain insurance through the state’s Medicaid programs.

States have the option of providing premium assistance to all Medicaid eligibles under a Health Insurance Premium Payment program under Section 1906 of the Social Security Act. Premium assistance programs use public funds to subsidize the employee’s contribution for private or employer-sponsored insurance. Wisconsin has opted to roll their HIPP program into BadgerCare and offer it to families with incomes below 185 percent of FPL.

BadgerCare and HIPP. The BadgerCare program began in July 1999 as an 1115 waiver to expand Medicaid eligibility to families with children under age 19 with incomes up to 185 percent of the FPL. Once enrolled in BadgerCare, families can maintain their eligibility until their income reaches 200 percent of FPL. As an 1115 waiver, BadgerCare qualifies for higher federal match than the traditional Medicaid program, with 71 percent of costs paid by the federal government.

Families enrolled in BadgerCare pay a monthly premium. The Wisconsin Department of Health and Family Services works in cooperation with employers to collect the premium through wage withholding or through electronic funds transfer from the member's checking or savings account.

Coordination with employer-sponsored insurance (ESI) is an integral part of the BadgerCare program. ESI is defined by BadgerCare as "family coverage under a group health insurance plan offered by an employer for which the employer pays at least 80% of the cost, excluding any deductibles or co-payments."¹⁵ If the employer pays more than 80 percent of the ESI premium, employees are not eligible to participate in BadgerCare. There are no specifications as to level of coverage provided under ESI.

For workers whose employers pay between 60 percent and 80 percent of the premium of ESI, premium assistance is available under BadgerCare through the HIPP program. Eligibility for HIPP is based on the following criteria:

- Families with children under 19 with incomes up to 185 percent of FPL (*childless adults are not eligible for HIPP*);
- Access to an ESI that is subsidized by the employer at 60 to 80 percent of the premium cost;
- Uninsured for six months prior to application.

If the state Medicaid agency determines that it is more cost-effective than providing coverage directly through BadgerCare, HIPP will pay the full employee cost for ESI, including the premium, co-insurance, and deductible. In addition, if the employer-sponsored plan does not cover the same benefits as the BadgerCare program, the state will provide wraparound coverage for non-covered services. As of March 2006, 1,388 individuals, representing 381 families, were enrolled in the HIPP.¹⁶

Subsidizing Employee Premiums through Medicaid

The BadgerCare HIPP program is a potential source for subsidizing the premium for eligible workers who are covered under health insurance plan offered through the PEO. There is no cap on enrollment into HIPP. When discussing the HIPP program with Wisconsin Department of Health and Family Services (DHFS) staff, they expressed interest in finding ways to increase enrollment in the program.

The ability for BadgerCare HIPP to support workers enrolled in coverage through the WRTP PEO will depend on two factors. First, BadgerCare is only available to families with children under age 19 with incomes up to 185 percent of FPL. While many home care workers will meet the income eligibility requirements, many will not qualify because they do not have minor children. HIPP could potentially support approximately half of the employees and their families. Arranging subsidies for low-wage childless workers would then need to be addressed.

Second, the state would need to determine if the PEO meets the state's ESI criteria that the employer must pay 60 to 80 percent of the premium. As currently structured, the PEO offers two types of plans (see **Appendix A**). The lower cost Lilac plan would not meet the definition of ESI as

it is not a health insurance product but rather provides access to certain services at a discount. Violet plans that provide insurance coverage for employees and their families would be eligible for HIPP assistance. **Table 2** shows the estimated premium amounts for the coverage categories for the Violet plans, and how much the employer would have to pay in order for it to meet the 60 to 80 percent requirement.

