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HEALTH CARE AND HUMAN SERVICES POLICY, RESEARCH, AND CONSULTING—**WITH REAL-WORLD PERSPECTIVE.**

Final Report
Costs and Options for Insuring Minnesota's Long-Term Care Workforce

Prepared for:
Minnesota Department of Human Services (DHS)

Submitted by:
The Lewin Group

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Minnesota Department of **Human Services**

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Report Summary

This Report Summary summarizes the key points from each chapter of the report. Please see the full report for additional technical details on the analysis and further discussion of findings and recommendations.

A) Background and Study Purpose

"Long-term care" includes a wide range of services to help older persons and people with physical disabilities, intellectual and developmental disabilities, and mental health/substance abuse issues live fulfilling, independent, and self-directed lives. Long-term care services are provided in an array of settings including individuals' homes, group homes, nursing homes, job sites, and schools.

Thousands of Minnesotans of all ages rely on long-term care services because of illness, cognitive impairment, or disability. These individuals count on a consistent, well-qualified workforce to provide support and services in a wide range of settings.

In Minnesota, and in other states nationwide, low wages and lack of health insurance make it difficult to recruit and retain long-term care workers to meet the growing demand for services. As the population of older persons and people with disabilities rapidly increases, the situation will likely worsen in the future. Frequent worker turnover can harm the quality of life of people receiving services, as well as reduce quality of services. High turnover is also expensive, in terms of direct and indirect costs for providers and public long-term care financing programs.[1]

Recent economic and political trends compound the problem of access to health insurance for workers. As health insurance costs continue to escalate, businesses nationwide increase costs for coverage and/or reduce coverage for workers. Meanwhile, budget pressures have resulted in cuts to the public insurance safety net for Minnesotans without access to affordable employer coverage.

Given the growing demand for long-term care services and supports—particularly services provided in homes and the community—states must address the barriers to people choosing direct service as a long-term career

[1] Dorie Seavey, *The Cost of Frontline Turnover in Long-Term Care,* Better Jobs Better Care, October 2004. http://www.bjbc.org/content/docs/TOCostReport.pdf

path. A growing number of studies indicate that health coverage plays a powerful role in recruitment and retention of direct service workers.[2]

To address these issues, in 2008, as part of Minnesota health reform legislation, the Minnesota state legislature directed the Department of Human Services (DHS) to conduct a study including "recommendations for a rate increase to long-term care employers dedicated to the purchase of employee health insurance in the private market."[3] The legislation specified that the study include all employees of long-term care providers, not just those who directly provide care services. For example, dietary, maintenance, and housekeeping staff were also included.

DHS contracted with The Lewin Group (Lewin) and its sub-contractors Ingenix Consulting and PHI to conduct the legislatively mandated research.

B) Study Methodology

The study projected participation rates and costs for a rate increase for long-term care employers designated for the purchase of health and dental insurance for their employees and their families. This involved three key study activities:

- Gather needed actuarial data and other employment-related information from surveys of providers and workers.
  - To gain needed actuarial data for the actuarial analysis, the Lewin team gathered information on the number and characteristics of long-term care workers, current health insurance coverage and costs, and other results from surveys of long-term care employers and employees. The surveys also provided an opportunity for workers and employers to comment on the proposed initiative. We also compared key findings with the available data from other studies on long-term care worker health insurance. In addition, we analyzed data from other sources, including PHI and Lewin analysis of data from the Current Population Survey (CPS) from the Bureau of Labor Statistics (BLS).

- Analyze actuarial data and develop cost and participation estimates.
  - Ingenix Consulting (IC) projected coverage impacts and costs for six levels of coverage: 1) MinnesotaCare Basic+2 (parents); 2)

[2] Health Care for Health Care Workers, "Health Insurance Vital to Job Retention," Fact Sheet, October 2007. http://www.directcareclearinghouse.org/download/RetentionFactSheet.pdf

[3] Law of Minnesota for 2008, Chapter 358–S.F.No. 3780, Sec. 13. Long-Term Care Worker Health Coverage Study. https://www.revisor.leg.state.mn.us/laws/?year=2008&type=0&doctype=Chapter&id=358

MinnesotaCare Basic+1 (non-parents); 3) a plan like MinnesotaCare+1 but without the $10,000 in-patient hospital limit; 4) the benefits provided by the state employees' health plan (Minnesota Advantage); 5) a sample low deductible ($100) commercial plan; and 6) a higher ($500) deductible commercial plan. Finally, IC projected three approaches for how employers obtain the insurance: 1) through the commercial market; 2) through a new risk pool; and 3) directly through MinnesotaCare. IC also projected dental insurance participation rates and costs for a sample commercial and MinnesotaCare dental plan, for both stand-alone (dental can be chosen separately from medical) and dental coverage tied to medical coverage. The study team then projected total program participation and costs for the various plan design/funding approach combinations.

- Develop implementation options and recommendations.
  - Finally, Lewin and PHI developed recommendations and presented implementation options for implementing a rate increase for health insurance in Minnesota, based on the findings from all components of the study, as well as a review of the experiences of other states.

C) Survey Findings

A total of 910 long-term care workers and 772 providers completed at least some portion of the surveys.

Key findings from the worker survey include:

- Many long-term care workers in Minnesota do not have private health insurance, primarily because they cannot afford it or they do not work enough hours.
- 25 percent of all long-term care workers (34% of direct service workers) have been uninsured within the past 12 months.
- 46 percent of all workers have unpaid medical bills.
- Coverage rates vary by employment setting and job type:
  - All facility based and all home and community based (HCBS) workers reported little difference in the percent uninsured—18 percent of facility based and 20 percent of HCBS workers.
  - Different job settings within these categories showed larger disparities. Notably, a related study by Lewin found exceptionally

high rates of uninsurance among workers in the Minnesota Personal Care Assistance program.[4]

- Disparities also emerged among workers in different occupations. Direct care / direct service workers (DSWs) (home health aides, personal care attendants, certified nursing assistants, direct support professionals, etc.) had the highest uninsurance rates. Compared with "professionals" (e.g., social workers, nurses, physical therapists, psychologists, and administrative staff) and other long-term care employees (e.g., maintenance, dietary, and laundry staff), DSWs also were more likely to work part-time, were more likely to hold more than one long-term care job, had the least longevity on the job, had the lowest incomes, and were more likely to lack private health insurance. At the same time, many of the other employees, particularly those in dietary, housekeeping, maintenance, and similar low-wage jobs, also reported a lack of insurance, low pay, and other challenges.

- Many workers— especially in home care— do not qualify for employee benefits because they work less than full-time.
  - Two thirds of workers (66%) work 32 hours or more for the employer who gave them the survey, the amount needed to qualify for coverage under the Minnesota proposal. The remaining third work less than this amount. One approach for expanding coverage to these part-time workers would be to offer full-time work: Of workers without private health coverage, 33 percent said they would try to work 32+ hours a week so they could get health insurance (47 percent said they already work 32+ hours a week). Another possible approach would be to offer coverage to those who work full-time in the long-term care field through more than one job: of workers surveyed with more than one long-term care job, 15 percent said they work 32+ hours through more than one part-time long-term care job.

- Many workers spoke of serious problems related to lack of affordable coverage and expressed support for a state initiative to address the issue.

Key findings from the employer survey include:

[4] The Lewin Group, *Recommendations for Minnesota's Personal Care Assistance Program,* Report for Minnesota Department of Human Services, Disability Services Division, Draft July 2009.

- 72 percent of providers surveyed offer health insurance and 59 percent offer dental insurance.
- 81 percent of employers rated lack of health insurance as a "high" or "medium" challenge in retaining workers, second only to low pay (96 percent).
- Providers generally supported the proposed rate increase for health insurance. Over half (56%) of providers said they support or strongly support the initiative, 21 percent neither oppose nor support it, 17 percent were unaware of it, and 8 percent opposed it.

To build on these findings, PHI and Lewin reviewed 30 previous surveys of long-term care employers or employees about health insurance. The literature supports our key findings, including that many long-term care workers decline health insurance because they cannot afford it, that many do not qualify for coverage because they work less than full-time, and that health insurance benefits is an important factor affecting long-term care employee retention.

D) Actuarial Analysis of Projected Participation and Costs

Actuarial staff from Ingenix Consulting (IC) projected participation and costs for several plan designs and approaches for how employers obtain insurance. The process consisted of six steps: 1) Specify the model insurance plans; 2) Determine funding sources; 3) Describe current employee contribution to plan costs and project change in employee contributions; 4) Describe current participation rates and project increased participation; 5) Project monthly premium rates; and 6) Calculate total projected statewide participation and costs for the various plan design/funding source combinations.

i) Specify the Model Insurance Plans

The legislation specified that the study consider three plan designs, providing the benefit levels of: 1) the MinnesotaCare program for low-income Minnesotans; 2) the state employees' health plan, Minnesota Advantage; and 3) a sample commercial plan but with a deductible limited to $100.

The actuarial staff of Ingenix Consulting (IC) simulated participation rates and costs for six specific model health insurance benefit plan designs. Because MinnesotaCare includes a number of different plans, IC projected outcomes for three model MinnesotaCare plans. The higher deductible commercial plan, although not consistent with the legislative proposal, was included for comparison purposes and because this design is more typical of plans available in the commercial market.

