PHI QUALITY CARE THROUGH QUALITY JOBS

Community Catalyst

ISSUE BRIEF:

CLOSING THE COVERAGE GAP: MEDICAID EXPANSION AND THE DIRECT CARE WORKFORCE

November 2024

EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act (ACA) of 2010 was originally designed to expand Medicaid eligibility to all adults with incomes below 138 percent of the federal poverty level across all states, among other provisions. However, a 2012 Supreme Court ruling allowed states to opt out of Medicaid expansion, and as of 2024, 10 states have still not expanded Medicaid. As a result, many people fall into the *coverage gap* in those states because they earn too much to qualify for Medicaid but not enough to receive marketplace subsidies for health insurance.

Many direct care workers—including personal care aides, home health aides, and nursing assistants who provide daily support to older adults and people with disabilities and serious illnesses across a range of settings—fall in the coverage gap. Despite their vital role, direct care workers are among the largest and the lowest-paid occupational groups in the United States and many lack health care coverage themselves. This report examines the size and composition of the coverage gap for direct care workers, estimates how many direct care workers could be covered if Medicaid were expanded in the remaining 10 states, and shares policy recommendations to support this workforce and improve health outcomes.

KEY FINDINGS

- Nearly 80,000 direct care workers are currently in the coverage gap.
- Direct care workers in the coverage gap are predominantly women and workers of color.
- The current proportion of direct care workers without any health insurance in states that have not expanded Medicaid is significantly higher than in those that have (23 percent versus 9 percent).
- Nearly 150,000 direct care workers (including 79,515 who are currently in the coverage gap and 68,044 who are currently eligible for market subsidies) would become eligible for coverage if the 10 remaining states expanded Medicaid.

POLICY RECOMMENDATIONS

- All 10 remaining states should fully expand Medicaid, without work requirements or other barriers to access.
- Further extend Medicaid eligibility by adopting the Basic Health Program or buy-in programs and removing citizenship, residency, and waiting period requirements.
- Invest in outreach to address under-enrollment among direct care workers who are already eligible for Medicaid.
- Enhance subsidies for health insurance marketplace and private insurance plans for direct care workers and incentivize employer-provided coverage.
- Increase hourly wages and stabilize work hours to ensure that direct care workers can afford health care costs, regardless of the type of coverage for which they are eligible.

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INTRODUCTION

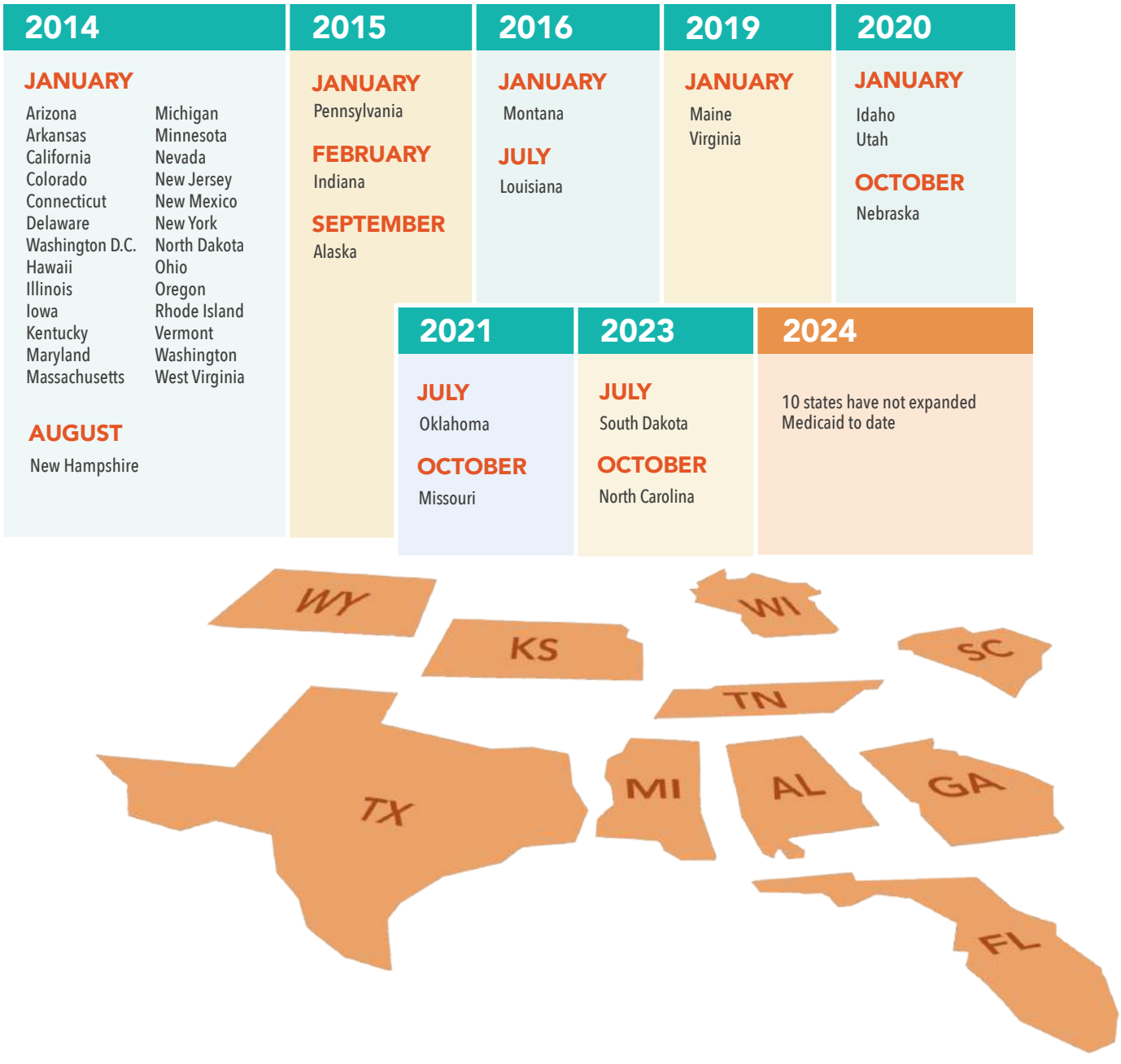
Direct care workers—including personal care aides, home health aides, and nursing assistants—play a critical role in the delivery of health and long-term care services to older adults and people with disabilities and serious illness across a range of settings. Yet many of these workers are unable to access health care for themselves, often because they cannot afford health insurance.

