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PHI's Comments on Senate Finance Committee Report
Expanding Health Care Coverage:
Proposals to Provide Affordable Coverage to All Americans

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Introduction

PHI commends the Senate Finance Committee for the breadth and scope of the options it has presented in its paper, *Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans*. As an organization dedicated to our nation's three million direct-care workers, and the millions of elders and people with disabilities they serve, PHI applauds your efforts to make health care coverage more affordable and accessible to all Americans. As a workforce that is more likely to be uninsured, with higher rates of chronic health conditions and a very high incidence of workplace injuries, direct-care workers have much to gain from reform that both expands coverage and increases attention to screening, prevention and health promotion services.

We are also encouraged by your attention to long term services and supports--particularly options for expanding home- and community-based service as an integral component of reform. Such provisions are critical for meeting the needs of our elders and those living with chronic illnesses or disabilities.

However, we also wish to bring to the Committee's attention the serious workforce implications of the policy directions supported by the Committee's proposals: **the twin goals of rebalancing and meeting expanding demand for long term services and supports cannot be accomplished without a corresponding focus on building and sustaining an adequate workforce to supply these services.** We are particularly concerned that the vast majority of states racing toward home-based care—while welcomed by all of us as consumers—are to date unwilling to develop a comparable workforce strategy capable of bearing the weight of this massive policy shift. While many states are beginning to realize that they must invest in their direct-care workforces, their efforts tend to be disparate and sporadic.

PHI urges the Committee to consider the workforce-related proposals we made in our comments on your Delivery Paper. As part of the Committee's proposed Health Care Infrastructure Investments, we proposed a new subsection titled "*Investing in the home- and community-based workforce for long-term services and support.*" Drawing on federal legislative

proposals already introduced, we recommended three essential but complementary workforce-related infrastructure investments:

- Creating requirements for **state workforce plans**
- Improving **training** for frontline health care workers in HCBS settings
- Developing systems **for workforce data collection and monitoring**

PHI submits the following comments on specific sections of the Coverage Report for your consideration:

Section I: Insurance Market Reforms

Insurance Rules: PHI supports the Committee’s proposals that would create new federal rating standards for private insurance plans, including guaranteed issue and renewability, and prohibitions against pre-existing condition exclusions and lifetime and annual caps. In addition, we support the proposal that would prohibit rating based on health status, gender, and occupation. We also support the inclusion of a risk adjustment mechanism to ensure that different pools and/or plans do not suffer from adverse selection and urge the Committee to apply this mechanism to the largest pools possible.

We urge the Committee also to consider phasing out age rating. This insurance company practice has resulted in many direct-care workers and their employers paying higher rates for insurance.. Many of these workers are older women – 40% of direct care workers are over the age of 45 -- who live with chronic health conditions. The statistics are even more troubling for personal and home care aides – jobs that are among the fastest growing in the country – with nearly half (48.8%) over the age of 45. Provisions that prohibit rating on age and health status are very important to improve access and affordability.

Health Insurance Exchange: PHI supports the creation of a health insurance exchange that can serve as a purchaser of coverage as well as a strong negotiator of premiums with private insurance plans. Creating an entity that is responsible for ensuring a level playing field for insurers and access to quality plans for consumers is critical to eliminating some of the inequities in our current system. We would encourage the Committee to have the Exchange be the sole venue for buying both individual and small group coverage--allowing insurers to operate outside the system could encourage adverse selection and prevent the Exchange from having a large enough pool for rating.

We urge the Committee not to allow multiple exchanges to compete within an area. The insurance system is complex and confusing, and one of the goals of reform is to simplify access to coverage options for consumers, rather than add navigation difficulties. In addition, we recommend that the Committee limit the number of permissible benefit levels available from the Exchange [addressed in Section II: Making Coverage Affordable, p.9). Our concern is that multiple levels will result in “tiering” leaving lower income enrollees at the lowest level of

coverage. Given the absence of caps on out-of-pocket costs, the lowest tier option with cost-sharing of approximately 24% could place enrollees at significant financial risk, with plan options that could leave people essentially under-insured.

Section II: Making Coverage Affordable

Benefit Options: We are pleased to see the Committee recommend a broad range of benefits as categories of services that must be offered in the non-group and small group market. We urge further definition from the Committee, the Exchange, or a quasi-governmental board to arrive at a defined coverage floor that is enforceable through the Exchange. The Exchange should be charged with negotiating benefits and rates with insurers wishing to offer coverage through the Exchange to ensure consumers are getting good value. We also want to reiterate our support for no lifetime limits on coverage or annual limits on any benefits, and support the first option of no cost-sharing on preventive care services. This will encourage low-wage direct-care workers to seek the medical care they need, rather than putting off going to the doctor for preventive care because of cost of co-pays or deductibles.