Plan 1: MinnesotaCare Basic Plus Two (parents) benefit package (a model commercial plan with the same deductibles, co-pays, benefits, and other elements as the MinnesotaCare Basic Plus 2 plan)

Plan 2: MinnesotaCare Basic Plus One (non-parents) ($10,000 annual inpatient max.) benefit package

Plan 3: MinnesotaCare Basic Plus One (same as Plan 2, but with unlimited inpatient maximum) benefit package

Plan 4: Minnesota Advantage (the plan for state employees) benefit package

Plan 5: A sample low deductible commercial plan

Plan 6: A sample higher deductible commercial plan

Highlights of the six model plans are described in ***Table RS.1***, below:

Table RS.1
Comparison of Insurance Plan Benefits

	MinnesotaCare + 2		MinnesotaCare + 1, $10,000 In Patient Maximum	MinnesotaCare + 1, No In Patient Maximum		Minnesota Advantage	Commercial, $100 Deductible		Commercial, $500 Deductible	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	$0		$0	$0		See table RS.2	$100	$400	$500	$1,000
Coinsurance	0%		10% In Patient Only	10% In Patient Only		See table RS.2	20%	40%	20%	40%
Out-of-pocket max [1]	None		None	None		See table RS.2	$2,000	$4,000	$2,500	$4,500
Copayments										
ER	$6 Copay for Non Emergency Visits		$6 Copay for Non Emergency Visits	$6 Copay for Non Emergency Visits		See table RS.2	$150	Deductible/ coinsurance	Deductible/ Coinsurance	Deductible/ coinsurance
Primary care	$3/Copay non-preventative visits		$3/Copay non-preventative visits	$3/Copay non-preventative visits		See table RS.2	$15 [2]	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance
Specialist	$3/Copay		$3/Copay	$3/Copay		See table RS.2	$30 [2]	Deductible/ coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance
Preventive	100% covered		100% covered	100% covered		See table RS.2	100% covered	Not covered	100% covered	Not covered
Eye exam	$3/Copay		$3/Copay	$3/Copay		See table RS.2	No	No	No	No
Rx copays										
Generic	$3		$3	$3		See table RS.2	$10		$10	
Brand-Preferred	$3		$3	$3		See table RS.2	$25		$35	
Brand-Non-preferred	$3		$3	$3		See table RS.2	40% with $40 minimum		40% with $50 minimum	

[1] Includes deductible and office visit copays (not Rx copays).

[2] Surgical procedures, laboratory, radiology, etc performed during an office visit are subject to the deductible and coinsurance.

[3] MinnesotaAdvantage Plans vary by provider level

Table RS.2 Minnesota Advantage Plan Summary of Key Benefit Features Out-of-Pocket Expense				
	Provider Level			
	1	2	3	4
Deductible [1]	$50	$140	$350	$600
Office Visit Copay [2]	$17	$22	$27	$37
ER Copay	$75	$75	$75	25%
Inpatient Hospital Copay	$85	$180	$450	25%
Outpatient Surgery Copay	$55	$110	$220	30%
DME	20%	20%	20%	30%
Preventative Services	$0	$0	$0	$0
Hospice & Skilled Nursing Facility	$0	$0	$0	$0
Lab, Pathology, Radiology	5%	5%	10%	30%
Other	5%	5%	10%	30%
Rx	← ← ←$10/$16/$30 for all levels → → →			
Out-of-Pocket Max: Non-Rx [1]	$1,100	$1,100	$1,100	$1,100
Out-of-Pocket Max: Rx [1]	**$800**	**$800**	**$800**	**$800**

[1] 2 times for family. Deductible applies prior to all copays & coinsurance

[2] Office visit copay is $5 more if employer does not complete health assessment and does not agree to a follow-up call from a health coach. Convenience clinics: $10 copay all levels, and deductible does not apply.

IC also projected costs for two dental insurance benefit plan designs: a model dental benefit that provides the benefits of MinnesotaCare dental insurance, and a typical commercial PPO dental plan. The dental plans were modeled for both stand-alone (dental can be chosen separately from medical) and dental insurance tied to medical coverage.

ii) Determine Funding Sources

The legislation specified that the study develop estimates assuming the insurance would be purchased in the commercial market. For comparison purposes and at the request of DHS, IC developed cost projections for two additional purchasing mechanisms: a dedicated risk pool and the plan as part of MinnesotaCare. The main difference between the three options was the proportion of premium devoted to expenses other than benefits, referred to in this study as "non-benefit costs." In addition, health care provider reimbursement under MinnesotaCare would be at MinnesotaCare levels, which is similar to Medical Assistance reimbursement levels.

For a comparison of non-benefit costs see ***Table RS.3***.

Table RS.3: Non-Benefit Costs for Model Plans		
	Percent of Premium for Non-Benefit Costs	**Types of Non-Benefit Costs Included**
Funding Source A – Commercial Market	For health insurance: 22.5% for small group 17.0% for large group	Administrative costs Broker commission Premium tax Assessment for MCHA
	For dental insurance tied to medical: 20% for small group 14.5% for large group	
	For stand-alone dental: 29% for small group 22% for large group	
Funding Source B – Risk Pool	10.25% for all plans	Administrative costs Catastrophic claim reinsurance costs Start-up costs Costs to build up stabilization reserve
Funding Source C – Minnesota Care	9% for all plans	Administrative costs

iii) Describe Current Employee Contribution to Plan Costs and Project Change in Employee Contributions

Based on the results of the employer survey, the current plans offered by long-term care providers require relatively high average employee contributions.

Table RS.4: Current Employee Contribution Levels Based on Employer Survey				
	Small Group (50 or fewer eligible employees)		Large Group (51+ eligible employees)	
	Single EE	Family	Single EE	Family
Medical Coverage				
Average employee monthly contributions	$144.38	$483.95	$109.06	$503.77
as % of total plan cost	27.3%	48.2%	22.8%	39.7%
Dental Coverage				
Average employee monthly contributions	$23.66	$70.57	$16.43	$54.94
as % of total plan cost	43.7%	55.7%	41.2%	54.1%

These figures are very similar to the findings from the Minnesota Department of Health's 2002 study, which reported average employee contributions of 24 percent for individual coverage and 45 percent for family coverage. In other studies examining long-term care employee health insurance, employee contributions for individual coverage have ranged from 23.5 percent to 65 percent, or between $50 and $193.

The proposed plan requires that employee contributions be no higher than these ranges for state employees. Therefore, IC modeled, for all plans, the impact of these monthly employee contributions on employee participation.

Table RS.5: Proposed Monthly Employee Contribution Rates[5]				
	Small Group (50 or fewer eligible employees)		Large Group (51+ eligible employees)	
	Single Employee	Family	Single Employee	Family
Medical	$0.00	$130.20	$0.00	$130.20
Dental	$5.00	$34.16	$5.00	$34.16

[5] While the employee contribution amount is the same for all proposed plans, the employer contribution, and hence the percentage contributions, vary by plan type.

iv) Describe Current Participation Rates and Project Increased Participation

Based on the employer survey, the **current participation rates in medical and dental plans**, expressed as percentage of employees eligible for coverage, are approximately:

- Small group (50 or fewer eligible employees): 50% for single coverage; 18% for family coverage
- Large group (51 or more eligible employees): 53% for single coverage; 28% for family coverage

Based on the employee survey, a significant number of these employees are covered by plans other than the one offered by the surveyed employer. A commercial carrier underwriting a group would consider these employees to have "other valid coverage" and not count them in the minimum participation requirement. IC therefore adjusted the current medical plan participation levels to reflect only those employees without other valid coverage. This adjustment increased the participation rate for small group single coverage from 50 percent of eligible employees to 73 percent of eligible employees without other valid coverage. The remaining **adjusted current medical participation rates** are shown below:

- Small group: 73% for single coverage; 26% for family coverage
- Large group: 77% for single coverage; 41% for family coverage

For dental plans, the current participation rates are approximately:

- Small group: 67% for single coverage; 20% for family coverage
- Large group: 71% for single coverage; 34% for family coverage

Other dental coverage is probably less common. Individual dental coverage is rare, and COBRA dental is unlikely given its cost. Therefore, it was not necessary to adjust dental participation rates to take into account other valid coverage.

Table RS.6 displays projected participation rates for each of the plans for the Metro region. While participation rates vary by region, the patterns are similar across regions. The proposed single employee contribution is $0. Because this is non-contributory coverage, **the projected participation rate for individual coverage is always 100 percent.**

The employee survey indicates a very high level of price sensitivity among these workers. **Only 41 percent of surveyed employees said that they are**

willing to pay $100 per month or more for family medical coverage. The family coverage participation rates vary as shown above in ***Table RS.5***. As one would expect, the highest projected participation rates are with the two MinnesotaCare benefit package Plans 1 and 3, the plans with the best benefits and highest total plan costs (and hence highest plan "values"), but at the same employee contribution amount as the lesser plans. Projected participation is higher for large groups, because the base current plans' participation rates, from which IC projected the new plans' participation, are higher to begin with.