Nationwide, fully 37 percent of direct care workers live in or near poverty (defined as earning less than 200 percent of the federal poverty level) and more than one in 10 are uninsured.[1] These factors, combined, can leave direct care workers' health care needs unmet, leading to poor health outcomes, turnover, and workforce shortages. Given that there are 8.9 million projected job openings in direct care over the next decade—a number that includes more than 860,000 new jobs [2]—there is an urgent need to improve direct care workforce recruitment and retention. In addition, the ongoing impacts of the COVID-19 pandemic on this workforce and the populations supported by direct care workers underscore the imperative to improve access to affordable health care.[3]

The Patient Protection and Affordable Care Act (ACA) of 2010 was designed to expand Medicaid eligibility to cover adults with incomes below 138 percent of the federal poverty level in every state.[4] The full impact of this historic legislation on uninsured rates among direct care workers and other low-wage workers was undermined, however, by a 2012 Supreme Court ruling that made Medicaid expansion optional.[5] As a result, only 25 states and Washington D.C. expanded Medicaid in 2014, while the remaining half of the states did not. Since then, an additional 15 states have followed suit, leaving 10 states yet to expand Medicaid. (See Figure 1 for a timeline of Medicaid expansion across states.)

Updating prior research on Medicaid expansion and the direct care workforce,[6] this report examines health insurance coverage rates among direct care workers in states that have expanded Medicaid versus states that have not. Critically, we identify direct care workers who fall into the *coverage gap* in states that have not yet expanded Medicaid. The analysis reveals disparities in eligibility across states (by Medicaid expansion status) and among direct care workers, with some segments of this workforce overrepresented in the coverage gap. The report ends with recommendations for policy interventions, including but not limited to Medicaid expansion.

FIGURE 1: Timeline of Medicaid Expansion by State, 2014 to 2024



What is the Coverage Gap?

As of 2024, 10 states—Alabama, Florida, Georgia, Kansas, Mississippi, South Carolina, Tennessee, Texas, Wisconsin, and Wyoming—have still not adopted Medicaid expansion. In these states, over 1.6 million adults fall into the coverage gap, meaning that they earn too much to qualify for Medicaid but too little to receive ACA subsidies to purchase coverage directly through the health insurance marketplace.[7] Many of these individuals are self-employed or work in industries where wages tend to be low and employers do not offer health coverage. In addition to direct care workers, those in the coverage gap often work in child care, construction, retail, and food services.[8]

On the Medicaid side, the income thresholds for Medicaid eligibility in states that have not yet expanded Medicaid are shockingly low. For parents with children under the age of 19, the median income threshold across these states is 34 percent of the federal poverty level (see Table 1), which translates to $5,120 per year for a one-person household and $8,779 per year for a family of three, according to the 2024 federal poverty levels.[9] Further, regardless of their earnings, adults without children are categorically excluded from Medicaid eligibility in every state that has not expanded Medicaid with the exception of Wisconsin, which implemented the BadgerCare Section 1115 demonstration waiver to cover these individuals.[10]

TABLE 1. Medicaid Eligibility in States that Have Not Yet Expanded Medicaid as a Percentage of the Federal Poverty and Income Levels, by Parental Status and Household Composition

	CHILDLESS ADULTS % of FPL	PARENTS % of FPL	One Person Household	Two Person Household	Three Person Household
Alabama	0%	18%	$2,711	$3,679	$4,648
Florida	0%	27%	$4,066	$5,519	$6,971
Georgia	0%	30%	$4,518	$6,132	$7,746
Kansas	0%	38%	$5,723	$7,767	$9,812
Mississippi	0%	27%	$4,066	$5,519	$6,971
South Carolina	0%	67%	$10,090	$13,695	$17,299
Tennessee	0%	105%	$15,813	$21,462	$27,111
Texas	0%	15%	$2,259	$3,066	$3,873
Wisconsin	100%	100%	$15,060	$20,440	$25,820
Wyoming	0%	45%	$6,777	$9,198	$11,619

Source: KFF. 2024. "State Health Facts." https://www.kff.org/statedata/; ASPE. 2024. "Poverty Guidelines." https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines.

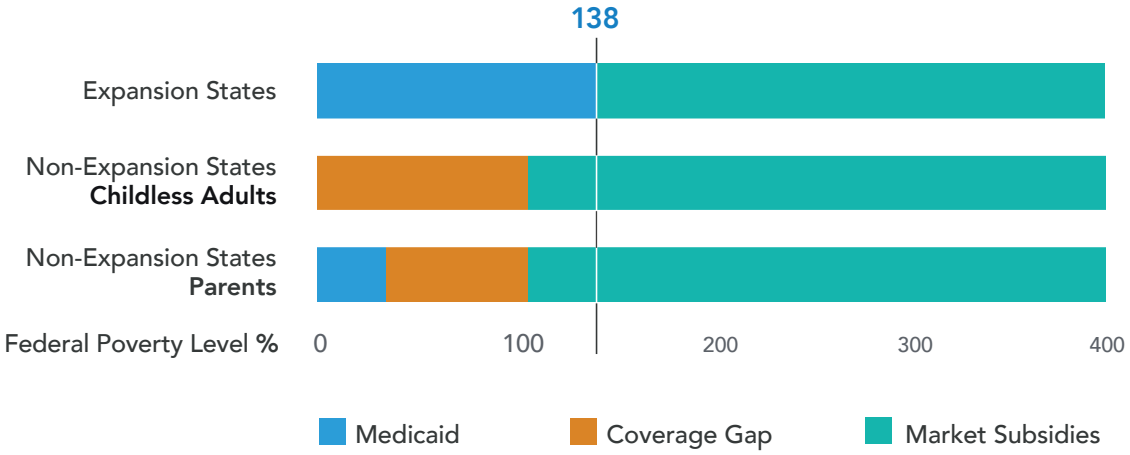
Altogether, these criteria prohibit many of even the lowest-earning direct care workers from accessing Medicaid.[11]

On the ACA marketplace side, individuals cannot qualify for federal tax credits or subsidies to purchase individual coverage on the health insurance marketplace until their income places them between 100 and 400 percent of the federal poverty level. [12]

Caught between these maximum (Medicaid) and minimum (marketplace subsidies) income eligibility thresholds in states that have not expanded Medicaid is a segment of workers who do not qualify for either form of coverage. As noted above, the only non-expansion state without this coverage gap is Wisconsin, which expanded Medicaid to cover all adults earning less than 100 percent of the federal poverty level through the BadgerCare Section 1115 waiver.[13]

Notably, as well as closing the coverage gap, Medicaid expansion also extends coverage to some workers who currently qualify for ACA marketplace subsidies but may nonetheless be unable to afford coverage. This group includes those earning incomes between 100 and 138 percent of federal poverty level, who qualify for ACA marketplace subsidies but may still struggle to afford private health insurance due to required expenditures like co-pays and other out-of-pocket costs.[14] Figure 2 illustrates how expanding Medicaid can close existing gaps *and* extend coverage to some of those who are eligible for marketplace subsidies, including adults with and without children.

FIGURE 2: The Coverage Gap in States that Have Not Expanded Medicaid



Note: While the income eligibility thresholds for Medicaid for parents across the non-expansion states vary widely, for the purposes of illustration, the median of the nine states (34%) is used. Wisconsin is excluded because there is no coverage gap due to the BadgerCare waiver.

Who are Direct Care Workers?

