

Briefing Paper

Exploring Opportunities to Expand Health Coverage for Low-Wage Workers in the Developmental Disabilities Field in New York State

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by

**William Ebenstein, Ph.D.
John F. Kennedy, Jr. Institute for Worker Education
The City University of New York**

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I- Introduction

Nationally, the lack of health insurance is re-emerging as one of the most important issues facing our society. According to the United Hospital Fund, in 2002, over 43 million people, 17% of the population in the United States, was uninsured. In New York State, 3 million people, 18% of the population, was uninsured. One in four New York City residents and one in six New York State residents did not have health insurance. Of those uninsured, two-thirds were workers. (Holahan, et al., 2004).

Recently, the situation has gotten worse. A 2004 survey conducted by the Kaiser Family Foundation revealed that health insurance premiums were continuing to increase at double-digit rates. Also, the share of companies of all sizes offering health benefits to their workers declined again, to 61 percent. As a result, five million fewer workers had access to employer provided health coverage. In August 2004, the Census Bureau reported that the nation's total number of uninsured people had risen by 1.4 million in 2003, to a record 45 million. (Freudenheim, 2004).

Turnover of Direct Care Workers in the Developmental Disabilities Field

Over the last several years there has been a growing interest in the health insurance coverage of direct care workers in the developmental disabilities field, especially as it relates to job tenure and turnover. The direct support workforce is the backbone of the service delivery system for persons with mental retardation and developmental disabilities. Indeed, next to family and friends, these frontline workers can be the most important individuals in the lives of consumers. They provide hands-on assistance with activities of daily living and community integration, and offer a wide range of other supports including advocacy, personal care, health care, housekeeping, transportation, and recreation.

High turnover rates have always existed in developmental disabilities agencies that provide services in the community. Nationally, there are about 340,000 full-time equivalent direct care positions in community residential settings.(Fegley, et al., 2003). Average turnover rates in these settings have ranged from 50% to 70% per year. (Larson, et al.,1998). In NYS, in 2002, the Coalition of Families to Support Direct Care Workers estimated turnover at 30% to 50%. (Puddington, 2002). In addition to affecting the quality of services and consumer satisfaction, high turnover increases the costs of recruiting, training and supervising replacement staff.

Non-profit agencies find themselves pouring resources into recruiting and training a constantly churning workforce that has neither the stability nor depth of experience necessary to truly provide high quality care. As the ranks of the uninsured continue to grow, and the costs of health care spiral out of control, especially for low-income workers and their families, there has been increased speculation that the provision of employer sponsored health insurance may be an important factor in recruiting and retaining a competent, caring, experienced, and motivated frontline workforce.

Many surveys indicate that a large majority of companies think it is “very important” that they provide health coverage to their employees and contribute to its cost. At the same time, workers say that employer-sponsored health insurance is a “very important” factor in their decision to take or keep a job. In addition to improving recruitment and retention of staff, most employers also believe that insurance coverage improves employee health, morale, and productivity. These widely held views acknowledge that the value of offering health coverage by an organization far exceeds its direct cost to employers. (O’Brien, 2003; Collins, et al., 2004). In the case of providing quality services to vulnerable people, including people with disabilities, it is critical that staff remains healthy, productive, and satisfied with their jobs.

NYS Office of Mental Retardation and Developmental Disabilities

The New York State Office of Mental Retardation and Developmental Disabilities (OMRDD) is the designated State agency that oversees the system of supports and services for individuals with developmental disabilities. New York’s not-for-profit network of over 700 provider agencies operates residential and other programs serving tens of thousands of individuals with developmental disabilities in a wide variety of settings including community residences (CRs), intermediate care facilities (ICF/DDs), individualized residential alternatives (IRAs), and at-home waiver programs.

In the developmental disabilities field reimbursements to employers are publicly funded through a combination of state funds and Medicaid program payments. The funding levels are the primary factor in how much providers can afford to pay for wages and benefits. The primary funding mechanism in New York State for serving people with developmental disabilities is the Home and Community Based Services (HCBS) waiver. OMRDD, in collaboration with the NYS Department of Health (DOH), manages this federally funded Medicaid waiver program.