Table RS.6: Projected Increased Employee Participation Rates - Medical*

Metro	Small Group (<51 eligible employees)		Large Group (51+ eligible employees)	
Plan	Single Employee	Family	Single Employee	Family
MinnesotaCare Basic+2	100.0%	47.5%	100.0%	58.7%
MinnesotaCare Basic+1, $10K in-patient limit	100.0%	35.8%	100.0%	46.9%
MinnesotaCare Basic+1, no in-patient limit	100.0%	48.2%	100.0%	59.3%
Minnesota Advantage	100.0%	41.6%	100.0%	52.7%
Commercial Plan, $100 ded	100.0%	41.6%	100.0%	52.7%
Commercial Plan, $500 ded	100.0%	40.6%	100.0%	51.7%

Because the proposed dental plan has an employee contribution for single coverage, the projected single participation level is less than 100 percent. For this group of employees with generally modest incomes, even the proposed low $5 monthly contribution for single coverage may be enough to dissuade many employees from taking dental coverage.

Table RS.7: Employee Projected Increased Participation Rates - Dental				
Metro	**Small Group (<51 eligible employees)**		**Large Group (51+ eligible employees)**	
Plan	Single Employee	Family	Single Employee	Family
Tied to Medical Coverage				
MinnesotaCare Plan	82.4%	35.7%	84.6%	48.5%
Commercial Plan	80.5%	30.2%	82.6%	42.6%
Stand-alone				
MinnesotaCare Plan	82.9%	37.3%	85.1%	50.0%
Commercial Plan	81.4%	32.8%	83.5%	45.1%

v) Project Monthly Premiums Rates

IC actuarial staff projected the premium rates for each model health and dental plan/funding source combination. The table below shows the **projected monthly premium** for each model health plan for the year 7/1/2009 through 6/30/2010, for all regions averaged together, with the projected increased employee participation levels. The projected rates are based on an IC model that incorporated provider reimbursement levels, network utilization, regional variations in costs, survey findings on employee demographics, and selection factors. This is the total premium (i.e., employer plus employee portions of cost).

Table RS.8: 2010 Total Projected Monthly Premiums for Health Insurance for LTC Workers: Weighted Average of All Regions With Projected Increased Employee Participation Levels

	Small Group (<51 eligible employees)		Large Group (51+ eligible employees)	
Funding Source & Benefit Plan	Single Employee	Family	Single Employee	Family
A. Coverage from market				
MinnesotaCare Basic+2	$443.89	$1,539.09	$414.70	$1,328.42
MinnesotaCare Basic+1, $10K IP limit	369.94	1,454.31	345.61	1,197.31
MinnesotaCare Basic+1, no IP limit	440.14	1,526.08	411.19	1,317.18
Minnesota Advantage	390.81	1,415.11	365.10	1,212.62
Commercial Plan, $100 ded	381.38	1,380.99	356.30	1,183.39
Commercial Plan, $500 ded	363.80	1,348.95	339.88	1,128.83
B. Coverage from dedicated risk pool				
MinnesotaCare Basic+2	$383.30	$1,327.91	$383.30	$1,227.85
MinnesotaCare Basic+1, $10K IP limit	319.44	1,254.74	319.44	1,106.67
MinnesotaCare Basic+1, no IP limit	380.06	1,316.68	380.06	1,217.47
Minnesota Advantage	337.46	1,220.92	337.46	1,120.82
Commercial Plan, $100 ded	329.33	1,191.48	329.33	1,093.80
Commercial Plan, $500 ded	314.15	1,163.86	314.15	1,043.37
C. Coverage directly from MinnesotaCare				
MinnesotaCare Basic+2	$210.51	$729.27	$210.51	$674.32
MinnesotaCare Basic+1, $10K IP limit	189.53	744.45	189.53	656.60
MinnesotaCare Basic+1, no IP limit	208.14	721.06	208.14	666.73

The highest cost health plans are the MinnesotaCare Basic+2 and Basic+1 with no in-patient limit purchased in the commercial market. The lowest cost plan in the commercial market is the $500 deductible commercial plan. Providing insurance through a new dedicated risk pool resulted in

significantly lower costs. The availability and funding scenario in which the plan is actually part of MinnesotaCare produces lower costs than insurance obtained in the commercial market, due to the low provider reimbursement rates and lower non-benefit costs of MinnesotaCare.

Table RS.9 shows model rates for the dental plans. The commercial dental plan—with coinsurance and a deductible applied to basic and major procedure costs and a $2,000 annual benefit—has a total cost (employer plus employee contributions) that is 44 percent less expensive than the MinnesotaCare model plan that provides 100 percent coverage without a deductible and a high, $5,000, benefit maximum.

Table RS.9: 2010 Projected Premiums for Dental Insurance for LTC Workers: Weighted Average for All Regions

	Small Group (<51 eligible employees)		Large Group (51+ eligible employees)	
Funding Scenario & Benefit Plan	Single Employee	Family	Single Employee	Family
A. Coverage from market				
Tied to Medical Coverage				
MinnesotaCare Plan	$ 69.84	$ 173.83	$ 65.38	$ 159.65
Commercial Plan	40.31	102.11	37.74	93.94
Stand-alone				
MinnesotaCare Plan	89.81	223.53	81.75	199.13
Commercial Plan	50.91	128.98	46.34	113.92
B. Coverage from dedicated risk pool				
Tied to Medical Coverage				
MinnesotaCare Plan	$ 62.25	$ 154.95	$ 62.25	$ 152.01
Commercial Plan	35.94	91.02	35.94	89.44
Stand-alone				
MinnesotaCare Plan	71.05	176.84	71.05	173.06
Commercial Plan	40.28	102.04	40.28	99.01
C. Coverage directly from MinnesotaCare				
Tied to Medical Coverage				
MinnesotaCare Plan	$ 30.70	$ 76.41	$ 30.70	$ 74.96
Stand-alone				
MinnesotaCare Plan	35.04	87.20	35.04	85.34

vi) Calculate Total Projected Statewide Participation and Costs

Based on the above analysis, the study team projected the total number of participants in each plan/funding source combination to develop an estimate of the cost to cover all participating long-term care workers and their families.

The **total number of LTC employees** was derived from low and high estimates of the number of long-term care workers in the state (77,000 and 181,000), taken from a report from the Minnesota Department of Health in 2002 entitled *Employer-Sponsored Health Insurance in the Minnesota Long-Term Care Industry: Status of Coverage and Policy Options*. A medium estimate was added based on the average of the two figures (129,000). Based on the employee survey, we estimated 66 percent of employees work enough hours to be eligible for benefits.

The statewide figures combine projections for single employees and employees with families, small group (50 or fewer) and large group (51 or more) employers, and for each combination of medical plans, dental plans, and funding sources.

Table RS.10 shows the **projected numbers of participants in health insurance** for each funding approach.

To estimate total participation, we added together: 1) the projected number of employees without families who enroll in individual coverage (100 percent for all plans because there is no cost to employees to enroll); 2) the number of employees with families who purchase family coverage (varies by plan depending on the richness of the plan); and 3) the number of employees with families who enroll in individual coverage (i.e., all employees with families who do not purchase family coverage).

Table RS.10: Total Projected Participation in Medical Insurance (Combined Metro & Non-Metro, Small and Large Group)					
Medical Plan		**Percent of Eligible Employees Participating**	**Low Estimate**	**Med Estimate**	**Hi Estimate**
MinnesotaCare Basic +2	**Individual Coverage**	**100% of eligible employees not enrolled in family coverage -- for all plans**	28,336	47,471	66,607
	Family Coverage	47.5% small group, 58.7% large group	22,484	37,669	52,853
	Total Enrolled	**100% of eligible employees -- for all plans**	50,820	85,140	119,460
MinnesotaCare Basic +1 $10k In-Patient Limit	Individual Coverage		33,031	55,338	77,645
	Family Coverage	35.8% small group, 46.9% large group	17,789	29,802	41,815
	Total Enrolled		50,820	85,140	119,460
MinnesotaCare Basic +1 No In-Patient Limit	Individual Coverage		28,093	47,065	66,037
	Family Coverage	48.2% small group, 59.3% large group	22,727	38,075	53,423
	Total Enrolled		50,820	85,140	119,460
Minnesota Advantage	Individual Coverage		30,729	51,481	72,233
	Family Coverage	41.6% small group, 52.7% large group	20,091	33,659	47,227
	Total Enrolled		50,820	85,140	119,460
Commercial $100	Individual Coverage		30,741	51,500	72,260
	Family Coverage	41.6% small group, 52.7% large group	20,079	33,640	47,200
	Total Enrolled		50,820	85,140	119,460
Commercial $500	Individual Coverage		31,137	52,164	73,191
	Family Coverage	40.6% small group, 51.7% large group	19,683	32,976	46,269
	Total Enrolled		50,820	85,140	119,460

The total **projected participation in dental insurance** is summarized in the ***Table RS.11***:

Table RS.11: Total Projected Participation in Dental Insurance (Combined Metro & Non-Metro, Small and Large Group)					
Dental Plan		**Percent of Eligible Employees Participating**	**Low Estimate**	**Med Estimate**	**Hi Estimate**
Minnesota Care - Tied to Medical	Individual Coverage	82.4% Small Group 84.6% Large Group	27,585	46,215	64,844
	Family Coverage	35.7% Small Group 48.5% Large Group	17,883	29,960	42,037
	Total Enrolled		45,469	76,175	106,881
Minnesota Care - Stand Alone	Individual Coverage	82.9% Small Group 85.1% Large Group	27,184	45,541	63,899
	Family Coverage	37.3% Small Group 50.0% Large Group	18,602	31,165	43,728
	Total Enrolled		45,786	76,706	107,627
Commercial - Tied to Medical	Individual Coverage	80.5% Small Group 82.6% Large Group	28,949	48,500	68,050
	Family Coverage	30.2% Small Group 42.6% Large Group	15,318	25,662	36,006
	Total Enrolled		44,267	74,161	104,056
Commercial - Stand Alone	Individual Coverage	81.4% Small Group 83.5% Large Group	28,350	47,496	66,642
	Family Coverage	32.8% Small Group 45.1% Large Group	16,475	27,601	38,726
	Total Enrolled		44,825	75,096	105,368

The projections of **total costs** for the plans are the costs of the health and dental plan combination, based on IC's projections for increased participation. Total costs for the employer portion of the premium varied widely, depending on the plan design and funding approach selected, from an average of $340 to $879 per insured worker per month, or a total of $17.3 million to $105.1 million a month depending on the number of workers and the model plan and funding source selected by the state (***Table RS.12)***. For the mid-range estimate of the number of workers, total monthly costs ranged from $28.9 million to $74.9 million. The total costs include the employer plus employee share. The employer share would be paid through a combination of Federal Medical Assistance match, state funds, and any required employer

contributions. The employee share could be paid by the employee, or by a subsidy provided by the employer or the state.

A mid-cost option is a plan modeled after Minnesota Advantage, with commercial dental insurance tied to medical insurance. This plan would cost $698 per insured worker per month, or $59.5 million a month to cover all participating workers and their families, using the medium estimate for the number of workers in the commercial market. A new dedicated risk pool could lower costs to an estimated $634 per insured worker per month, or $54.1 million total monthly costs.

The lowest costs were for the option in which the plan is actually part of MinnesotaCare itself, with a cost per insured worker from $340 to $396. This is because the average provider reimbursement in MinnesotaCare is assumed to be at the Medical Assistance level, which is far less than provider reimbursement under commercial plans. Also, MinnesotaCare has much lower non-benefit, or administrative, costs than typical commercial plans.

For the options where insurance is purchased commercially, the lowest cost plan was the $500 deductible commercial plan, purchased through a new dedicated risk pool, with dental tied to medical ($586 per member per month). The $100 deductible plan cost somewhat more, at $618 per member per month if purchased through a dedicated risk pool. The medical plans with the benefits of MinnesotaCare, purchased through the market, were the most expensive options ($673 to $877 per member per month). The projected total costs for each scenario are included in ***Table RS.11***, below:

Table RS.12: Combined Monthly Medical and Dental Insurance Monthly Costs Excluding Employee Contributions

Medical Plan & Dental Plan	Funding Source	Dental Plan Type	Average Cost per Insured Worker per Month	Estimated Total Monthly Cost (In Millions)		
				Low Estimate # of workers	Med Estimate # of workers	Hi Estimate # of workers
MinnesotaCare +2 / MinnesotaCare Dental	Market	Tied to Medical	$854	$43.4	$72.8	$102.1
		Stand Alone	879	44.7	74.9	105.1
	Dedicated Risk Pool	Tied to Medical	777	39.5	66.2	92.9
		Stand Alone	791	40.2	67.4	94.6
	MinnesotaCare	Tied to Medical	389	19.8	33.2	46.6
		Stand Alone	396	20.1	33.7	47.3
MinnesotaCare Basic +1 10k IP with MinnesotaCare Dental	Market	Tied to Medical	$673	$34.2	$57.3	$80.4
		Stand Alone	716	36.4	60.9	85.5
	Dedicated Risk Pool	Tied to Medical	629	31.9	53.5	75.1
		Stand Alone	642	32.6	54.7	76.7

Table RS.12: Combined Monthly Medical and Dental Insurance Monthly Costs Excluding Employee Contributions						
Medical Plan & Dental Plan	**Funding Source**	**Dental Plan Type**	**Average Cost per Insured Worker per Month**	**Estimated Total Monthly Cost (In Millions)**		
				Low Estimate # of workers	**Med Estimate # of workers**	**Hi Estimate # of workers**
	MinnesotaCare	Tied to Medical	340	17.3	28.9	40.6
		Stand Alone	346	17.6	29.5	41.4
MinnesotaCare Basic +1, No IP with MinnesotaCare Dental	Market	Tied to Medical	$834	$42.4	$71.0	$99.6
		Stand Alone	877	44.6	74.7	104.7
	Dedicated Risk Pool	Tied to Medical	775	39.4	66.0	92.6
		Stand Alone	789	40.1	67.1	94.2
	MinnesotaCare	Tied to Medical	387	19.6	32.9	46.2
		Stand Alone	393	20.0	33.5	47.0
Commercial Plan, $100 Ded with Commercial Dental	Market	Tied to Medical	$670	$34.1	$57.2	$80.2
		Stand Alone	693	35.3	59.1	83.0
	Dedicated Risk Pool	Tied to Medical	618	31.5	52.7	74.0
		Stand Alone	625	31.8	53.3	74.8
Commercial Plan, $500 Ded with Commercial Dental	Market	Tied to Medical	$634	$32.3	$54.1	$75.9
		Stand Alone	658	33.5	56.1	78.7
	Dedicated Risk Pool	Tied to Medical	586	29.8	49.9	70.1
		Stand Alone	592	30.1	50.5	70.8
MinnesotaAdvantage with Commercial Dental	Market	Tied to Medical	$698	$35.5	$59.5	$83.5
		Stand Alone	711	36.2	60.6	85.0
	Dedicated Risk Pool	Tied to Medical	634	32.3	54.1	75.9
		Stand Alone	641	32.6	54.6	76.7

Low Estimate: Assumes 77,000 employees; 50,820 eligible for coverage
Med Estimate: Assumes 129,000 employees; 85,140 eligible for coverage
Hi Estimate: Assumes 181,000 employees; 119,460 eligible for coverage

E) Conclusions, Recommendations, and Implementation Options

The surveys document that low wages, part-time and fluctuating hours, and eroding employer benefits leave many long-term care employees without access to affordable coverage. At the same time, small size, rising insurance costs, and heavy reliance on public funding make it difficult for many long-term care employers to offer affordable coverage to their employees. This section presents recommendations and implementation considerations for a rate increase to expand coverage for this workforce, based on findings from all components of the study, as well as examples and lessons learned from other states.

i) Recommendations for Benefit Plan Design and Funding Options

The legislation mandated that this study develop estimates of a rate increase for insurance assuming the insurance would be obtained in the commercial market.

The plan modeled after Minnesota Advantage, with the commercial dental plan tied to medical, provides the most cost effective plan with reasonable coverage for this workforce.

Because individual premiums are $0 for all plans, the main areas where the plans differ are in projected costs and projected enrollment in family coverage:

- The MinnesotaCare+2 plan and the model plan of MinnesotaCare+1 without the $10,000 in-patient limit are the most expensive plans (***Table RS.12***), but also result in higher enrollment in family coverage, due to the better benefits. These may not be the most advantageous plans for covering all eligible long-term care employees because of the very high cost.
- We recommend the plan modeled after Minnesota Advantage. This plan has a total cost that is about 2.5 percent higher than the $100 deductible plan, but has a better chance of controlling future cost increases due to its tiering structure. Our recommendation assumes that a commercial carrier or third party administrator (TPA)—usually a claims processor[6]— can develop a tiered provider network for the plan.
- We do not recommend the $500 sample commercial plan or the MinnesotaCare+1 plan with the $10,000 in-patient limit, because these plans would not provide adequate coverage for this workforce.

For a dental plan, we recommend the commercial plan tied to medical coverage. As with medical coverage, the MinnesotaCare dental plan is very costly. Tying dental coverage to medical coverage can increase participation in the initiative. One of the stated goals is to reduce the number of employees and their families who are now in public plans. If stand-alone dental coverage is offered, some employees may stay in the public medical plan but take the separate dental plan. This would result in employees and their dependents remaining in the more costly public medical plans, and dental costs being higher due to anti-selection by employees choosing just the dental insurance.

[6] A TPA is essentially an entity that doesn't take insurance risk but just pays claims, arranges the provider network, and performs disease management, and similar functions.

Montana provides an example of the feasibility of a rate increase to cover health insurance.