Direct care workers include personal care aides, home health aides, and nursing assistants (as formally classified) who are employed in a range of settings, such as home care, residential settings such as assisted living, and nursing homes, among other settings.[15] These workers provide vital daily support that enables older adults and people with disabilities to maintain optimal health, function, and wellbeing. Their complex and skilled role includes assistance with daily tasks, such as dressing, bathing, and eating, as well as interpersonal engagement to combat loneliness and social isolation. In the home care setting, personal care aides help their clients with additional tasks such as meal preparation, housekeeping, and attending appointments, while home health aides and nursing assistants also perform certain clinical tasks under the supervision of a licensed professional (such as vital sign readings, wound care, and range-of-motion exercises, among other tasks).[16] One segment of the direct care workforce, direct support professionals, primarily supports individuals with intellectual and developmental disabilities, including by facilitating their engagement in education, employment, and other community integration activities.[17]

Direct care workers, who are predominantly women and Black or Latino, and disproportionately immigrant workers, face persistently low wages and other occupational challenges—despite growing demand for direct care due to population aging. Even with recent wage gains—largely driven by federal and state investments during the earlier phase of the COVID-19 pandemic—the national median wage for direct care was just $16.72 in 2023. As a result, 39 percent of this workforce lives in or near poverty and 46 percent rely on public assistance programs to make ends meet. In addition, nationwide, 38 percent of direct care workers work part-time and 19 percent work part-year, with implications for their ability to predict and maintain eligibility for health insurance. While some workers may choose to work part-time or part-year to balance financial, educational, and/or caregiving obligations, many involuntarily work insufficient and unstable hours. Work hours in home care can be particularly inconsistent as clients have different authorized hours of care and because employment can be interrupted when clients care needs change or they pass away.[18]

Direct care jobs are also physically and emotionally demanding and characterized by disproportionately high rates of workplace injuries—underscoring the importance of adequate health coverage and care for this essential workforce.

The Physical Toll of Direct Care

"This field is one of the fields that can really put some pain in your body. Sometimes they even may say, 'Oh well we got lifts' or this partner is helping. And it's still going leave you with some kind of pain... Some days, like today, I didn't even get a break."

MICHELLE GODWIN, *Certified Nursing Assistant, Florida*

Why States Should Prioritize Health Coverage for Direct Care Workers

The positive impacts of increasing health care coverage for direct care workers ripple across the entire health and long-term care system. First, considering workers themselves, direct care is challenging and often hazardous work.[19] Direct care workers are often exposed to secondhand smoke and other environmental toxins,[20] and they disproportionately experience musculoskeletal disorders.[21] In addition, these workers frequently face workplace isolation and loneliness[22] as well as workplace violence, such as verbal abuse[23] and physical violence.[24] Reflecting these working conditions, occupational injury and illness rates are 1.4 times higher for home health and personal care aides and 8 times higher for nursing assistants as compared to the average U.S. worker.[25]

Without health insurance, direct care workers are unlikely to access routine preventive care or the care they need to address workplace injuries and illnesses. Research confirms that health insurance coverage is a key predictor of health care use and health outcomes more broadly. For instance, PHI's previous research shows that direct care workers with continuous health insurance coverage are 1.3 times more likely to have a usual place of medical care than those with insurance gaps.[26] Another study showed that uninsured home care workers, specifically, are twice as likely to report fair or poor health compared to their insured counterparts.[27] Conversely, Medicaid expansion is associated with a range of positive outcomes related to health insurance coverage; access to, affordability of, and utilization of care; diagnosis and treatment; health outcomes overall and for a number of specific conditions; state economic indicators; and more.[28]

As well as harming workers, inequitable health care access and outcomes impact care quality for consumers and their families. When direct care workers experience poor health at work, require time off, or have to leave their jobs or the workforce entirely, the individuals they support face interrupted care, unmet needs, and adverse health outcomes.[29] In addition, these individual outcomes can drive up health care costs overall, through higher workforce costs and increased rates of emergency department use, avoidable hospital admissions, and other costly outcomes.[30] The COVID-19 pandemic only exacerbated the challenges of poor health coverage for this workforce.[31]

In turn, family caregivers must shoulder even more responsibility, leading to reduced work hours, dropping out of the labor force entirely, and family caregiver burden.[32] Together, these findings reinforce why expanding Medicaid eligibility is critical to supporting the health of direct care workers, care recipients, and their families and reducing overall costs to the system.[33]

Finally, Medicaid is both a key source of health insurance coverage for direct care workers *and* the largest payer for most direct care services.[34] Consequently, Medicaid reimbursement rates have an outsized impact on direct care workers' wages and their ability to afford employer-sponsored health insurance (if available), private insurance, and other health care costs.