Table 2
Premium Costs of the Five Violet Plans Estimates of Employer Share at 60 and 80%

Type of Coverage	Violet A	Violet B	Violet C	Violet D	Violet E
Employee and Children					
Full Cost	\$121.88	\$146.25	\$213.28	\$273.00	\$383.91
60%	\$73.12	\$87.75	\$127.96	\$163.80	\$230.34
80%	\$97.50	\$117.00	\$170.64	\$218.40	\$307.12
Family					
Full Cost	\$219.83	\$263.70	\$384.69	\$492.41	\$692.45
60%	\$131.89	\$158.22	\$230.84	\$295.44	\$415.47
80%	\$175.86	\$210.96	\$307.92	\$393.92	\$553.96

The BadgerCare HIPP program could further benefit eligible workers by providing wrap-around coverage for services not provided by their insurance plan and paying the deductible and co-payments for covered services. **Appendix B** compares the benefit package of the Violet plans and the BadgerCare benefit. As can be seen in this table, BadgerCare provides a number of additional benefits, including family planning services, physical therapy, and vision care.

Given the wrap-around nature of the HIPP program, home care employers would get the maximum state assistance by offering their employees the Violet A plan. For employees, services not covered under Violet A plan would be provided by BadgerCare. At the same time, employers would be able to keep their costs relatively low per employee.

“Premium Assistance”—or Subsidies—for Employers

Medicaid pays for the majority of Wisconsin’s home care services. The reimbursement formula—i.e., the amount agencies receive for providing services—does not include the cost of health insurance for direct-care workers. To look at how Medicaid rates might be increased to help employers cover the cost of health insurance for employees, first it is important to understand how the state structures its Medicaid-funded home care services. Appendix C provides an overview of Wisconsin’s community-based long-term care programs that provide home care services.

Medicaid-Funded Home Care Services

State Medicaid-funded home care services include both fee-for-service and managed-care programs. The Community Options Program (COP) and HCBS waiver programs, administered by county agencies, provide care on a fee-for-service basis. The state Department of Health and Family Services (DHFS) annually allocates funding to counties for these services based on the

previous year's utilization and projections for the current year. Counties then negotiate rates with provider agencies for the services provided. Counties are allowed to contribute their own funds to provide services as well. Counties must assure that funds are spent on services in accordance with the State's Allowable Cost Policy, a formula for determining rates. This policy sets the methodology for how counties determine the rate for services but not what counties pay; therefore, rates vary by county.

Family Care is a combination 1915(b)/(c) Medicaid waiver that provides home- and community-based services as a managed-care program. The state pays a capitated rate for services to the Care Management Organization (CMO), and then the CMO negotiates rates with providers. These capitated rates must be actuarially sound, as determined by an independent actuary, and be approved by CMS. At this time, the CMO in Milwaukee County is the Milwaukee County Care Management Organization under the Milwaukee County Department on Aging. Dane County is not yet in the program, but Family Care is expected to become a statewide program in the near future. As a statewide program, Family Care will be administered regionally as opposed to the current county-based structure. To facilitate this regional approach, DHFS recently awarded planning grants to 10 regions across the state to begin to develop strategies to expand Family Care and other long-term care reform measures. Milwaukee and Dane counties both received expansion grants.¹⁷

Premium Assistance through Increased Rate Payment to Home Care Employers

To assist employers in covering the cost of the PEO health insurance plan, WRTP could explore an increase in payments received by providers from the state's long-term care financing programs.

Wage pass-through for fee-for-service programs. One method of providing an increase in provider payments is through a wage pass-through designated for health insurance coverage for home care workers who provide services to individuals in the fee-for-service community-based long-term care programs. A pass-through is a designated funding allocation provided through Medicaid reimbursement for the specific purpose of increasing wages and/or benefits to direct-care workers. States can use two approaches in implementing a pass-through:

1. Designate a certain amount of the Medicaid reimbursement towards worker wages and/or benefits; or
2. Require that providers spend a percentage of an increase in the Medicaid reimbursement towards benefits. To determine the appropriate funding level, further work would need to be done with PEO-participating employers to calculate current reimbursement rates and the additional cents/hour or fee per enrollee that would be necessary to cover health care premiums.

California and Washington State both offer health insurance coverage to home care workers funded through the Medicaid reimbursement rate. In Washington for SFY 2007, the Department of Social and Health Services is paying home care agencies a maximum of \$413.14/month per employee to cover health insurance for home care workers employed for at least 20 hours/week.¹⁸ Health insurance benefits for independent providers[†] (IP) in the In-Home Supportive Services

[†]The term "independent providers" refers to direct-care workers who are hired directly by the consumer to provide services.