Although several states (including Minnesota) have enacted rate increases designated for wages (called wage pass-throughs), Montana is the first and to date only state to establish a health insurance pass-through. Montana's plan was launched in January 2009 for employers delivering Medicaid-funded personal assistance or private duty nursing services. The coverage is for individuals only. Employers may choose their own plan as long as it meets the state's "benchmark" criteria for an insurance plan, which stipulates a maximum $1,000 individual and $3,000 family deductible, 70 percent co-insurance, individual premium no greater than $25/month, and other plan design requirements.[7]

The program is voluntary and was expected to cover about 1,000 uninsured workers. As of April 2009, the plan covers 900 personal assistance services workers and private duty nurses.[8] Across the state, approximately 4,000 caregivers provide personal assistance services. In the first round of funding for the Montana program, 20 of the 28 Medicaid personal assistance service agencies (71%) participated in the rate increase for insurance.[9] Seven of the 20 Medicaid private duty nursing (PDN) agencies participated, and these 7 agencies provide approximately 71 percent of the total PDN services in Montana. Montana's health insurance program is more limited in scope in several respects than the plan under consideration in Minnesota (***Table RS.13***).

[7] Montana Department of Public Health and Human Services, "Department's Benchmark Standards," http://www.dphhs.mt.gov/sltc/services/communityservices/HCWorkers/Index.shtml

[8] Conference call with staff at Montana Department of Health and Human Services, Senior Long-Term Care Division, April 2009.

[9] Montana Department of Public Health and Human Services, "Health Care for Direct Care Workers Application 1 Report." http://www.dphhs.mt.gov/sltc/services/communityservices/HCWorkers/Index.shtml

Table RS.13: Montana and Minnesota Health Insurance Initiative Designs		
	Montana Health Insurance Rate Increase	**Minnesota Proposed Rate Increase**
Employees covered	Direct care workers in Medicaid-funded personal assistance and private duty nursing service providers only. The state is studying how the program would work for nursing homes and developmental disability service providers.	All long-term care employees
Coverage type	Individual coverage only; dental is optional if employer funding allows	Individual and family coverage; medical and dental
Key features of plan design	Max $1,000 individual and $3,000 family deductible 70% co-insurance Individual premium no greater than $25/month	$100 deductible for model commercial plan Co-pays vary by model plan design Individual premium $0

Although the Montana plan differs in scope from the Minnesota proposal, most closely resembling the $500 sample commercial deductible plan, we recommend that Minnesota keep abreast of developments in Montana for potential ideas and lessons learned.[10]

Creating a dedicated risk pool could significantly reduce costs.

Sharing the risk is essential for lowering insurance premiums. That is why it is easier for large companies with multiple facilities that share a single health plan to make insurance affordable. In the employer survey, several employers commented that their small size made it difficult for them to obtain affordable health insurance benefits for their employees.

In Ingenix Consulting's (IC) actuarial analysis, projected costs for commercially purchased insurance were significantly lower when purchased through a new dedicated risk pool. This is primarily due to the lower administrative and other non-benefit costs of a risk pool.

[10] For more information, contact Mike Hanshew, Montana Health Solutions, LLS mikeh@consumerdirectonline.net, PHI, *Coverage Models from the States*, 2007. . See also the Montana Department of Health and Human Services' Health Care for Health Care Workers web page at http://www.dphhs.mt.gov/sltc/services/communityservices/HCWorkers/Index.shtml.

We recommend coverage be obtained from carriers in the commercial market for the first five years of the program. After the first five years of operation, the plan would have enough experience on which to base premiums and to build a dedicated risk pool. This is ultimately the better approach, provided that all long-term care employers that accept the rate increase from the state would have to get their benefit plan from the dedicated risk pool.

A few states have considered health insurance risk pools for long-term care employers. Montana has an insurance pool for small businesses (2 to 9 employees) called "Insure Montana," which is not specific to healthcare workers.[11] However, this strategy has had limited impact on long-term care workers, because most home care agencies have more than 10 employees. The Wisconsin Regional Training Partnership, the nonprofit training organization affiliated with the Wisconsin AFL-CIO, established an innovative purchasing arrangement—a union-sponsored Professional Employer Organization (PEO).[12] A PEO is a co-employment strategy in which participating employers share a human resources service to reduce costs. Although the risk pool helped reduce costs, a subsidy was also needed to make insurance affordable to employers.

Providing insurance directly through MinnesotaCare would be a less expensive approach, but low provider reimbursement rates could present a challenge.

For comparison purposes, the study also projected participation and costs for the approach where insurance was actually part of MinnesotaCare. This funding option yielded significantly lower projected costs due to the much lower provider reimbursement rates and non-benefit costs of MinnesotaCare compared with the typical commercial plan. However, this approach may be unrealistic because providers would have to accept very low reimbursement for private employer plans. The result could be that many providers, particularly outside the Twin Cities, would refuse to accept the plan's reimbursement, and members would be left with a very limited provider network.

In addition, this approach would not leverage as much in federal funds. For a Medical Assistance rate increase, the state could capture the 60.19 percent temporary enhanced Federal Medical Assistance match for reimbursements for services provided by the American Recovery and Reinvestment Act

[11] PHI Health Care for Health Care Workers, Case Study: Montana, "Healthcare for Montanans Who Provide Healthcare," http://www.dswresourcecenter.org/tiki-download_file.php?fileId=27

[12] PHI, *Subsidizing Health Insurance Coverage for the Home Care Workforce in Two Wisconsin Counties: An Analysis of Options*, February 2007, http://www.directcareclearinghouse.org/download/HealthInsCovWIreport.pdf

(ARRA). The match reverts back to 50 percent in January 2011. By comparison, the federal match for MinnesotaCare (31 percent in 2007)[13] is much lower, because there is no federal match for adults without children in MinnesotaCare.

ii) Implementation Recommendations, Options, and State Examples

Several criteria are critical to ensuring the success of the proposed Minnesota long-term care workforce health insurance initiative. The 2008 Minnesota health reform legislation identified two key criteria that the proposal should meet:

- Ensures equitable treatment between employers that currently offer insurance and those who do not, and those with differing insurance costs and plans,
- Ensures the requirement that the rate increase be expended for the intended purpose.

In addition, a 2007 PHI report about the experiences of the CMS DSW Demonstration grantees identified five key design elements for this workforce:[14]

- Accessible to all long-term care workers,
- Affordable for workers and employers,
- Adequate benefit plan,
- Simple, easy to understand and enroll in, and
- Sustainable over time.

This chapter provides recommendations for how the Minnesota initiative can meet these goals, based on the results of the surveys, actuarial analysis, and review of other states' experiences.

To ensure equitable treatment of providers, make participation voluntary and do not base eligibility on previous expenditures for health insurance.

Some employers in Minnesota have emphasized health coverage, while others have offered better wages.[15] Hence, the Minnesota Health Care for

[13] Minnesota House of Representatives, December 2008, "MinnesotaCare," http://www.house.leg.state.mn.us/hrd/pubs/mncare.pdf

[14] PHI, Emerging Strategies for Providing Health Coverage to the Frontline Workforce in Long-Term Care.

[15] The Minnesota Legislative Commission on Health Care Access, Health Care for Long-Term Care Workers working group, 2007.

Long-Term Care Workers working group recommended that the state address fair treatment of providers regardless of prior decisions on the issue of better health insurance benefits versus better wages. This issue was also identified in the legislation mandating this study.

Montana's initiative provides an example of how to meet this goal, as the amount of the rate increase is based on the percentage of revenue a provider receives from Medicaid, and not on previous expenditures for health insurance or wages. If an agency's current plan meets the benchmarks, the agency can use the enhanced rate to offer the current plan to their uninsured workers.[16] If the agency's plan does not meet the benchmarks, they will need to enroll in a different plan to obtain the enhanced rate. The difference in reimbursement must go to pay insurance premiums.

Consider impacts of the initiative on equity across long-term care workers.

The legislation directed the study examine a rate increase for insurance for the entire long-term care workforce. However, given limited state funds, beginning with one sector of the workforce with the highest rates of uninsurance and expanding to other sectors – as is the Montana plan – may be a viable strategy for Minnesota. Montana is beginning with home care and private duty nursing workers and studying how the rate increase would work in other settings. Most other states have also targeted their health insurance initiatives for workers in specific sectors, particularly individual providers, home care workers, and workers supporting people with intellectual/developmental disabilities. If this option is considered, funding should be targeted to sectors with the greatest need, to improve parity in compensation for workers in similar jobs across provider types.

Although the survey found small differences between workers in institutional and home and community based settings, our findings indicate much larger differences by workplace setting *within* home and community based or institutional settings, with lower paid direct service staff at the greatest disadvantage. A related study by Lewin on Minnesota's Personal Care Assistance program also found exceptionally high uninsurance rates among PCAs.[17] Minnesota should consider giving priority to workers in the specific provider types with greatest need.

[16] "Health Insurance for Health Care Workers: Frequently Asked Questions," http://www.dphhs.mt.gov/sltc/services/communityservices/HCWorkers/Index.shtml

[17] The Lewin Group, *Recommendations for Minnesota's Personal Care Assistance Program,* Report for Minnesota Department of Human Services, Disability Services Division, Draft July 2009.

Build and maintain accountability systems to ensure that the rate increase is spent for the intended purpose.