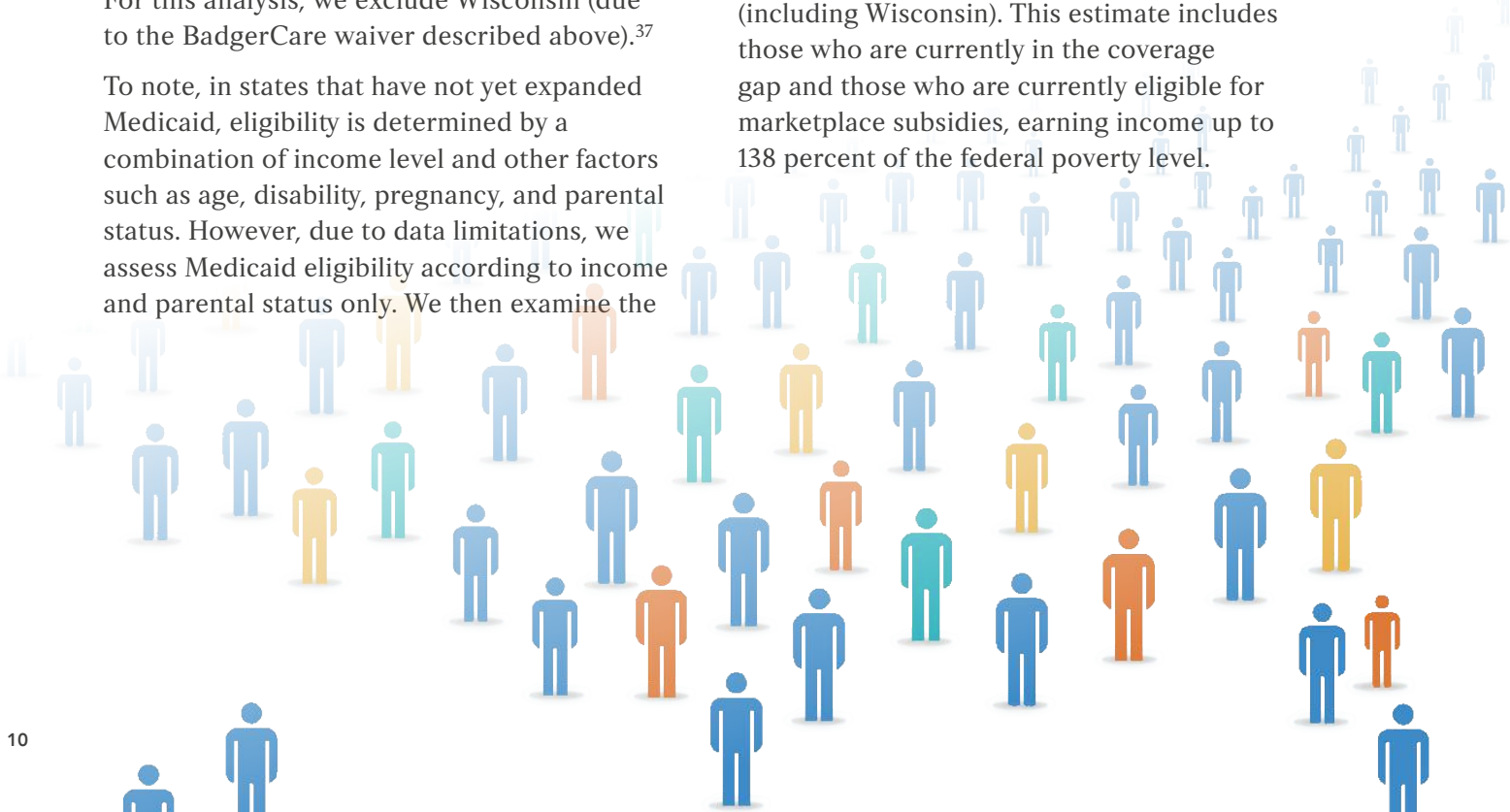
METHODOLOGY

This Report draws from the U.S. Census Bureau's American Community Survey (ACS) 5-year data from 2018 to 2022.[35] We restrict the analytic sample to personal care aides, home health aides, and nursing assistants employed in the following industries: employment services; home health care services; hospitals; nursing care facilities; residential care facilities; individual and family services; vocational rehabilitation services; and private households.

We begin by comparing the rates of direct care workers who are enrolled in Medicaid and those who are uninsured between states that have and have not yet expanded Medicaid as of 2024. Next, restricting the sample to states that have not yet expanded Medicaid as of 2024, we estimate the number of direct care workers who fall into the coverage gap by applying survey weights to the analytic sample.[36] For this analysis, we exclude Wisconsin (due to the BadgerCare waiver described above).[37]

To note, in states that have not yet expanded Medicaid, eligibility is determined by a combination of income level and other factors such as age, disability, pregnancy, and parental status. However, due to data limitations, we assess Medicaid eligibility according to income and parental status only. We then examine the demographic profile of direct care workers in the coverage gap, focusing specifically on gender, race/ethnicity, and parental status. Parental status is defined as having at least one child under the age of 19 living at home.

Finally, we estimate the number of direct care workers who would become newly eligible for coverage through Medicaid expansion in all 10 states that have not yet expanded Medicaid (including Wisconsin). This estimate includes those who are currently in the coverage gap and those who are currently eligible for marketplace subsidies, earning income up to 138 percent of the federal poverty level.



FINDINGS

This section presents the findings from our analysis of direct care workers' insurance rates, the number and characteristics of direct care workers in the coverage gap in states that have not expanded Medicaid, and the potential impact of Medicaid expansion in those states.

Medicaid Expansion Improves Health Insurance Coverage for Direct Care Workers

Compared to direct care workers in states that have expanded Medicaid, those in states that have not expanded Medicaid are less likely to have Medicaid coverage and more likely to go without any insurance coverage (See Figure 3). Specifically, the proportion of direct care workers without any health insurance is 9 percent in states that have expanded Medicaid, but nearly a quarter (23 percent) in states that have not. Further, only 15 percent of direct care workers in non-expansion states are covered by Medicaid, as compared to 32 percent in states that have expanded Medicaid. Together, these findings indicate that the state-level decision not to expand Medicaid has a sizable impact on direct care workers' access to health insurance.

Direct care workers in states that have not yet expanded Medicaid are nearly three times as likely to lack health insurance coverage compared to those in the expansion states.

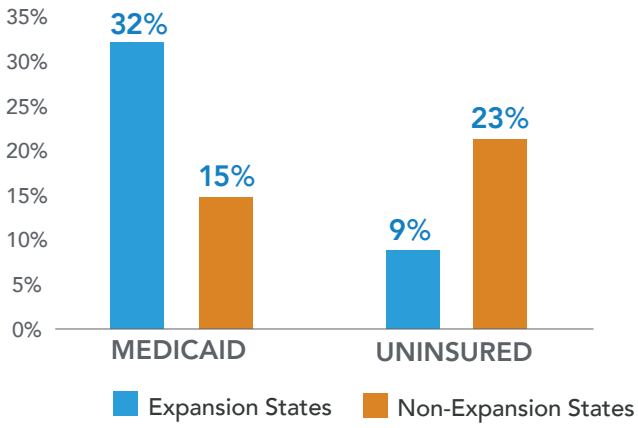
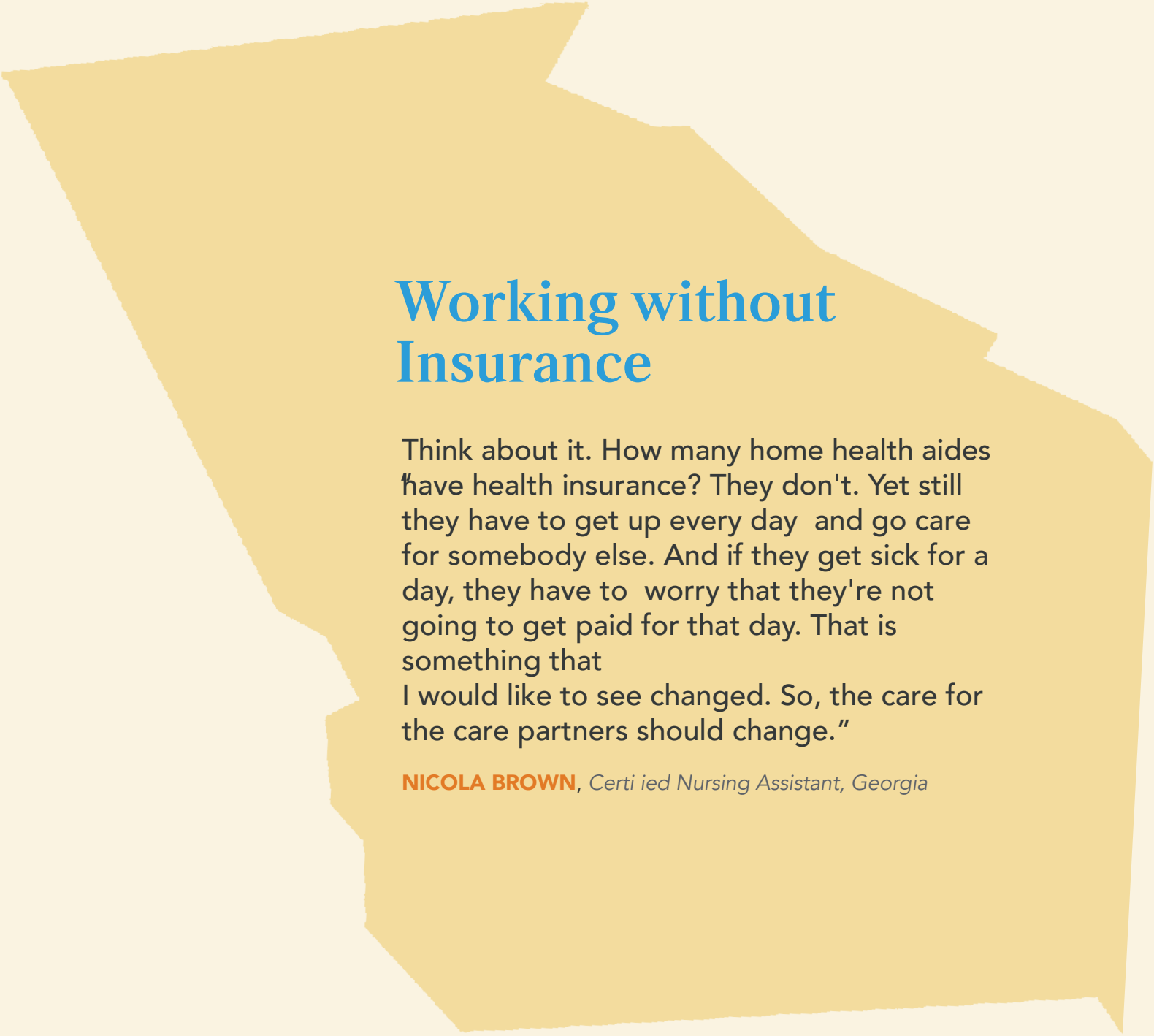