NYS Association of Community and Residential Agencies

In NYS, the rising cost of health insurance is worrying providers represented by the NYS Association of Community and Residential Agencies (NYSACRA). NYSACRA is a professional trade association that represents 200 not-for-profit agencies throughout NYS. Its members are viewed as key stakeholders in the development and implementation of critical initiatives affecting people with developmental disabilities. Currently, non-profit agencies negotiate rates for health insurance plans on their own. With health insurance premiums expected to continue to go up at double-digit rates, NYSACRA is interested in exploring alternative means for financing health benefits for workers.

John F. Kennedy, Jr. Institute at The City University of New York

The John F. Kennedy, Jr. Institute for Worker Education at The City University of New York in collaboration with NYSACRA and OMRDD received a grant from the United Hospital Fund to “provide information and analysis that will help determine the feasibility of alternative plans to expand health coverage to low-wage workers employed by non-profit developmental disabilities agencies.” The information and analysis will be used by OMRDD and NYSACRA to address the health insurance crisis, an area of mutual and mounting concern. The Institute convened an Advisory Group consisting of high-level staff from OMRDD and NYSACRA, and human resources directors from non-profit agencies throughout NYS, to provide direction and technical assistance for the project. (Appendix I: Advisory Group).

Co-principle investigator Niev Duffy, Ph.D. of the John F. Kennedy Jr. Institute for Worker Education, analyzed several years of data from OMRDD’s Consolidated Fiscal Report (CFR). 225 non-profit agencies with at least 20 FTEs in residential programs, and a minimum of 5 direct care worker FTEs across all programs, were chosen for analysis. The Institute also sent out a comprehensive Health Benefits Survey to all selected agencies.(Appendix II). The 225 selected agencies employed a total of 59,400 FTEs. Of these, almost three-quarters or over 44,000 FTEs were employed as direct care workers, including over 32,000 direct care FTEs in residential settings. The agencies employed an average of 460 full and part-time employees, totaling over 103,000 individuals. (see attached: Duffy, N., *Keeping Workers Covered: Employer Provided Health Insurance Benefits in the Developmental Disabilities Field*, The John F. Kennedy, Jr. Institute, October 2004).

II- Overview of Health Coverage of Direct Care Workers

The following section provides an overview of health insurance coverage of direct care workers in the developmental disabilities field, and other low-wage workers in health and human services occupations.

Expenditures for Salaries and Health Coverage

Based on OMRDD's Consolidated Fiscal Report (CFR), the average salary for direct care workers in 2001 was \$10.48 per hour. This figure includes overtime, which agencies use to fill gaps in staff coverage due to turnover, and direct care workers need to earn extra money to make ends meet. Statewide, the total wages of direct care workers represented 90% of all agency salaries. Also, on average, nearly 50% of the personnel in the selected OMRDD agencies made \$10 or less per hour. From 2000 to 2001, the average salary of direct care workers rose just 2.6%, less than the rate of inflation for the same period. At the same time, between 2000 and 2001, health expenditures increased an average of 7.5% across all agencies. Also, during this time period, a growing share of agency operating budgets went toward health care expenditures. In 2003, agencies spent an average of \$4,534 in health insurance costs per covered worker. (Duffy, 2004).

Rates of Uninsurance and Employer Provided Coverage

Of all workers, low-wage workers, including 2.2 million direct care workers in the healthcare field, are more likely to be uninsured. For example, almost one-quarter of all nursing home aides did not have health insurance coverage. For home care aides, uninsurance rates averaged over 40%. Low-wage workers in healthcare fields were also less likely to get health insurance through an employer plan. Only forty-two percent of nursing home aides, and just twenty-six percent of home care aides had employer sponsored health coverage. (Lipson and Regan, 2004).

Low-Wage Workers Are Paying an Increasing Share of Health Costs

Employers recognize the importance of providing affordable health insurance to their employees and their families to be able to continue to recruit and retain a skilled and motivated workforce. However, because of escalating health insurance costs, companies have been increasing the share of premiums that their employees pay and increasing cost sharing at the point of service. Employers have also offset health premium increases with smaller raises for their employees. Therefore, in general, they have preserved benefits, but have increased costs to their workers. These changes are having a devastating impact on low-wage workers. (Collins, et al., 2004; Edwards, et al., 2004).