(IHSS) program in California are funded by both state and federal funds. California includes the cost of wages and benefits for IP providers in calculating the total cost of the services to IHSS consumers, thus picking up federal Medicaid funds to match state and county expenditures.¹⁹

In discussing the feasibility of a pass-through for health insurance coverage with representatives from the DHFS, several challenges were identified. First, the state's Medicaid waivers apply statewide; therefore, to increase the rate for two counties participating in the PEO, while not doing so for the rest of the state, may require approval from CMS. Second, DHFS believes that an enhanced rate for health insurance coverage would not meet the State's Allowable Cost Policy designating that counties must spend funds directly on services to clients.

DHFS also noted that any wage pass-through would be dependent on the legislature, not the department, designating specific funds. Moreover, a previous 5 percent wage pass-through for certified nursing assistants employed by nursing homes included in the state's 1999-2001 budget appears not to have been entirely successful. That wage pass-through allowed DHFS to increase the Medicaid allocation to counties specifically to increase wages for workers. While no formal evaluation is available, discussions with advocates suggest that a majority of the increases did not go to workers but simply enhanced the rate paid to providers. This is a common challenge for states implementing wage pass-throughs and indicates why such legislation should have a built in mechanism for monitoring and ensuring the goal of the pass-through is achieved.²⁰

Rate enhancement through family care. Another option to explore is a rate enhancement for health insurance coverage for workers providing services in the Family Care program. This would have to be tied to the capitation rate the state pays to the CMO; the 2006 CMO capitation rate for Milwaukee County is \$2,055.01/pmpm.²¹

Under the Family Care Program, a rate enhancement would require overcoming several obstacles. First, under the current Family Care contract—the document that details the program services and how the rate is set for services—CMOs cannot pay providers more than the Medicaid fee-for-service rate for services unless DHFS approves a higher rate. A higher rate may be granted if it will increase quality or if can be shown that the availability of providers is not sufficient at the current rate.

Second, a rate enhancement would require additional negotiations between the state and CMS, which must approve any amendment to the existing waiver contract. CMS has very specific requirements for capitation rate enhancements under managed care.²² Rate enhancements to contractors under managed care are called incentive payments. These payments cannot be more than 105 percent of the approved rate. In addition, incentive payments must:

1. Be for a set period of time;
2. Not be automatically renewable;
3. Be made available to public and private contractors;
4. Not be conditioned on intergovernmental transfer agreements; and,
5. Be necessary for specific activities or targets.

Local or county funding. In addition to exploring an increase in state-level support, it may be beneficial to look to local funding sources for support of TRIADA's health insurance plans. Counties have some discretion in how they allocate funds for long-term care services. Since TRIADA is initially starting in Dane and Milwaukee counties, it would be beneficial to begin developing relationships with the aging divisions in these counties to gain support and gauge their interest in supporting health insurance coverage for home care workers in their counties. With success at the local level, the insurance program may garner increased support from DHFS or in the legislature.

One way to consider building local support is through the local planning efforts to expand the Family Care program. As the state embarks on significant long-term care reform and the expansion of the Family Care program, WRTP may want to consider getting involved in some of the regional planning grant work to promote living wage standards for direct-care workers in the program. Although it may not result in immediate funding for the WRTP PEO, such involvement would highlight the need for workers' wages and benefits to be considered in the rate setting and contract parameters of future Family Care sites.

Public Reinsurance Reform Proposal

The PEO may also be able to lower costs by taking advantage of the state's newly proposed reinsurance program.

Recognizing the continuing need to address the challenges that small businesses face in finding affordable health insurance, Governor Jim Doyle signed an Executive Order in July 2006 establishing the "Healthy Wisconsin Council," which is tasked with establishing the structure and funding of the Healthy Wisconsin Program. Healthy Wisconsin will be a reinsurance program that will cover the costs of catastrophic care. The council is to complete its work by December 2006, in order for the program to receive legislative funding in the 2007-2009 biennial budgets. In addition, federal funding for this program will be explored through an 1115 waiver, which could generate new federal matching funds for existing health care expenditures.