FIGURE 3: The Proportion of Direct Care Workers with Medicaid and without Any Insurance, by States' Medicaid Expansion Status

Data Source: Ruggles, Steven, Sarah Flood, Matthew Sobek, Daniel Backman, Annie Chen, Grace Cooper, Stephanie Richards, Renae Rodgers, and Megan Schouweiler. 2024. *IPUMS USA: Version 15.0 American Community Survey, 2022.* Minneapolis, MN: IPUMS. https://doi.org/10.18128/D010.V15.0.

Note: Nine states that expanded Medicaid between January 2018 and December 2022 are excluded from the analysis.



Working without Insurance

Think about it. How many home health aides have health insurance? They don't. Yet still they have to get up every day and go care for somebody else. And if they get sick for a day, they have to worry that they're not going to get paid for that day. That is something that
I would like to see changed. So, the care for the care partners should change."

NICOLA BROWN, *Certi ied Nursing Assistant, Georgia*

Nearly 80,000 Direct Care Workers Fall into the Coverage Gap

Analyzing the nine states that have not yet expanded Medicaid (excluding Wisconsin, due to the waiver described above), we found that 16 percent of direct care workers in these states fall into the coverage gap, amounting to a total of 79,517 workers (see Table 2).

Looking closer, Mississippi has the highest proportion of direct care workers in the coverage gap (24 percent), followed by Texas (22 percent) and Kansas (17 percent). The states with the highest absolute numbers of direct care workers in the coverage gap are Texas (39,461), Florida (11,810), and Georgia (7,896). The variations in the proportion and number of direct care workers in the gap are likely due to a number of factors, including the size of the direct care workforce, hourly direct care wages, and Medicaid income eligibility thresholds and other requirements in each state. Nonetheless, these results underscore that a substantial number and proportion of direct care workers are left without Medicaid to cover their health care as a result of their states not expanding Medicaid.

An estimated 79,517 direct care workers fall into the coverage gap in the states that have not expanded Medicaid. The number represents 16 percent of the workforce in these states.

TABLE 2. Proportion and Population of Direct Care Workers in the Coverage Gap

	PROPORTION	POPULATION ESTIMATE
Alabama	17%	4,300
Florida	11%	11,810
Georgia	18%	7,896
Kansas	17%	3,725
Mississippi	24%	4,922
South Carolina	14%	4,180
Tennessee	7%	2,650
Texas	22%	39,461
Wyoming	16%	573
TOTAL	**16%**	**79,517**

Data Source: Ruggles, Steven, Sarah Flood, Matthew Sobek, Daniel Backman, Annie Chen, Grace Cooper, Stephanie Richards, Renae Rodgers, and Megan Schouweiler. 2024. *IPUMS USA: Version 15.0 American Community Survey, 2022.* Minneapolis, MN: IPUMS. https://doi.org/10.18128/D010.V15.0.

The High Costs of Falling into the Coverage Gap

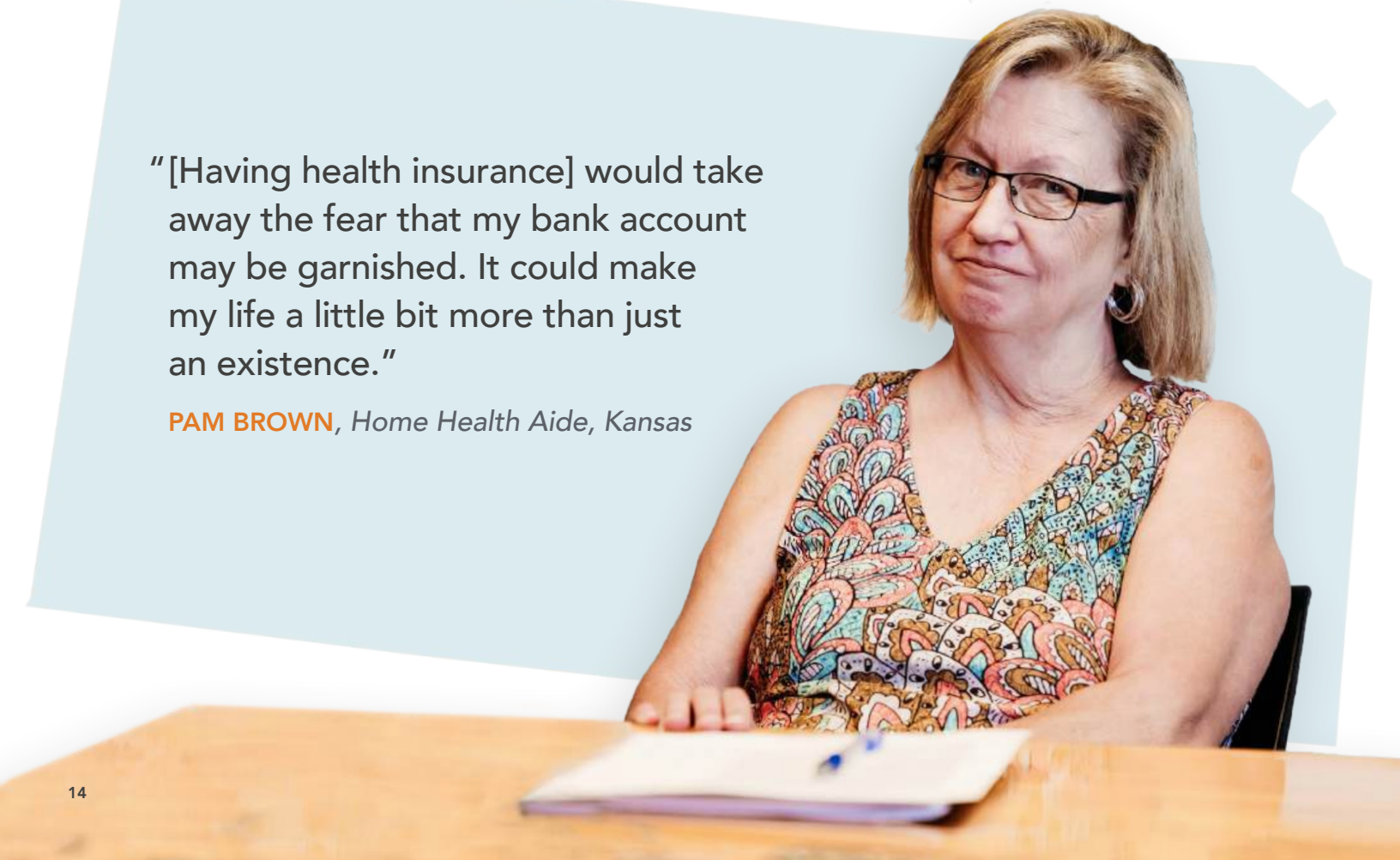
Pam Brown is a home health aide, mother, and grandmother in Kansas who spends her work hours caring for people with health needs so they can stay in their own homes. Pam's work is valuable to those she cares for and to her community more broadly, but she is not offered insurance through her job. She doesn't make enough to qualify for insurance through the ACA and she makes too much to qualify for Medicaid in Kansas. Like so many other direct care workers, Pam lives in the coverage gap because her state lawmakers have not expanded Medicaid.