In NYS, from 2001 to 2003, workers paid a greater share of the cost of premiums. For individual coverage their share rose from 11% to 18%. For family coverage their share rose from 17% to 23%. Contributions for family coverage rose 54%, as the percentage of workers opting to pay for family coverage dropped from 49% to 40%.(Edwards, et al. 2004). At these levels, many low-wage workers just cannot afford to participate even if they are eligible for their employer's plan. With the low salaries paid to frontline direct care workers, the cost of employer sponsored individual and especially family coverage may represent a significant percentage of their income. Nearly 40% of workers who earned less than \$10 per hour spent more than 5% of their income on premiums. This does not include other out-of-pocket expenses such as deductibles and co-payments, which have also been increasing. The research in this area indicates that when premium costs reach 5 percent of family income, enrollment among low-wage earners falls off dramatically. (Ku and Coughlin, 2000; Collins, et al., 2003).

Low-wage workers who allocated at least 5 percent of their income for premiums also reported the least comprehensive coverage and the least satisfaction with their health plans. Dissatisfaction with health benefits may cause workers to consider other employment opportunities. They are less likely to have coverage for prescription drugs, dental care and vision care than higher-wage earners. Over 40% of low-wage earners reported having trouble paying medical bills even when they did have access to the health care system. They also went without needed health care because of the high cost of additional out-of-pocket medical expenses. (Collins, et al., 2003).

New Hires and Part-Timers Are Less Likely To Be Eligible for Coverage

In a national survey the most frequent reason given for not being eligible for employer provided insurance was not having worked long enough. (Garrett, 2004). Increasingly, employers are requiring that workers be employed at least three months before becoming eligible for benefits. In NYS, the percentage of companies that provided coverage immediately dropped from 33% in 2001 to 19% in 2003. The percentage of employers making employees wait at least three months rose from 33% in 2001 to 39% in 2003. (Edwards, et al. 2004). On average, OMRDD funded agencies required about a two and one-half month waiting period. Some agencies required up to a six-month waiting period.

Full-time employment in the developmental disabilities field appears to be declining. At the same time, many part-time workers are not eligible for health benefits. Increases in health costs may be contributing to this trend. From 2000 to 2003, rates of full-time employment in OMRDD funded agencies declined from 72.8% to 68 %. Thus, about one-third of the workforce was part-time. About 62% of OMRDD funded employers offered health coverage to part-time staff.(Duffy, 2004).

Health Insurance Eligibility and Take-Up Rates

About 75%, or 78,000 workers employed by OMRDD funded agencies, were eligible for employer-provided health insurance benefits. The take-up rate or share of eligible workers that actually enrolled in these plans was 70%. Thus, about 52% or 54,000 of all employees in OMRDD funded agencies actually enrolled in an employer-sponsored plan.(Duffy, 2004). In a national survey, approximately 64% of low-wage workers who were eligible for their employers' coverage took it, compared with 86% of high-wage workers. (Collins, et al, 2003). It is likely that in OMRDD funded agencies management and clinical staff had higher take-up rates than low-wage direct care workers. The overall rate of enrollment in OMRDD funded agencies is slightly lower than the 58.5% of all residential care workers in the U.S. who obtained health coverage through their jobs in 2001. (Fegley, et al., 2003).

Eligible Workers Who Do Not Participate in Employer Health Plans

About one-quarter of all workers in OMRDD agencies were not eligible for benefits, mainly because they worked part-time or had not been employed long enough. About 30% of those who were eligible did not take-up the offer. Some workers were enrolled in Medicaid. Other workers had health coverage through a spouse or other person. Most of the others found premiums unaffordable and just went without coverage. Affordability of health insurance premiums is a key determinant of why workers are uninsured.(Collins, et al., 2003;Garrett, 2004).

Health Benefits and Employee Tenure

In the developmental disabilities field, 25%-50% of turnover occurs during the first year of employment.(Larson, et al., 1998). At the same time, a sizeable core staff has made a longer-term commitment to the field. Studies have consistently shown that almost half of all direct care workers have been employed at the same agency for at least three years. (Ebenstein and Gooler,1993; Howes et al.,2002; Fegley, et al., 2003).

The average tenure of a worker employed by an OMRDD funded agency was 4.6 years. Employees at agencies with rates of enrollment in health benefits plans greater than 60% had an average of one additional year of on-the job tenure compared to those agencies with rates of enrollment below 50%. Also, average tenure was seven months greater in agencies that spent over \$5,000 per enrollee relative to agencies that spent less than \$4,000 per enrollee. Data from the National Longitudinal Study of Youth (NLSY) indicates that on average workers enrolled in employer health plans have more than twice the tenure as those who do not have coverage through their employer. (Duffy, 2004).