Another key issue identified in the legislation is the importance of developing mechanisms to ensure that rate increases are spent for the intended purpose. Minnesota has already developed an accountability system for previously enacted rate increases (COLAs) for long-term care providers earmarked for employee wage increases and benefits. Within six months after the effective date of each rate adjustment, providers must provide a Provider Statement of Assurance letter to the Department of Human Services Commissioner and those counties with which they have a contract. The letter provides assurances that the provider has developed and implemented a compensation plan that estimates the amounts of money that must be used to meet compensation and wage requirements and details the distribution plan for the money.

However, Minnesota officials consulted for this study commented that this has not really worked, as many providers have not returned this statement. In addition, a few survey respondents commented that their employer had not used the COLA for wage increases as required. Research in other states has found that even when accounting mechanisms have been specified, providers have not always passed on rate increases to employees.[18]

Hence, Minnesota should also ensure a system is in place to track and monitor outcomes of the rate increase on employee health insurance. For example, in Montana's program, payments are advanced to employers monthly, and every quarter the employer must send in reports attesting to their actual costs.

Research on the experiences of these states suggests several possible approaches to enforcement of a rate increase designated for wages or benefits:[19]

- Surveying providers after the rate increase to determine whether and how they participated;
- Requiring providers to submit expanded cost reports;
- Random audits; and

[18] Dorie Seavey and Vera Salter, *Paying for Quality Care: State and Local Strategies for Improving Wages and Benefits for Personal Care Assistants*, Washington, DC: AARP Public Policy Institute, 2006, http://www.aarp.org/research/longtermcare/quality/2006_18_care.html

[19] PHI and IFAS, State Wage Pass-Through Legislation: An Analysis," Workforce Strategies No. 1April 2003. http://www.directcareclearinghouse.org/download/WorkforceStrategies1.pdf.

- Tracking employer deductions for health insurance on business tax returns.

Explore options for making insurance more accessible to part-time workers or ensuring full-time work.

Many long-term care workers, particularly direct service workers, do not qualify for health insurance benefits because they work part-time or irregular hours, particularly those in home care. A third of workers reported working less than 32 or more hours per week. Potential strategies for expanding coverage to part-time workers include:

- **Ensure full-time work—** Of the 33 percent of workers who indicated they do not have private health insurance, 33 percent said they would try to work at least 32 hours if that would qualify them for coverage. Another 47 percent said they already work 32 or more hours. This suggests that ensuring full-time work could be a promising strategy for Minnesota. For example, Cooperative Home Care Associations (CHCA) in New York has developed a guaranteed hours program that blends regular hours with replacement hours worked and "on-call" hours not actually worked.[20] The program guarantees participants 30 hours of paid work a week. In addition, ensuring guaranteed continuous eligibility for 12 months would significantly reduce the administrative burden on the state caused by workers churning in and out of employer and public coverage.[21]

- **Design the premium structure to ensure part-time workers are eligible for the full employer contribution—** Under the Minnesota Advantage plan, employees receive the full employer contribution to premium if they work more than 30 hours a week, partial contribution (50% or 75%) if they work 20 to 29 hours, and no contribution if they work less than 20 hours.[22] Based on the results of the worker survey, few workers would be able to afford premiums of over $100 a month for insurance, so it is unlikely that many part-time employees would enroll unless the cost of premiums were fully subsidized or very low.

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[20] PHI, The Guaranteed Hours Program, Workforce Strategies No. 4, http://www.directcareclearinghouse.org/download/WorkforceStrategiesNo4.pdf

[21] This has been a significant issue in New York State. See Berliner, H.S. *Home Care Workers Health Insurance Demonstration Project: Final Evaluation*, June 28, 2004.

[22] Email from Beth Arntson, Workforce Planning Consultant, Minnesota Department of Human Services, June 19, 2009.

- **Create an alternative plan for those workers who are working part-time for multiple employers and not eligible for any single employer**—In the worker survey, 15 percent of respondents indicated they work 32 or more hours a week through more than one part-time job. This suggests that another strategy for Minnesota may be to develop a way to count workers as full-time if they work a total of 32 hours through multiple part-time long-term care jobs.

Conduct outreach efforts to increase awareness of the health benefit and encourage participation.

The experiences from Maine and Washington states' CMS grantees,[23] and most recently from New York's Family Heath Plus Buy-in,[24] stress the need for concerted outreach efforts. It is important to ensure that long-term care workers are aware of the insurance benefit, the benefits of insurance and how it works, and how to enroll. Minnesota might consider mechanisms to gain direct access to workers, either with the permission of their employers or independently through direct service worker associations or labor unions representing the direct service workforce.[25] Community organizations where many workers are active are another potential venue for reaching workers.

Ensure that the rate increase is adequate to make insurance affordable to employers.

For the initiative to have significant impact, the payment made to employers would need to be of sufficient size to provide an incentive for employers to participate.[26] In Montana, several of the providers who did not participate said the reason was because the Medicaid rate increase was insufficient to cover the cost of an insurance plan that meets the state's criteria.[27] Maine's experience with a health insurance subsidy for employees also illustrates the difficulty of expanding coverage when the employers have a hard time paying premiums, especially when they are funded primarily with public dollars.

[23] PHI, CMS Direct Service Workforce Demonstration Grants: Overview and Discussion of Health Coverage Interventions, 2006.

[24] PHI, Coverage Models from the States, 2007.

[25] PHI, Emerging Strategies for Providing Health Coverage to the Frontline Workforce in Long-Term Care: Lessons from the CMS Direct Service Community Workforce Grants, January 2007.

[26] Minnesota Department of Health, 2002.

[27] Montana Department of Public Health and Human Services, "Health Care for Direct Care Workers Application 1 Report." http://www.dphhs.mt.gov/sltc/services/communityservices/HCWorkers/Application1Summary.pdf

To ensure sustainability over time, build in mechanisms to ensure that funding keeps pace with escalating health insurance costs.

Several of the long-term care worker health insurance initiatives undertaken by other states were short-lived demonstration programs that were unsustainable when the grant period ended, due to lack of a steady financing source. In some cases, rising health care costs led employers to increase costs or reduce benefits for employees.

To be sustainable, the Minnesota initiative should build in mechanisms to ensure that funding keeps pace with escalating health insurance costs.

iii) Conclusion

In conclusion, implementing the proposed rate increase for health insurance in Minnesota will require careful planning and investment. However, given the growing need for a strong, stable workforce to support Minnesota's growing population of older persons and people with disabilities, the link between health coverage and retention, and the importance of a stable qualified workforce to quality of care, we believe that the results of undertaking this endeavor will be well worth it.

1.0

Introduction

- "Long-term care" includes a wide range of services to help older persons and people with physical disabilities, intellectual and developmental disabilities, and mental health/substance abuse issues live fulfilling, independent, and self-directed lives.
- Low wages and lack of health insurance make it difficult to find and keep long-term care workers to meet the growing demand for services.
- As health insurance costs continue to rise, businesses are raising employee contributions and/or reducing coverage for workers. Meanwhile, budget pressures have resulted in cuts to the public insurance safety net for Minnesotans without access to affordable employer coverage.
- To address these issues, the Minnesota legislature mandated this study to project costs and develop recommendations for a rate increase for long-term care providers dedicated to purchasing health insurance for employees.

Chapter 1: Introduction

Thousands of Minnesotans of all ages rely on long-term care services because of illness, cognitive impairment, or disability. These individuals rely on a reliable, well-qualified workforce to provide support and services in a wide range of settings, including private homes, nursing facilities, ICF/MRs, group homes, mental health and chemical health agencies and other settings. Support services might include transportation assistance, educational opportunities, employment support and many other services.

Although in the past, many people thought "long-term care" meant care in a nursing facility, the modern definition refers to a wide range of services and supports designed to meet medical, personal, and social needs in a variety of settings to help people live fulfilling lives as independently as possible.[28] Although the direct service workforce is highly fragmented, similar recruitment and retention challenges exist across the aging, physical disabilities, intellectual and developmental disabilities, and behavioral health sectors.[29] States are increasingly recognizing the importance of collaboration

[28] State of Connecticut, "Long-term care: what is long-term care?" http://www.ct.gov/longtermcare/cwp/view.asp?A=1398&Q=272914.

[29] Amy Hewitt, Sheryl Larson, Steve Edelstein, Dorie Seavey, Michael A. Hoge, and John Morris, A Synthesis of direct service workforce demographics and challenges across intellectual/developmental disabilities, aging, physical disabilities, and behavioral health, National Direct Service Workforce Resource Center, November 2008, http://www.dswresourcecenter.org/index.php/dsw/what_s_new/cross_disability_synthesis_white_paper

and coordination across these sectors in an effort to address direct service workforce challenges.

High staff turnover and vacancies among direct service workers, who provide the bulk of long-term care services, are urgent concerns to many states. Frequent worker turnover can harm the quality of life of people receiving services, as well as reduce quality of services. High turnover is also expensive, in terms of direct and indirect costs for providers and public long-term care financing programs.[32] A number of factors contribute to instability in the long-term care workforce, including low wages and lack of benefits, inadequate training, and organizational and societal cultures that undervalue long-term care workers.