Pam has health issues of her own which prevent her from working more hours in her job. She receives medical bills daily that she struggles to pay and owes thousands in medical debt. She fears finding herself in more medical debt and, at times, skips buying her prescribed medications and getting care that her doctor recommends.

Pam wants to work more hours as a home health care aide to help more individuals and families, but she needs to improve her own health first. She's joining the health justice movement and using her power to push her state leaders to expand Medicaid.

"[Having health insurance] would take away the fear that my bank account may be garnished. It could make my life a little bit more than just an existence."

PAM BROWN, *Home Health Aide, Kansas*



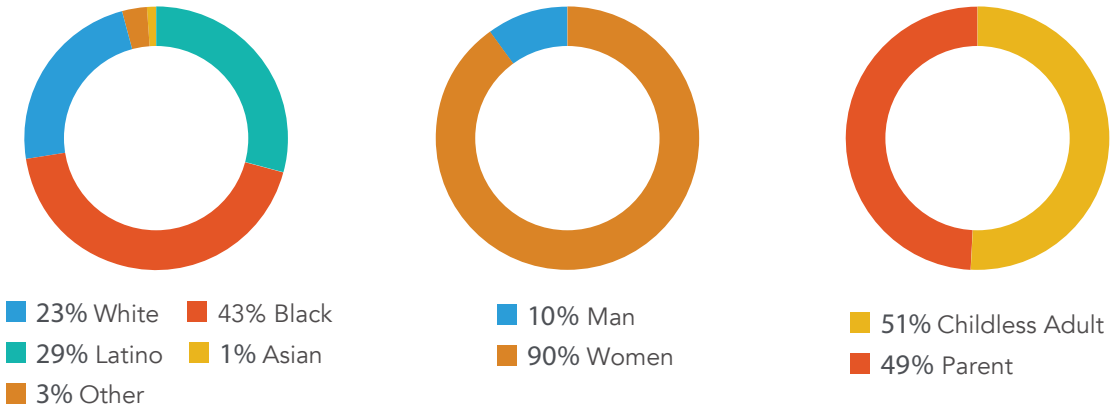
The Coverage Gap Reflects Broader Structural Inequities for Direct Care Workers

Here, we turn to the results on the demographic composition of direct care workers in the coverage gap. Figure 4 displays three graphs illustrating the proportion of direct care workers in the gap by race/ethnicity, gender, and parental status. Black workers represent the highest proportion (43 percent) of direct care workers in the coverage gap, followed by Latino workers (29 percent), white workers (23 percent), workers reporting "other" race/ethnicity (3 percent), and Asian workers (1 percent). These statistics show how broader structural inequities are reproduced in the coverage gap. Specifically, while 67 percent of the total direct care workforce in non-expansion states are people of color, direct care workers of color constitute 76 percent of those in the coverage gap. These disparities in the coverage gap for the direct care workforce are also reflected in the broader population, where 24 percent of people in the coverage gap are Black and 34 percent are Latino.[38]

Direct care workers of color are overrepresented in the coverage gap. Despite constituting 67 percent of the direct care workforce overall in states that have not expanded Medicaid, they represent 77 percent of those in the coverage gap.

With respect to gender, 90 percent of direct care workers in the coverage gap are women and 10 percent are men. These statistics closely align with the gender composition of the total direct care workforce. The proportion of workers with children versus without children in the coverage gap is relatively even (49 percent versus 51 percent). Yet, direct care workers with children are overrepresented in the coverage gap, as they constitute just 34 percent of this workforce overall.

FIGURE 4: Demographic Distribution of Direct Care Workers in the Coverage Gap



Data Source: Ruggles, Steven, Sarah Flood, Matthew Sobek, Daniel Backman, Annie Chen, Grace Cooper, Stephanie Richards, Renae Rodgers, and Megan Schouweiler. 2024. *IPUMS USA: Version 15.0 American Community Survey, 2022.* Minneapolis, MN: IPUMS. https://doi.org/10.18128/D010.V15.0.

As recently as 2023, two additional states expanded Medicaid.

Together, South Dakota in July 2023 and North Carolina in December 2023 extended Medicaid coverage to 15,282 more direct care workers.

In the 40 states plus Washington D.C. that have expanded Medicaid as of 2024, over 400,000 direct care workers earn below 138 percent of the federal poverty level. (See Appendix Table A1 for details.) Most of these workers would not have been eligible for Medicaid if their states had not adopted Medicaid expansion.

Medicaid Expansion Could Reach Nearly 150,000 More Direct Care Workers

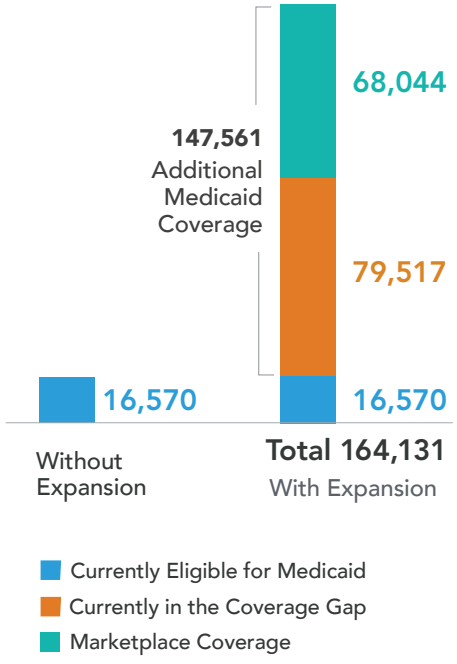
Our research indicates that expanding Medicaid in the 10 remaining states would extend Medicaid eligibility to an additional 147,561 direct care workers, including 79,517 workers who are currently in the coverage gap and another 68,044 who are eligible for marketplace subsidies (because they earn up to 138 percent of the federal poverty level). This would result in a total of more than 164,000 direct care workers who could be covered by Medicaid in these states if they expanded coverage. By comparison, only 16,570 direct care workers are currently covered by Medicaid in those 10 states.