We would also urge the Committee to consider creating a Benefit Board or Commission of some type that would define, and redefine as needed, the benefits and services covered within each plan option. This should be an independent board, consisting of consumers and medical experts, charged with: a) evaluating new data that emerges from comparative effectiveness studies, and b) ensuring that necessary services and benefits are included in plans approved by the Exchange.

Low-Income Tax Credits: We are pleased that the Committee is recommending a sliding scale, refundable, advanceable tax credit for consumers with modified adjusted gross incomes (MAGI) up to 400% FPL who purchase insurance in the Exchange. We also support the provision that individual premiums be capped at a certain percentage of MAGI. However, PHI recommends expanding this protection beyond the premium contribution to include all health care costs -- deductibles, co-insurance and co-payments in order to truly reflect the cost-sharing burden on individuals.

Tax Credits for Small Businesses: The Small Business Tax Credit option is a positive step that will assist many long-term care employers to provide coverage to their workers. The elder care/disability services industry employs more people than nearly any other industry in the country and is a leading industry for job growth. Yet many are small businesses and are unable to afford health coverage for their workers, so providing assistance to these small employers is critical.

However, many long-term care employers are non-profits and, therefore, would be ineligible for the tax credit. PHI urges that the credit be structured so that it could be applied against the payroll taxes paid by both for-profits and non-profits. Precedent for this can be found in the American Resource and Recovery Act where the COBRA subsidy for employers operates as a

credit against payroll taxes. Whatever form the tax credit takes, it is important that it take a simple form in order to ensure the highest levels of participation.

Section III: Public Health Insurance Option

PHI supports the proposal to include a public health insurance option for consumers. This could provide critical competition and choice for consumers purchasing health insurance in the Exchange, and help ensure accountability and transparency in this new insurance market. Many areas of the country lack meaningful competition among health insurers – leaving consumer little or no choice among insurance plans. Studies show that a public health insurance option would help drive down costs for all competing plans in a market. The experience with Medicare --with its administrative efficiencies --is a model worth considering. In addition to low administrative costs, public insurance has succeeded in controlling cost growth better than private coverage. Between 1997 and 2006, private health insurance spending per enrollee rose an average of 7.3% per year. Spending under Medicare grew only 4.6% per year. Administrative efficiencies and better cost controls under a new Medicare-like plan could inject competition into the market and force private plans to develop strategies to deliver a more cost efficient, high quality product.

Section IV: Role of Public Programs

Medicaid Coverage: The Medicaid program has been a crucial source of coverage for direct-care workers and their families. A third of direct-care workers live in households receiving Medicaid benefits. The low wages of direct-care workers, combined with the often part-time nature of the work, has meant that many more workers would be uninsured if it weren't for the Medicaid program.

Yet state Medicaid programs have many different eligibility categories, each of which are often associated with different income-eligibility thresholds. This complicated array of eligibility rules results in inequitable access to health care for low-income Americans across the country. We strongly support the creation of a uniform Medicaid eligibility for families with children, which—as proposed—would require a suggested eligibility threshold of 150 % FPL (using a new modified adjusted gross income standard) for pregnant women, children, and parents. Further, it is critical to ensure that states do not roll back their commitments to currently covered populations above 150%. A maintenance of effort provision that protects currently-covered populations is essential.

We also urge the Committee to include low-income childless adults in a new national Medicaid eligibility floor of 150%. The Committee's paper is currently silent on this population except in the section that indicates that childless adults below 115 % FPL would be eligible for federal tax credits to either purchase Exchange coverage or buy into the Medicaid program. In most states, regardless of how low their income level is, childless adults are not eligible for publicly-sponsored health insurance. Many direct care workers are childless adults and fall between the

cracks of eligibility for public coverage and employer-sponsored insurance (either because it is not offered, they can't afford it if it is offered, or they are not eligible because they work less than full-time).

Enrollment and Retention Simplification: PHI strongly supports a requirement for states to adopt simplified Medicaid enrollment processes, such as through the elimination of face-to-face interview requirements and assets tests, and the establishment of 12-month continuous eligibility. While Medicaid and other public programs remain major sources of health coverage for direct care workers, numerous barriers prevent eligible workers from getting enrolled and *staying* enrolled. One of the key barriers to coverage in the current system involves the constant fluctuation of work hours for these workers.

In the current system, this can lead to “churning” between employer-sponsored insurance and Medicaid. A solution to this churning is guaranteed continuous eligibility. Continuous eligibility would not only improve overall coverage, but would significantly reduce the administrative work necessitated by workers transitioning in and out of coverage. To maintain coverage beyond 12 months, efforts should be made to minimize churning at the point of annual recertification.