These findings are consistent with other studies that suggest that workers in jobs with health insurance coverage change jobs less frequently than do workers in jobs without health benefits. The “job-lock” literature suggests that for certain individuals having employer provided health insurance reduces turnover, and the possibility of losing health benefits when leaving a job, also reduces turnover.(O’Brien, 2003). Although the research is sometimes contradictory, it appears that the strongest evidence of job-lock is among married and single women. (Buchmueller and Valletta, 1996).

Gender and Age Issues

Women comprise about 80% of the direct care workforce in health and human services occupations. Since women use health care services more than men, this workforce is particularly sensitive to access and affordability of health coverage. The aging of workforce also makes health coverage a critical issue. In a recent study of homecare workers, the majority were over 40 years of age, and 28% were over age 55.(Howes, et al., 2002). In a national study in 2001, 21% of uninsured workers were between 45 and 64 years of age.(Garrett, 2004). Individuals covered by employer sponsored health insurance plans are less likely to retire before they become eligible for Medicare at 65, if doing so would mean losing their health benefits. Therefore, it is important that employers maintain access to affordable health coverage not only to recruit new workers, but also to forestall a wave of early retirements in the upcoming years, especially among women.

Union Issues

In NYS a significant percentage of direct care workers employed by non-profit developmental disabilities agencies is represented by unions such as the 1199 Health Employees Union, the United Federation of Teachers, and District Council 1707. Historically union members are far more likely to have employer provided health insurance and more generous health plans. Also, employers of unionized workers generally pay a larger share of both individual and family coverage. (Mishel, L.and Walters, M., 2004; Buchmueller, T. and DiNardo, J. 2001).

The growing health insurance crisis is becoming a contentious issue in labor-management contract talks. Both unions and employers must balance the necessity of modest wage increases with the desire to maintain existing benefits. Organized labor tends to regard the shift in health costs to represented workers as an attack on a traditional perk of union membership. Access to high-quality, low-cost health insurance is an important part of the history of the labor movement and one of its most important organizing and marketing tools. Rising health costs are also causing problems for union administered health insurance programs. A recent survey of major unions in New York City indicated that several union funds were experiencing significant financial difficulties and were being forced to dip into their reserve funds. (Five Borough Institute, Survey, 2003).

If the solvency of union health and welfare funds is threatened this will put greater pressures on labor negotiators to increase the employer share of rising health costs. If workers feel threatened they might turn more to unions to represent their interests. OMRDD, non-profit employers, and unions need to work collaboratively, in their mutual interest, to stabilize health care costs for all parties.

III- Innovative Approaches to Financing Health Coverage

Having a “good job” means earning a living wage, having health benefits, and having opportunities for professional development and career advancement. These are the basic elements that must be in place to have a stable, competent and motivated direct care workforce to provide quality services to children and adults with disabilities. The data indicates that in these areas the developmental disabilities field is in retreat. Wage increases are not keeping up with inflation, and increases in health care costs are being passed along to those who are least able to afford it. Meaningful wage increases for low-wage workers are unlikely until health care costs are contained. It is clear that these issues are part of a broader national problem. Trends in health coverage for direct care workers in the developmental disabilities field are similar to those for frontline workers in related health and human services occupations, and for low-wage workers in other sectors of the economy. Nevertheless, it is important that the developmental disabilities field takes the lead in implementing practices and creative new ideas that begin to address the growing health insurance crisis.

Prorating Premiums Based On Salaries and Hours Worked

Based on the principle of “vertical equity,” employers could re-distribute existing health costs within an organization by prorating premiums based upon salaries. (Meyer and Wicks, 2003). Most employers require the same premium contributions for the same health plan for all workers irrespective of their salaries or family income. A few agencies are experimenting with sliding scales for premiums based upon a percentage of a worker’s salary. If an agency’s priority is covering direct care workers, prorating employee contributions based upon their salaries is a relatively fair way of spreading health care costs and re-distributing purchasing power across all personnel categories within an organization. Also, many eligible part-timers do not enroll in employer provided insurance because they are required to pay a greater share of the cost of premiums, compared to full-timers. Agencies could prorate premium contributions based on the number of hours worked per month. (Lipson and Regan, 2004). However, in re-distributing the cost of benefits within an organization, these innovative practices do not address the system-wide crisis of escalating health care costs.