Expanding Medicaid in the remaining 10 states would extend Medicaid eligibility to 147,561 additional direct care workers.

TABLE 3. Projected Coverage through Medicaid Expansion by State

	Currently in the Coverage Gap (<100% FPL)	Currently Eligible for Marketplace Subsidies (100-138% FPL)	Total
Alabama	4,300	3,880	8,180
Florida	11,810	12,099	23,909
Georgia	7,896	5,640	13,536
Kansas	3,725	2,762	6,487
Mississippi	4,922	3,567	8,489
South Carolina	4,180	4,010	8,190
Tennessee	2,650	4,621	7,271
Texas	39,461	26,636	66,097
Wisconsin	0	4,538	4,538
Wyoming	573	291	864
TOTAL	**79,517**	**68,044**	**147,561**

FIGURE 5. Direct Care Workers who Would be Eligible for Medicaid if Their States Expanded Medicaid



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DISCUSSION:

Health Coverage and Compensation

According to PHI's prior research, after the first wave of Medicaid expansion (implemented by 29 states and Washington, DC), one in three direct care workers remained uninsured and nearly 300,000 fell into the coverage gap in 21 states.[39] Since then, 11 additional states have expanded Medicaid. Yet, as this report has shown, nearly 80,000 direct care workers are still stuck in the coverage gap and one in four are entirely uninsured in the remaining non-expansion states, compared to fewer than one in ten uninsured workers in states that have expanded the program.

This analysis has further shown that the coverage gap disproportionately impacts direct care workers of color and those with children. If the 10 remaining states pass Medicaid expansion, we estimate that an additional 147,561 direct care workers would be newly eligible for Medicaid. This expansion of coverage would translate into a total of at least 164,131 direct care workers who could be covered by Medicaid in these states.

Medicaid is a particularly complex program, and this analysis has not accounted for varying eligibility rules and other criteria across all Medicaid waivers. Nonetheless, the findings send a clear message: expand Medicaid in Alabama, Florida, Georgia, Kansas, South Carolina, Mississippi, Tennessee, Texas, Wisconsin, and Wyoming.

Lifting up direct care workers as a leading example, we have shown that expansion meaningfully increases health insurance rates for low-wage workers, with positive implications for their health, overall wellbeing, and labor force participation, as well as for care quality and state economic outcomes. In addition, Medicaid expansion addresses a basic economic and health justice imperative, which is that those who provide essential health and long-term care services should not, themselves, go without care.

Medicaid expansion is not the only necessary solution, however. Policymakers, employers, and other leaders should consider a range of additional strategies to enhance access to health insurance and earnings for direct care workers.[40] Specific recommendations are detailed below.

Recommendations

Further Expand Medicaid Eligibility

■ All 10 remaining states should fully expand Medicaid, without including work requirements or other barriers to access.

What not to do: In 2023, Georgia launched the Pathways to Coverage Program to offer Medicaid to adults who earn up to 100 percent of the federal poverty level but included certain work/study requirements. Such requirements have been shown to serve as barriers to maintaining eligibility, particularly for low-wage workers who work fluctuating hours. In addition to these barriers, enrollment in Georgia's Pathways program has been hindered by low awareness of the program, complexities in the verification process, and delays in processing time.[41] With all of these barriers in place, efforts to expand Medicaid are unlikely to benefit a significant number of those in need.

■ In addition to Medicaid expansion, states should explore further opportunities to extend Medicaid eligibility. For example, states could consider the Basic Health Program option, which allows states to provide affordable coverage for low-income residents whose income fluctuates around Medicaid eligibility levels;[42] buy-in programs, which allow people with disabilities who are working and whose income and/or assets exceed Medicaid eligibility limits to "buy-in" to Medicaid coverage;[43] and/or waivers that allow lower-income households who are eligible for marketplace coverage to access no-cost health insurance and additional services.[44]

■ States should also consider extending coverage to specific groups that are disproportionately uninsured and who face particular barriers to health coverage and eligibility for public programs like Medicaid. As one example, direct care workers are disproportionately immigrant workers.[45] States can address inequities faced by immigrant workers by adjusting eligibility rules,[46] or developing state-funded programs to extend access to more individuals and families regardless of immigration status.[47]

■ States can also enhance health coverage continuity by establishing bridging funds to support those who may have to move between Medicaid and the healthcare marketplace (as their hours or incomes change). Direct care workers are particularly at risk of losing coverage as they often experience unstable work hours and incomes that may vary significantly according to caseload and other factors.[48]

Recommendations
continue

Invest in Health Care Coverage Outreach, Enrollment, and Access

- States should invest in targeted outreach and support to increase enrollment, since even individuals who are eligible for Medicaid may not be covered due to lack of awareness and/or application barriers.
- States can also enhance support with premium and out-of-pocket costs for those who are eligible for state-based health insurance marketplace plans by introducing additional state-funded subsidies.[49] (Federal marketplace subsidies are set at the federal level and cannot be enhanced with state funds.) States with either federal or state-based marketplaces should continue to leverage federal funding and build on lessons from recent federal initiatives, such as the American Rescue Plan Act of 2021 and the Inflation Reduction Act of 2022, which temporarily increased subsidies and made them available to more people. Making these reforms permanent could help ensure that more direct care workers have access to stable health coverage.[50]

Incentivize and Extend Employer-Sponsored Plans

- In the Medicaid-funded long-term care space, states can increase Medicaid reimbursement rates to better cover employer-sponsored health insurance or create an incentive pool that enables employers to offer affordable plans. For example, in New York, the state established the Quality Incentive Vital Access Provider Pool to incentivize home care employers to offer robust health benefits.[51]
- State leaders should also consider establishing health insurance funds to ensure that direct care workers have access to quality and affordable health coverage. For example, the SEIU 775 Benefits Group—which is a public-private partnership in Washington State that administers a range of benefits for eligible home care workers (the largest segment of the direct care workforce)—offers medical and dental insurance for all eligible workers for $25 per month.[52] Workers can also insure their children for an additional $100 per month.

Recommendations

continue

Increase Direct Care Worker Hourly Wages and Stabilize Work Hours

■ States and employers must improve direct care wages to a livable and competitive wage, so that workers can afford to pay for health insurance premiums and health care costs.[53] Currently, direct care workers' median hourly wages are lower than those for all other occupations with similar or lower entry-level requirements in all 50 states and D.C.,[54] and part-time/part-year employment and unpredictable hours make it even more difficult for direct care workers to access and afford health insurance and care.