Reinsurance is essentially insurance for insurance companies. It allows an insurance company to contract with a separate company or entity to transfer all or part of their risk or liability for high-cost, catastrophic health care claims. The reinsurer would then be responsible for payment of the high-cost claims.

The goal of reinsurance programs is to stabilize or reduce health insurance premiums by keeping health care costs at a manageable and predictable level for insurance companies and businesses. Reinsurance plans are becoming of greater interest to states as they attempt to address the challenges that small businesses and low-wage workers face in obtaining affordable health insurance coverage. When the details of the Wisconsin reinsurance plan become available in early 2007, the potential cost impact on premiums for the PEO should be analyzed.

Additional Sources of PEO Funding

Additional support for the PEO's health insurance plans may be available through local, federal, or private sources.

- The successful lobbying of the Wisconsin Federation of Cooperatives (WFC) that resulted in the creation of Co-Op Care provides a model for potentially gaining federal and state support for the WRTP PEO. Co-Op Care is a pilot project of five health insurance purchasing cooperatives aimed at dairy farmers in Wisconsin. WFC was successful in highlighting the need for affordable health care among farmers in Wisconsin and gaining the attention of U.S. Senator Herb Kohl for funding and Governor Doyle to initiate the pilot. Funding for Co-Op Care is primarily from federal appropriations (\$4.5 million) and other state grants related to agriculture.²³ At this time, health insurance available through Co-op Care is targeted to dairy farmers and the organization does not anticipate making it available to other cooperatives, such as home care cooperatives currently operating in Wisconsin.²⁴ Given the anticipated growth of Family Care and other rebalancing efforts for community-based care, the WRTP PEO could pursue similar support. By highlighting the need and shortage of direct-care workers, the WRTP may be able to gain attention of legislators and other government officials to sponsor the PEO's health insurance product.
- In New York, a three-year, state-funded demonstration program allocated \$200 million to address home care worker recruitment and retention. Employers of personal care aides in cities and counties with populations of one million or more received funds to provide continuous health benefits to home care workers and to evaluate the impact. The demonstration successfully showed greater job satisfaction largely due to seamless access to health benefits²⁵ and increased tenure among personal care aides. Pilot projects such as this could be pursued in Wisconsin to meet the state's twin goals of insuring the working uninsured and ensuring a stable, quality long-term care workforce.

Conclusion: Recommended Options for Subsidizing PEO Premiums

A series of pilot programs financed by private and public funds have tested options to increase coverage of the uninsured by combining group purchasing and premium subsidies for small employers and individuals.²⁶ The key lessons learned from these programs, which can be applied in shaping the TRIADA program are:

- The larger the subsidy for low-wage workers, the higher the participation rate;
- Small employers will participate if (a) they feel the amount they must contribute is affordable and predictable, and will remain so over time; and (b) their administrative burden is minimized and simplified.

To make the PEO a success, WRTP needs to explore potential subsidies for home care workers and their employers to cover their health care premiums. As discussed above, WRTP should explore three possible alternatives:

1. Direct premium subsidies for home care workers, which could be provided through the Badger Care HIPP program. The challenge with this subsidy program is that it would likely cover only half the workforce, as adult workers without children are not eligible for premium assistance.
2. An increase in the Medicaid rate for home care providers, designated specifically for health insurance benefits. Challenges here include (a) building legislative support and then ensuring that a wage-pass through is in fact applied to health insurance premiums, and (b) negotiating rate increases, in the case of managed long-term care, with CMS.
3. Seeking additional private and public support by showing that health insurance is essential to attract and retain the home- and community-based workers Wisconsin needs to provide quality long-term care.