FMAP Formula Change: We support the proposed change to the FMAP formula, which would incorporate data on a state's poverty level in addition to data on per capita income. The current FMAP formula, which relies solely on a state's per capita income when determining the level of federal reimbursement for its Medicaid expenditures, may not adequately reimburse those states with particularly large gaps between high and low-income populations. A state with a substantial number of both high- and low-income individuals may have a high per capita income but also have a large low-income population that qualifies for the Medicaid program—by factoring in two different measures of state poverty, the proposed FMAP formula is more responsive to state needs.

Medicare Coverage: PHI supports both Medicare coverage proposal that would allow 55-64 year-old adults to buy into the Medicare program. Allowing an early Medicare buy-in program for those 55-64 in age would benefit many direct-care workers. Overall, 15% of all direct-care workers are between the ages of 55 and 64; that number rises to an astonishing 20% for personal and home care aides. To ensure that the buy-in option expands access to coverage in an equitable and meaningful way for low-income individuals, the low-income tax credit must also be available to individuals buying into the Medicare program.

Section V: Shared Responsibility

PHI strongly believes that reform must ensure that everyone has access to affordable coverage and that individuals, employers and government all share in the responsibility to pay for that coverage.

Persons Responsibility Coverage Requirement: The high cost of premiums and copayments is the most frequently cited obstacle to the participation of direct-care workers in employer-sponsored plans. Many surveys of health insurance coverage for direct-care workers document this problem – many workers do not take coverage offered by their employer because it is not affordable. For example, a recent survey of home care agencies in New York State (outside of New York City) found that one in five home care workers are offered coverage but do not enroll primarily due to unaffordable premium costs. In Iowa, a survey of certified nursing assistants found a 41 percent increase from 2001 to 2004 in the number of workers who did not take the coverage offered by their employers due to cost. Workers whose median hourly wage was \$10.48 in 2007, \$4.62 per hour less than the median wage for all US workers, can only be asked to contribute a minimal amount towards their health coverage. Without ensuring that an individual's contribution is affordable, many workers will continue to lack access to coverage

The Committee takes several positive steps to ensuring affordability. First, the proposal would provide greater help to lower-income individuals, with the tax credit subsidizing the highest benefit option for lowest income. Second, the lowest-income people would have increased access to the cost-sharing and benefit protections of Medicaid. Third, premiums in the Exchange would be capped at a percentage of income. PHI would urge the Committee for an additional assurance of affordability: an overall cap for total enrollee cost-sharing, based on percentage of income.

Employer Requirement: PHI believes that all employers should share in the financing of coverage whether it is in the provision of health insurance to their employees or a payment in lieu of coverage. We also believe that for direct care workers, their employers must pay for a significant portion of the premium if employees are to enroll in that coverage. Studies have shown that the two major reasons why direct care workers do not participate in employers-sponsored insurance that they are offered is because it is too expensive or that they do not work enough hours to be eligible.

However, several unique characteristics of long-term care employers must be addressed. First, many workers who provide in-home care are hired directly by consumers. Some states and counties have formalized these arrangement and established structures for providing benefits to this workforce, but many workers do not have any employer but the client they assist. Secondly, many employers are heavily dependent on public funding (Medicaid and Medicare) to pay for services, and inadequate reimbursement rates are a major barrier to offering health insurance. Some states, like Montana, recently passed a law providing an enhanced Medicaid reimbursement rate specifically to pay for health insurance to Medicaid-funded providers who deliver in-home personal assistance and private duty nursing services to the elderly and people with disabilities.

We urge the Committee to address both these trends by either providing sufficient funds to ensure that long-term care employers providing services paid for by public dollars can pay for coverage, or ensure that these workers have access to an affordable public health insurance

coverage option. Also, as the paper proposes, the employer requirement should only apply to full-time workers, exempting employers with predominantly part-time workforce like home care. Any employer requirement should apply to all workers, with a contribution requirement proportional to hours worked. This would reduce the incentive for employers to drop hours of work in order to avoid contribution liability.

Section VI: Options To Improve Access To Preventative Services and Encourage Healthy Lifestyles

PHI strongly supports options to improve access to preventative services and encourage healthy lifestyles. These provisions are important for direct care workforce for two reasons:

- **Direct care workers have high rates of chronic medical conditions**, such as diabetes and hypertension. Broader inclusion of screening and prevention services would improve the lives and health of these workers and help to stabilize the workforce overall.
- **Direct care workers are an underutilized public health resource.** Every day, over 3 million direct care workers are in direct contact with millions of Americans with chronic diseases and disabilities. With increased training and a more expansive view of their role, these workers are a substantial human capital asset to be leveraged in operationalizing new models of care aimed at preventing illness and promoting health.