■ Paying direct care workers a livable and competitive wage is critical to job quality and workforce recruitment and retention more broadly. Evidence shows that higher wages improve financial stability for workers, reduce turnover and associated costs for employers, increase workforce productivity, improve care quality for consumers, and strengthen local economies.[55]

■ Specifically, since Medicaid is the largest payer of long-term care and direct care services, states should ensure that Medicaid rates and related policies support higher wages for direct care workers. Wage floors (i.e., minimum wages for direct care workers) and wage pass-through policies (whereby a specific percentage of rates or dollar amount must go directly to compensation) are two key strategies here.[56]

Unstable Work Hours and Implications for Eligibility

Maria Marrero, a Certified Home Health Aide in New Jersey, explained how the fluctuation in Medicaid-funded care hours results in fluctuations between overwork and underwork for direct care workers:

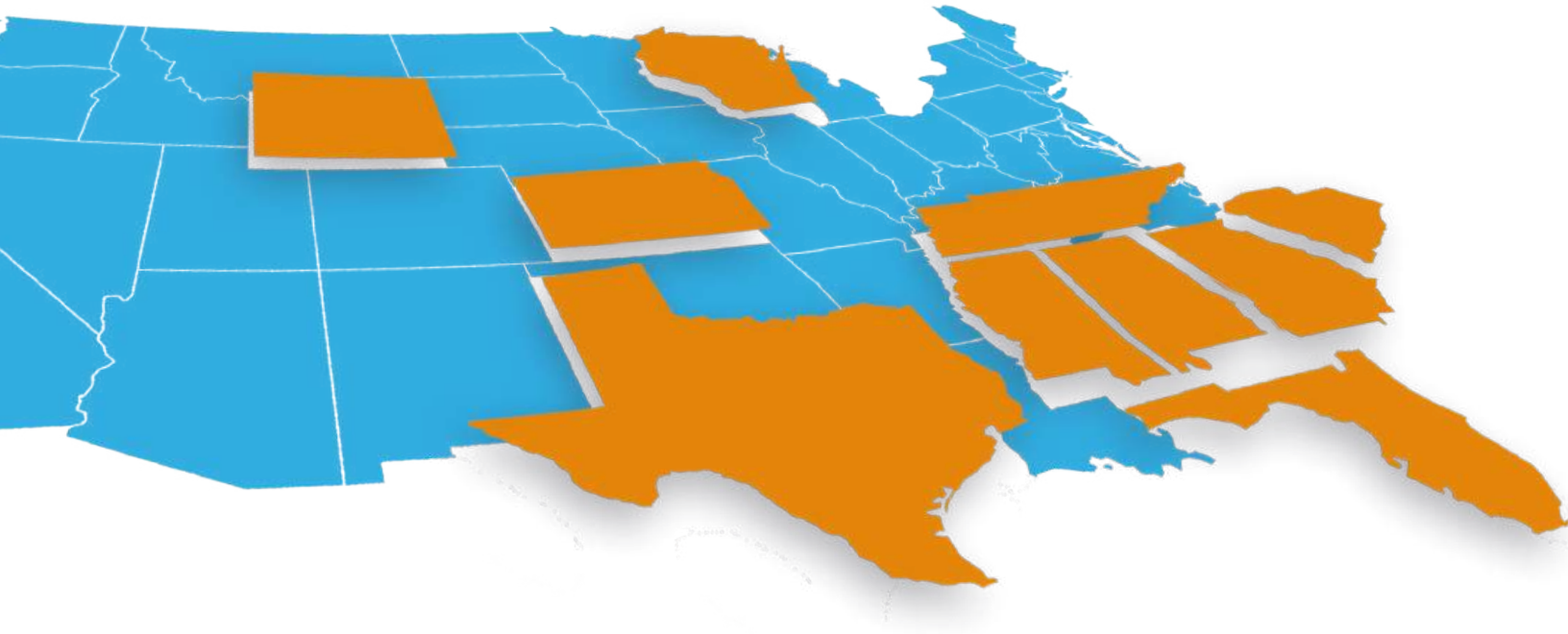
"And then on the other end of the spectrum, clients need aides, but there aren't enough to work. So sometimes you're being asked to work more hours than you're available and that's stressful, whereas other times you don't have enough hours that you want. It's like that you are in the rollercoaster"

MARIA MARRERO, *Certified Home Health Aide, New Jersey*

This instability of hours can in turn impact workers' Medicaid eligibility.

CONCLUSION

Direct care workers provide crucial support to older adults and people with disabilities but face challenging and hazardous working conditions as well as low wages and limited employment benefits.[56] As demand for direct care workers continues to grow, improving job quality and supporting the wellbeing of this workforce—including through better access to health coverage—is imperative for improving workforce recruitment and retention. By expanding Medicaid in the remaining ten states and further enhancing health coverage for vulnerable workers and their families across the country, policymakers can help ensure that those who provide essential care can access care themselves.



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Authors
Jiyeon Kim, PhD
Lina Stepick, PhD
Kezia Scales, PhD

Contributors
Ellen Taverna, JD
Kaylan Szafranski, MSW

Design
RD Design

Photo Credits
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APPENDIX

TABLE A1: Direct Care Workers Whose Household Income is Less than 138 Percent of the Federal Poverty Level in Expansion States, 2022

State	Total
Alaska	850
Arizona	9,583
Arkansas	7,218
California	56,267
Colorado	6,811
Connecticut	7,299
Delaware	1,888
District of Columbia	931
Hawaii	767
Idaho	4,343
Illinois	25,523
Indiana	12,627
Iowa	5,926
Kentucky	7,277
Louisiana	15,127
Maine	2,316
Maryland	6,319
Massachusetts	13,789
Michigan	18,718
Minnesota	13,801
Missouri	14,976
Montana	1,863
Nebraska	3,315
Nevada	2,422
New Hampshire	1,326
New Jersey	11,375
New Mexico	7,728
New York	68,590
North Carolina	16,791
North Dakota	1,673
Ohio	26,035
Oklahoma	6,846
Oregon	8,238
Pennsylvania	30,248
Rhode Island	1,951
South Dakota	1,006
Utah	2,493
Vermont	949
Virginia	12,559
Washington	8,762
West Virginia	5,147
TOTAL	**451,673**

Data Source: Ruggles, Steven, Sarah Flood, Matthew Sobek, Daniel Backman, Annie Chen, Grace Cooper, Stephanie Richards, Renae Rodgers, and Megan Schouweiler. 2024. *IPUMS USA: Version 15.0 American Community Survey, 2022.* Minneapolis, MN: IPUMS. https://doi.org/10.18128/D010.V15.0

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PHI QUALITY CARE THROUGH QUALITY JOBS

261 Madison Avenue, Suite 913
New York, NY 10016
Phone: 718.402.7766
Email: info@PHInational.org

Community Catalyst

Two Liberty Square, 11th Floor
Boston, MA 02109
Phone: (617) 338-6035
communitycatalyst.org