Participation in Large Insurance Purchasing Pools

There are over 700 non-profits that are funded through OMRDD and each one negotiates its own health plans with insurers. Most agencies offer several different plans. The cost and quality of the plans is not uniform across companies, between large agencies and smaller ones, or even within the same organization. To stabilize health care costs and to create a standard of comprehensive coverage within the field, opportunities and incentives to participate in “group purchasing arrangements” should be expanded.

One possibility is the New York State Health Insurance Program (NYSHIP). NYSHIP is the largest public employer insurance program in the nation outside of the federal government. NYSHIP's Empire Plan was developed as a result of collective bargaining between the State and its employee unions. Thus, the benefit package available through NYSHIP is similar to the one offered to State employees. If special legislation was passed, OMRDD funded providers could join NYSHIP under the "quasi-public" organization rubric.

Another example of an existing "group purchasing arrangement" is the 1199 SEIU Health Employees Union, National Benefit Fund, which purchases coverage for over one hundred thousand direct care workers employed by developmental disabilities and home care agencies, hospitals, mental health clinics, and nursing homes. In addition, the federal government's proposed "Association Health Plans," which would allow employers to band together to provide insurance, might be another possibility provided that all workers were allowed to participate, and consumer protections were built-in.

Greater participation in "group purchasing arrangements" would provide a certain degree of protection from inordinate rate increases, especially for smaller agencies, and would save on human resources costs associated with over 700 individual agencies negotiating with so many private insurers. Since about 80% of the direct care workforce is women, and health care costs for women tend to be higher because of greater use of services, participation in a larger and more diverse insurance pool should be an advantage. The participation of hundreds of non-profits in larger insurance pools would also provide an opportunity to re-establish comprehensive coverage as a standard within the industry.

Shifting Costs to Public Insurance vs Supporting Employer Provided Coverage

In a time of double-digit increases in the cost of health benefits, the possibility of maintaining and even expanding health coverage for direct care workers in the developmental disabilities field is a daunting challenge. The trade offs between modest wage increases that do not keep pace with inflation, and continued health coverage, cannot continue to be made at the expense of direct care workers, or increasingly, they will "opt-out" of the system of employer provided health insurance.

There are many reasons to support the employer-based system. It can provide coverage for the whole family and it can reach families who would otherwise avoid public coverage because of the stigma that they might associate with it. Job-based enrollment, and premium payments through payroll withholding are convenient features. However, affordability of premiums is a key factor.

Increasingly OMRDD agencies are providing bonuses to employees who can demonstrate that they have health coverage through another source, such as a spouse. A possibility for the lowest-wage workers is enrollment in Medicaid and Family Health Plus. In recent studies of comparable healthcare workers, 18% of nursing home aides and 19% of home health aides had family incomes below the poverty level, and over 10% were enrolled in Medicaid. (GAO-01-750T; Yamada, 2002). Many OMRDD funded agencies facilitate the enrollment of their workers into public programs, or would be willing to do so. These bonuses can amount to a significant increase in discretionary income. At the same time the agency saves on its share of the premiums for these workers.

The decision to facilitate enrollment in public programs for eligible direct care workers or to develop alternatives that strengthen the employer-based system, is a critical choice point. In the absence of any realistic options more and more workers will be forced to enroll in public programs, and will be encouraged to do so by their employers. In the long run this will weaken the bond between the worker and the employer and may have other undesirable consequences. More workers will refuse additional hours of employment to maintain their income eligibility for public insurance. Opportunities for promotions and career advancement will be turned down. Also, direct care workers will be more likely to turnover if doing so does not result in the loss of their health benefits. This approach insures that the working poor will remain poor.

As an alternative to shore up rather than undermine the employment-based system, NYS should consider crafting a premium subsidy program via the Health Insurance Premium Payment (HIPP) program and/or the Health Insurance Flexibility and Accountability demonstration (HIFA), or through some other mechanism, that could be used to help purchase comprehensive coverage, through large insurance pools, for targeted direct care workers.