To realize this potential as public health workers, an investment is needed to ensure that workers have the training they need to assume this function.

Specifically with regard to the *Prevention and Wellness Innovation Grants*, PHI encourages the Committee to identify the direct-care workforce as key participants in team-based care. Further, PHI recommends including as an example of an innovative approach one that would think of the worker and the consumer as a health dyad where resources could be focused on changing the behavior and improving health status of the two, together. Through a mix of education and modest incentives, direct-care workers could support certain health-related behaviors, and thus address conditions of their clients, that are acquired or exacerbated by poor eating habits, lack of physical activity, and social isolation. At the same time the worker would gain valuable knowledge and experience that could be applied toward improving the worker's own health and lifestyle.

Section VII: Long-Term Care Services and Supports

The coverage proposals for long-term care services and supports are highly commendable and seek to meet the preference of our elders and others with disabilities for services at home and in their communities. At the same time, they raise the question of how to develop a sufficient workforce capacity to fulfill this promise to expand home- and community-based services

(HCBS). The effectiveness of policies that expand eligibility and access to HCBS are likely to be severely compromised if equivalent attention is not given to developing the frontline HCBS workforce to provide these services.

While workforce development issues are clearly the province of the Committee's Delivery Report, we wish to bring to you attention the following areas under Section VII that have specific workforce implications:

Increase Federal Match for Medicaid HCBS

In light of the essential need to encourage states to develop comparable workforce strategies capable of bearing the weight of a the proposed policy shift toward Medicaid HCBS, we recommend, at a minimum, that the Committee consider conditioning the receipt of the proposed 1% FMAP increase on successful submission by each state of a workforce development plan . The requirement of a plan could be linked to the so-called "equal access" provision of Title XIX of the Social Security Act (§1902(a)(30)(A) which directs that:

A state plan for medical assistance...[must] provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan...as may be necessary to...assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

We further recommend that state HCBS workforce plans address the following areas:

- Assessment of the adequacy of current workforce to meet demand for services,
- Analysis of the impact of the expansion of HCBS benefits and future growth of eligible consumer populations on the adequacy of the HCBS workforce,
- Demonstration of the adequacy of average compensation to build a sufficient workforce, and training and retention programs for home and community-based services workers (which may include, as determined appropriate by the State, allowing participation in such training to count as an allowable work activity under the State temporary assistance for needy families program funded under part A of title IV),
- Plans to assist consumers with finding and retaining qualified workers, and
- Description of State efforts to collect a minimum data set of information on their workforce across long-term care settings that includes:
 - numbers of direct service workers (full time and part time),
 - stability of workforce (turnover and vacancies), and
 - average compensation of workers (wages and benefits).

In addition, attention must be paid to the relatively low-wages of the direct care workforce overall (\$10.48 per hour in 2007 compared to \$15.10 for all workers) and the fact that, when adjusted for inflation, wages for workers who provide HCBS services [home health aides, home care aides and personal care aides] have actually declined over the last eight years. In order to

make these occupations competitive and to retain workers in the field for the longer-term, **PHI recommends that a significant percentage of the 1% increase be structured as a direct pass through to direct-care workers.**

Further, to both meet the goals of providing HCBS to greater numbers of consumers and to provide adequate compensation to the workers who provide those services, **PHI recommends considering an increase in FMAP for HCBS services beyond 1%.**

Long Term Care Grants Program

In the Committee's description of current long-term care grant programs, we recommend adding a description of the CMS National Direct Service Worker Resource Center (DSW-RC). CMS created the Resource Center in 2006 to assist states in responding to the large and growing shortage of workers who provide direct care and personal assistance to individuals who need long-term supports and services. The Resource Center supports state efforts to improve recruitment and retention of workers who assist people with disabilities and older adults to live independently and with dignity in the community. Over the last 3 years, through a competitive process, the Resource Center has provided technical assistance to 15 states, and an additional 11 states have received short term general assistance. The Center is currently supporting workforce initiatives to Money Follows the Person grantees.

Under the proposed option to the LTC Grants Program, PHI recommends adding a seventh discretionary funding category that would facilitate the delivery of HCBS by ensuring that states put in place comprehensive workforce development plans designed to ensure an adequate and stable direct-care workforce sufficient to deliver the services and supports demanded by public programs.

Money Follows the Person Rebalancing Demonstration

PHI supports the extension of the MFP Demonstration and recommends that the Committee propose that grants made under the extension emphasize state solutions to what have proved to be the two greatest obstacles to transitioning individuals from institutional care to home and community settings and preventing reliance on institutional care in the first place—namely, lack of housing and shortages of direct-care workers available to provide services and supports in home- and community-based settings.