The PEO is a clear example of the kind of innovation that the state should support to improve recruitment and retention of direct-care workers, reduce administrative inefficiencies, and support quality care for Wisconsin's elderly and disabled population. In partnership with SEIU, it offers an innovative model for providing coverage with a range of health insurance products that are affordable to home care employers and their workers. This range of options will allow the PEO, and its participating employers, to offer plans that build on each other and can be improved over time. The key to the PEO's success is ensuring that premium levels are affordable to low-wage workers and to the publicly funded agencies providing human services in the community.

Endnotes

1. Wisconsin Council on Long Term Care Reform (2005). *Strengthening Wisconsin's Long Term Care Workforce: Final Report from the Direct Care Workforce Issues, WI Council on Long-Term Care Reform*. Available at www.wcltc.state.wi.us/CDCcharge.htm
2. U.S. Bureau of Labor Statistics. *November 2004 OES State Occupational Employment and Wage Estimates*. Available at: www.bls.gov/oes/current/oes_wi.htm. BLS defines home health aides as workers who provide routine, personal health care, such as bathing, dressing, or grooming, to elderly, convalescent, or disabled persons in the home of patients or in a residential care facility. Personal and home care attendants are defined as workers who assist elderly or disabled adults with daily living activities at the person's home or in a daytime, non-residential facilities. Duties performed at a place of residence include keeping house (making beds, doing laundry, washing dishes and preparing meals). May advise families, the elderly, and disabled on such things as nutrition, cleanliness, and household utilities.
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Appendix A – Description of Plans Offered through the WRTP PEO*

Lilac Plan

Lilac provides information, support, and guidance to assist in gaining access to the health care system, and provides financial savings for health and well-being services. The plan focuses on the opportunities for the lowest income workers with the least or no employer support. Lilac focuses on health care access and direct services, not traditional insurance, because the existing health care delivery system, unless obtained through public sponsorship, is too expensive.

NurseLineSM*	24-hour telephone access to registered nurses. Help with caring for minor illnesses and injuries, understanding diagnosed conditions and chronic diseases; discovering and evaluating possible benefits and risks of various treatment options; learning about specific medications; preparing for doctor visits; improve and maintain health; choose the right care in the right place at the right time.
Health Risk Assessment (HRA)	A confidential self-assessment of an individual's current health status that can be used to promote a healthier lifestyle for the individual. Available for each member and their spouse. Based on the results of the HRA there is intervention to assist members with modifications to their lifestyle and health risk factors.
Health & Well-being Savings Network	Increased access to a broad range of services, including health care products and services. An ID card is used to access a network of providers and facilities that include: General Medicine, Complementary/Alternative Medicine, Wellness Services, Pharmacy, Dental, Vision, Behavioral Health, Long-Term Care Services, Hearing, Infertility. Members receive a lower cost and avoid the common problem of being turned down for services.
Dental Coverage	2 cleanings, 1 exam per participant per year. \$10 co-pay per visit in network. Out of network has a 50 percent co-insurance. Access to the lower costs provided by the Health & Well-being Savings Network apply.
Vision	1 eye exam per participant per year. Access to the lower costs provided by the Health & Well-being Savings Network apply.
SEIU Member Assistance	Access to advocates that assist with referrals to the most helpful public programs, charitable programs and local services. Also, confidential help over the phone with the concerns of life, including: depression, managing stress, strengthening personal relationships, communicating effectively, workplace effectiveness, parenting and family concerns, coping with grief and loss, physical abuse, legal and financial assistance.

*Source: United Health Group and Service Employees International Union.

Appendix A – Description of Plans Offered through the WRTP PEO*

Violet Plans

This plan builds upon the access initiated through Lilac by combining Lilac with one of four insurance plans. The focus is workers with some employer support and/or higher incomes. Violet offers insurance coverage focusing on access to the right care at the right place at the right time, because access to preventive care, immunizations, lab work, diagnostics and accident coverage improve the health of members and lowers the overall cost of health care. Violet consists of Lilac plus additional insured coverage.