For a variety of reasons many direct care workers employed by OMRDD funded agencies who are eligible for Medicaid, Family Health Plus, and Child Health Plus, do participate in employer provided health plans. Nationally, over 45% of individuals with incomes between 100% and 200% of the poverty level had employer coverage. In a recent study almost one-quarter of all residential care staff in mental retardation and mental health agencies had family incomes below 200 percent of the poverty level. (Fegley, et al., 2003). A significant percentage of low-wage workers and their children who participate in employer plans are eligible for public insurance programs. However, instead of facilitating enrollment in public programs by providing incentives to “opt-out”, another approach seeks to build upon the advantages of a job-based system. (Neuschler and Curtis, 2003).

Through the Health Insurance Premium Payment (HIPP) program, NYS could use Medicaid and/or SCHIP funds to help pay the health insurance premiums for an estimated 10% of its direct care workforce. Premium contributions paid by OMRDD on behalf of eligible employees amounts to a significant subsidy of the publicly funded health insurance system. Through HIPP, OMRDD could be reimbursed for the health care costs of employees and their dependents who could be covered by Medicaid, Family Health Plus, and Child Health Plus, if they were not participating in an employer sponsored plan. (Mitchell and Osber, 2002.)

With federal approval, through the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative, states can also use Medicaid and SCHIP funds to subsidize the purchase of health insurance for “expansion populations” that do not satisfy existing Medicaid requirements. (Sachs, 2003). For example, an “expansion population” could include low-wage workers, 19-64 years of age, with family incomes of up to 200 percent of the poverty level. This “expansion population” would likely include a large percentage of uninsured childless adults. Single workers without children make up 51% of uninsured workers, and 55% of uninsured workers have family incomes below 200 percent of the poverty level.(Garrett, 2004).

OMRDD is in a unique position to administer premium subsidies through its current payment system. A “pass-through” could be created to insure that the additional subsidies would be used only for health benefits and only for the targeted direct care workers and their families. Subsidies for Medicaid eligible workers would pay their share of the premium and all co-payments and deductibles. Additional benefits would be wrapped around a standard benefit plan, such as the Empire Plan, to bridge any differences with the public benefit package. For workers in the expansion population, a sliding-scale mechanism could be calculated to combine government subsidies, and employer and worker contributions. The public subsidy would increase or decrease based on the worker’s family income. A maximum contribution for a targeted worker should not exceed 5% of family income.

IV- Concluding Comments

The significant differences in employer contributions and the multiplicity of plans currently being sponsored make it virtually impossible for OMRDD to properly evaluate or contain health care costs. The proposals, to participate in several larger insurance pools, and to target premium subsidies to direct care workers with family incomes up to 200 percent of the poverty level, would require greater oversight and monitoring of health care expenditures by OMRDD. A wage and benefit “pass-through” would provide a means and a mechanism to monitor expenditures in these inter-related areas. At the same time, OMRDD’s current payment system provides a powerful tool to administer subsidies, and to blend this additional funding with its current health expenditures.

Participation in larger insurance pools is also critical because it would stabilize costs and create a standard benefit package that could serve as a platform for the targeted premium subsidies. A system of cost sharing based upon family income with sliding scales for government subsidies and worker contributions is a relatively equitable way of re-distributing health care costs and purchasing power across the network of non-profit agencies. This would make it easier for virtually all direct care workers to afford coverage.

If nothing is done, agencies will continue to shift the health insurance burden to public insurance programs by expanding “opt-out” incentives with wage bonuses. This will result in further erosion of the employer-sponsored system. Perhaps as much as 10% of the non-profit, OMRDD funded direct care workforce, may be eligible for public programs such as Medicaid, Family Health Plus, Child Health Plus, or Healthy NY, but for a variety of reasons, is not currently enrolled.

The other approach is to apply subsidies, funded through Medicaid and SCHIP, to help direct care workers get health insurance through their jobs. This option builds upon the many strengths of the employer-based system and could be designed to provide an incentive to participate in a large insurance purchasing pool. From the point of view of decreasing turnover, increasing job tenure and job satisfaction, enhancing productivity, improving morale, and fostering organizational commitment, this latter approach is preferable.

Implementing these ideas would require a statewide initiative and would have to be expanded beyond OMRDD to include frontline workers in related, publicly funded, health, education and human services occupations. If a consensus could be achieved and details worked out, the upcoming renewal of HCRA could provide a venue to move forward.

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