Given the growing demand for long-term care services and supports—particularly services provided in homes and the community—it is critical for states to address barriers to people choosing direct service as

What is Long-Term Care?

The legislation mandating this study required the inclusion of Minnesota providers who were eligible for the cost of living adjustment (COLA) and provide any of 11 types of long-term care services (see ***Focus Box***):[30] [31]

"Long-term care" includes a wide range of health, personal, and social services provided to help people live fulfilling, independent, and self-directed lives. The legislation mandating this study defined long-term care providers broadly to include providers of the following services:

1. Home and community based waiver services for persons with developmental disabilities
2. Home and community based waiver services for the elderly
3. Waiver services under community alternatives for people with disabilities
4. Community alternative care services
5. Traumatic brain injury waiver services
6. Nursing services and home health services
7. Personal care services
8. Private duty nursing services
9. Day training and habilitation services for adults with developmental disabilities
10. Alternative care services
11. Various program grants *(includes group residential housing, deaf and hard of hearing grants, epilepsy service grants, HIV case management, living at home/block nurse grants, eldercare development partnerships, county mental health and screening services, and Minnesota Board on Aging volunteer and nutrition grants)*

[30] 2008 Minnesota Laws Chapter 358, Article 3, Section 13 The service types are listed in Minnesota Laws 2007, Chapter 147, Article 7, Section 17, Subdivision B.

[31] Additional information about the COLA is available at http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_138858

[32] Dorie Seavey, *The Cost of Frontline Turnover in Long-Term Care,* Better Jobs Better Care, October 2004. http://www.bjbc.org/content/docs/TOCostReport.pdf

a career path and staying in it. A growing number of studies indicate that health coverage plays a powerful role in recruitment and retention of direct service workers.[33]

In addition, states are interested in extending health insurance to uninsured citizens. When states are considering expanding coverage to uninsured adults, they have often given priority to low wage workers especially those in high demand jobs where lack of health insurance has been identified as a challenge to retention and recruitment, and to workers employed by small employers that have difficulty offering employee benefits. Many people believe that fairness dictates that priority should be given to workers who provide health-related services to others. States have also given priority to workers who are paid primarily with public dollars. In a classic free market, industries can respond to worker shortages by improving wages, benefits, and other job attributes until enough workers are willing to fill the positions. However, in the long-term care industry, which is funded primarily by Medicaid, little room is left for the market to adjust.[34] This is especially true for nursing facilities, because Minnesota is one of only two states with a "rate equalization" law dictating that nursing homes cannot charge private pay residents more than the Medicaid rate.[35] In response to all these factors, several states have sought to expand health insurance coverage for direct service workers.[36, 37, 38]

A) Study Purpose

The State of Minnesota has taken steps to improve compensation for long-term care workers by requiring that 75 percent of recent Medical Assistance cost-of-living rate increases be spent on employee wages and benefits. In 2007, the Minnesota Legislative Commission on Health Care Access, Health Care for Long-Term Care Workers Working Group examined the impacts of

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[33] Health Care for Health Care Workers, "Health Insurance Vital to Job Retention," Fact Sheet, October 2007. http://www.directcareclearinghouse.org/download/RetentionFactSheet.pdf

[34] Institute of Medicine (IOM), *Retooling for an Aging America: Building the Health Care Workforce*, 2008. http://www.iom.edu/?id=53452.

[35] Kane, Robert L, Greg Arling, Christine Mueller, Rob3rt Held, and Valerie Cook, "A Quality-based Payment Strategy for Nursing Home Care in Minnesota," *The Gerontologist*, 47:108-115. http://gerontologist.gerontologyjournals.org/cgi/content/full/47/1/108

[36] Duffy, Niev. (2004, October). *Keeping workers covered: Employer-provided health insurance benefits in the developmental disabilities field.* JFK, Jr. Institute for Worker Education, City University of New York, *New York.* http://www.pascenter.org/publications/publication_home.php?id=92

[37] Health Care for Health Care Workers, "Healthcare for Montanans Who Provide Healthcare," http://www.directcareclearinghouse.org/1_art_det.jsp?res_id=273010.

[38] PHI, *Emerging Strategies for Providing Health Coverage to the Frontline Workforce in Long Term Care*: Lessons from the CMS Direct Service Community Workforce Demonstration Grants, January 2007, http://www.dswresourcecenter.org/index.php/dsw/reports/emerging_strategies_in_providing_health_coverage_to_the_frontline_workforce_in_long_term_care.

these rate increases and concluded that, while this increase may have helped employers pay health insurance premiums, it was doubtful that the money available through this mechanism had allowed employers to improve coverage plans or expand coverage to more employees. [39]

The Working Group recommended that the Legislature provide a Medical Assistance rate increase to help long-term care providers purchase employee health insurance. In 2008, as part of Minnesota health reform legislation, the legislature directed the Department of Human Services (DHS) to study costs and options for implementing such a rate increase. The legislation tasked DHS with preparing a report including "recommendations for a rate increase to long-term care employers dedicated to the purchase of employee health insurance in the private market."[40] The legislation specified that the study include all employees of long-term care providers (i.e., all those covered by the COLA provisions), not just those who directly provide care services.

To assist DHS with the legislatively mandated study, DHS Continuing Care Division contracted with The Lewin Group to:

1. Gather data through surveys of long-term care employers and workers in Minnesota,
2. Conduct an actuarial analysis to project participation levels and costs for the three coverage options proposed in the legislation, and
3. Develop implementation options, considerations, and recommendations for Minnesota.

B) Organization of Report

The remainder of this report includes the following chapters:

- Chapter II: Study Methodology
- Chapter III: Survey Findings
- Chapter IV: Actuarial Analysis of Projected Participation and Costs
- Chapter V: Conclusions, Recommendations, and Implementation Considerations
- Appendices

[39] The Legislative Commission on Health Care Access, Health Care for Long-Term Care Workers working group, "Health Care Access Commission Working Group Recommendation," Report to the Minnesota Legislative Commission on Health Care Access, 85th Legislative Session, 2007. http://www.commissions.leg.state.mn.us/lchca/long-term%20care.pdf

[40] Law of Minnesota for 2008, Chapter 358–S.F.No. 3780, Sec. 13. Long-Term Care Worker Health Coverage Study. https://www.revisor.leg.state.mn.us/laws/?year=2008&type=0&doctype=Chapter&id=358

C) Background on Minnesota's Long-Term Care Workforce and Health Insurance Issues

In Minnesota, as in most states, little data are available on the number and characteristics of long-term care workers.[41] [42] The 2002 Minnesota Department of Health study on *Employer-Sponsored Health Insurance in the Minnesota Long-Term Care Industry* analyzed data for 581 employers representing 39,000 employees. Using statistical weights, the authors estimated that the Minnesota long-term care industry as a whole included 77,000 (the lower end estimate) to 181,000 (the upper end estimate) employees. These estimates vary depending on the definition of long-term care employees and the data source used in the analysis.

The Bureau of Labor Statistics tracks three categories of DSWs: Nursing Aides, Orderlies and Attendants, Home Health Aides, and Personal and Home Care Aides. Direct service workers are the backbone of the long-term care industry, providing an estimated 70 to 80 percent of the paid hands-on long-term care and personal assistance to elders and individuals living with physical disabilities, intellectual/developmental disabilities, or other chronic conditions. Health care and social service professionals such as licensed nurses, physical therapists, and social workers provide the remainder of the services. They are a lifeline for those they serve, as well as for families struggling to provide quality care. They are overwhelmingly female (88 percent), with average age between 38 and 49 years.[43]

Most long-term care workers are employed by a facility or agency; however, national figures estimate that a growing number of workers providing care in individuals' homes are employed and supervised directly by a consumer. For this study, we included consumer-directed workers who work for the Minnesota Personal Care Assistance (PCA) Choice program, but did not survey those hired privately by consumers, who operate in more of a "grey market."

[41] Steven Edelstein and Dorie Seavey, The Need for Monitoring the Long-Term Care Direct Service Workforce and Recommendations for Data Collection, National Direct Service Workforce Resource Center, February 2009. http:\\www.dswresourcecenter.org/index.php/dsw/what_s_new/dsw_data_collection_recommendations

[42] US Department of Human Services, Health Resources & Services Administration (HRSA), February 2004, Nursing Aides, Home Health Aides, and Related Health Care Occupations—National and Local Workforce Shortages and Associated Data Needs, ftp://ftp.hrsa.gov/bhpr/nationalcenter/RNandHomeAides.pdf

[43] Hewitt et al, November 2008.

i) Challenges in Meeting Growing Demand for Workers

… I feel the healthcare field is under appreciated. It is hard work and very underpaid.

– Provider

PHI (formerly the Paraprofessional Healthcare Institute) analysis of Current Population Data estimates that Minnesota will need 42,794 new direct service workers by 2016 (see ***Table 1.1***) due to increases in the aging population. [44] The U.S. Census estimates that, by 2030, Minnesota's 65+ population will increase by 100.8 percent.[45] [46] In the same period the traditional care-giving workforce (women aged 25 to 44) will grow by only 4.8 percent, leaving a significant "care gap."