Lilac	Intrinsic to the design of Violet is the member's access to and participation in Lilac. The plan includes access to a wide range of health and well-being providers, with savings, as well dental and vision benefits and 24/7 telephone or online access to registered nurses. Please refer to the Plan Designs spreadsheet for details.
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PLUS

Office Visits	Plans A & B have a \$15 co-pay with a \$450 annual maximum benefit for plan A & B. Plans C & D have a \$10 co-pay with a \$500 annual max. Plan E has a \$10 copay, with a \$1,000 max.
Diagnostics, Lab & X ray	For all Plans, coverage is 80 percent in network with a \$300 annual maximum benefit.
Outpatient Surgery Facility	Plans B, C, D & E provide coverage for a percentage of the charges with a plan annual maximum.
Inpatient Facility & Inpatient Physician Services	Plans D & E provide coverage for inpatient stays, with an annual maximum benefit.
Out-of-network	Plan pays some costs for services accessed out-of-network. Out-of-network the plan will base reimbursement on Medicare reimbursement rates. Members are responsible for their portion of the deductible and coinsurance in addition to the amount between the Medicare allowable rates and the providers' actual charge.
Lifetime Maximum	\$2 million
Pharmacy	Plans C, D & E provide a retail pharmacy benefit with a \$10/\$25/\$50 member co-pay structure. Plan E also includes mail order, and a higher annual benefit maximum.
Accident Benefit	80 percent coverage for Emergency Room, facility, supplies and equipment and all professional fees including physician services for treatment of a trauma related (accident) injury on an outpatient basis at an emergency room.

*Source: United Health Group and Service Employees International Union.

Appendix B – Comparison of Covered Services

Covered Services	BadgerCare	Violet A	Violet B	Violet C	Violet D	Violet E
Dental	Covered	Discount	Discount	Discount	Discount	Discount
Diagnostic, screening, preventative, and rehabilitative services	Covered					
EPSDT Services	Covered					
Family planning services	Covered					
Inpatient hospital services	Covered	Discount	Discount	Discount	Covered	Covered
Laboratory and x-ray services	Covered	Covered	Covered	Covered	Covered	Covered
Nurse midwife services	Covered					
Other specified and remedial care	Covered					
Outpatient hospital services—Surgical	Covered	Discount	Covered	Covered	Covered	Covered
Outpatient hospital services—Nonsurgical	Covered	Discount	Discount	Discount	Discount	Discount
Physical therapy and related services	Covered					
Physician services—Office visits	Covered	Covered	Covered	Covered	Covered	Covered
Physician Services—Inpatient	Covered	Discount	Discount	Discount	Covered	Covered
Physician Services—Outpatient	Covered	Discount	Discount	Discount	Discount	Discount
Prescription drugs	Covered	Discount	Covered	Covered	Covered	
Primary care case management services	Covered					
Prosthetic devices	Covered					
Eyeglasses	Covered					

Appendix C – Community-Based Long-Term Care Programs in Wisconsin*

Waiver Name	Waiver Type	Geographic Area	Target Population
Community Options Program Waiver (COP-W) and Community Integration Program II	1915(c)	Statewide (except Fond du Lac, La Crosse, Portage, and Richland)	Elderly and individuals with physical disabilities
Community Integration Programs 1A and 1B (CIP)	1915(c)	Statewide (except Fond du Lac, La Crosse, Portage, and Richland)	Individuals with developmental disabilities
Brain Injury Waiver	1915(c)	Statewide(except Fond du Lac, La Crosse, Portage, and Richland)	Adults with brain injury
Children's Waivers	1915(c)	Statewide	Children with disabilities and autism
Community Options Program	Not a federal waiver program. COP operates with state funds only.	Statewide (except Fond du Lac, La Crosse, Portage, and Richland)	Elderly, individuals with physical or developmental disabilities, and individuals with mental health or substance abuse issues
Family Care	1915(b)/(c)	Fond du Lac, La Crosse, Milwaukee, Portage, and Richland	Elderly and individuals with physical or developmental disabilities

*The Family Care program in Milwaukee County differs from the others because it is not the primary means of providing services to individuals with physical or developmental disabilities. Family Care in Milwaukee County is open to individuals over age 60, regardless of whether they have a disability. Individuals with a disability who are under 60 receive services under the CIP or COP programs.



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