The growth in demand will be greatest for personal and home care aides and home health aides, which represent two of the three fastest growing occupations in Minnesota. Of all new direct care jobs, two-thirds will be in home and community based settings.

Table 1.1
Top Five Fast-Growing Occupations in Minnesota, 2006-2016

Occupational Title	2006 Estimated Employment	2016 Projected Employment	Percent Change	Numeric Change
1. Personal and Home Care Aides	29,333	47,008	60.3%	16,675
2. Network/Data Communications Analysts	5,723	8,666	51.4%	2,943
3. Home Health Aides	25,032	36,720	46.7%	11,688
4. Veterinary Technologists and Technicians	1,782	2,562	43.8%	780
5. Computer Software Engineers, Applications	16,096	22,634	40.6%	6,538

Source: PHI Calculations of pooled 2006-2008 Current Population Survey March Supplements

This demographic shift poses critical challenges to all long-term care employers, many of whom currently face significant obstacles to staff

[44] Direct-care workers are defined and counted by the Bureau of Labor Statistics in three occupational categories: personal and home care aides; nursing aides, orderlies, and attendants; and, home health aides.

[45] U.S. Census Bureau, U.S. Population Projections, Table 4: Change in Total population and population 65 and older by state: 2000 to 2030, http://www.census.gov/population/www/projections/projectionsagesex.html

[46] PHI National Clearinghouse on the Direct Care Workforce, "State Activities: Minnesota," http://www.directcareclearinghouse.org/s_state_det.jsp?action=view&res_id=23

recruitment and retention. In the comprehensive Direct Service Worker Resource Center review of national studies across long-term care populations, estimated annual total turnover in home care was between 40 and 60 percent.[47] A 2007 survey by the American Health Care Association (a nursing home trade association) found a 58 percent annual turnover rate for CNAs in Minnesota nursing facilities.[48]

ii) Low Pay and Lack of Health Insurance

- ***Low Pay:*** Low pay and lack of health insurance make these jobs unsustainable for those already in the field and unattractive to new workers. Although hourly wages for direct service workers in Minnesota are among the highest in the nation, they still leave a family of four with an annual income barely above 100 percent of the federal poverty level (***Table 1.2***). Data from the Current Population Survey (CPS) for the West North Central Region, of which Minnesota is a part, found that 39 percent of direct-care workers live in households that have some reliance on public assistance such as Medicaid, food stamps, or housing subsidies.[49]

Table 1.2
Annual Income for a Direct Service Worker Family in Minnesota
Poverty Level for a Family of Four

Federal Poverty Level - $22,050	
Occupation	**Average Annual Income for One Household**
Home and Personal Care Aides	$22,870
Home Health Aides	$22,670
CNA	$26,260

Source: PHI Calculations of pooled 2006-2008 Current Population Survey March Supplements

While wages are low for all direct service workers, those working in the home and community based services sector earn almost $4,000 less per year than CNAs working in nursing homes.

[47] Hewitt et al, 2008.

[48] American Health Care Association (2008). *Report of Findings 2007 AHCA Survey Nursing Staff Vacancy and Turnover in Nursing Facilities*. Available on-line: http://www.ahcancal.org/research_data/staffing/Documents/Vacancy_Turnover_Survey2007.pdf

[49] Calculations from PHI based of 2006-2008 pooled data from Current Population Survey, March Supplements.

…Last year we had a staff person (who was a nurse) die of breast cancer. She didn't have insurance. For all employees, we stress the need for insurance.

– Provider

- ***Lack of Health Insurance:*** In addition, regional data reveal that a quarter (24%) of nursing assistants, personal and home care aides, and home health aides in the West North Central region lack health insurance. By comparison, Minnesota data indicate that 7 percent of the general population in Minnesota is uninsured.[50]

Access to employer-sponsored insurance is unequal between different DSW sectors and settings. For instance, in the West North Central region, only 43 percent of home care aides are covered by their employer—compared to 59 percent of nursing care facility aides (see ***Table 1.3***).[51]

Table 1.3: Proportion of Direct Service Workers by Setting and Occupation Receiving Employer Sponsored Insurance: West North Central Region of U.S.[52]

By Employment Setting		By Occupation	
Direct Service Workers in Hospitals	86 %	Nursing/Psychiatric/Home Health Aides:	59 %
Direct Service Workers in Nursing Care Facilities	54 %		
Direct Service Workers in Home Care	*- - (reliable data not available because sample size is less than 30)*	Personal and Home Care Aides:	43%

Source: PHI Calculations of pooled 2006-2008 Current Population Survey March Supplements

A number of factors contribute to long-term care employers' difficulty providing affordable coverage for their employees. Many long-term care providers are small providers, which might have smaller profit margins and have a more difficult time negotiating affordable health insurance rates than larger agencies. In general, because so many long-term care agencies rely on limited Medical Assistance reimbursement rates, it is difficult for them to offer adequate pay and benefits to their employees. In Minnesota, long-term care employers pay a lower percentage of health insurance premiums than employers in other industries.

[50] Stefan Gildemeister, Assistant Director, Health Economics Program, Minnesota Department of Health. Conference call, June 5, 2009.

[51] PHI (2008). *The Invisible Care Gap: Caregivers without Health Coverage*. Available on-line: http://hchcw.org/wp-content/uploads/2008/05/phi-cps-report.pdf

[52] The CPS has a small sample size, and valid data on health coverage for direct service workers are available only for the 5 largest states. As noted above, in some cases regional data are also unreliable due to small sample size (indicated in the table).

Even if a long-term care agency is able to offer health and dental benefits, many workers are unable to enroll because they do not work enough hours to qualify or because they cannot afford the premiums. In terms of not qualifying for health insurance due to not working enough hours, a 2002 Minnesota survey found that only 57 percent of long-term care employees who worked in establishments that offer health insurance coverage were eligible for the benefit, compared to 83 percent of employees statewide.[53]

In terms of not qualifying for health insurance because not being able to afford premiums, in 2000, the take-up rate (percentage of eligible employees enrolled) in the Minnesota long-term care industry was 68 percent, 20 percentage points lower than the statewide average for all industries in 1997. This finding is supported by the National Nursing Assistant Survey, in which 42 percent of uninsured CNAs said they were not participating in coverage offered by their employer because they could not afford the premiums.[54]

This lack of affordable, comprehensive health insurance affects workers' health outcomes. Direct service workers' need for coverage is particularly essential because many suffer from high rates of chronic health conditions such as asthma, diabetes and hypertension. Such conditions require medical attention and management.[55] In addition, direct service workers experience astonishingly high rates of on-the-job injuries.[56] For instance, nursing assistants, nursing aides, orderlies, and attendants have the highest rate of on-the-job injuries and illnesses of any job type, with a rate of 465 per 10,000 full-time worker, or 4.7 percent of workers of this type.

> *"State Medicaid programs should increase pay and fringe benefits for direct-care workers through such measures as wage pass-throughs, setting wage floors, establishing minimum percentages of service rates directed to direct-care labor costs, and other means."*
>
> - Institute of Medicine

[53] Minnesota Department of Health. (January 2002). Employer-sponsored health insurance in the Minnesota long-term care industry: Status of coverage and policy options. Minnesota Department of Health, http://www.directcareclearinghouse.org/download/LTCWorkerHealthInsurance.pdf.

[54] Squillace, Marie R., Robin E. Remsburg, Lauren D. Harris-Kojetin, Anita Bercovitz, Emily Rosenoff, and Beth Han, "The National Nursing Assistant Survey: Improving the Evidence Base for Policy Initiatives to Strengthen the Certified Nursing Assistant Workforce," *The Gerontologist*, 49, no. 2, 185-197, April 2009, accessed April 24, 2009 at http://gerontologist.oxfordjournals.org/cgi/reprint/49/2/198.

[55] Several studies document these problems including a 2008 survey of Pennsylvania direct care workers in which 25% reported having a chronic condition such as heart disease, diabetes or asthma. For additional studies, see www.coverageiscritical.org

[56] Bureau of Labor Statistics, U.S. Department of Labor, Survey of Occupational Injuries and Illnesses. Available at http://www.bls.gov/news.release/osh2.nr0.htm.

iii) The Financial and Economic Climate for Uninsured Workers in Minnesota

Recent economic and political trends threaten to worsen the problem of uninsured long-term care workers in Minnesota. If current insurance industry trends continue, health insurance will become even more unaffordable for low-wage workers, as businesses continue to pass on rising insurance costs to their employees. According to Mercer's annual national survey of employer-sponsored health plans:[57]

- Total health plan costs per employee rose by 6.3 percent in 2008, and employers expect a similar increase for 2009 (6.4 percent). This projected cost increase is due to many factors, including the fact that health insurance utilization tends to increase during a recession (as people who may lose their coverage seek medical care as soon as possible). Also, laid-off workers on COBRA (who tend to have higher utilization rates) might seek more treatment, and health plans and providers might raise prices to make up for losses in other areas due to the economic crisis.
- The median deductible for individual coverage in traditional Preferred Provider Organization (PPO) plans jumped to $1,000 in 2008, up from $500 the previous year. Preferred Provider Organizations (PPOs), plans where health providers agree to provide services at a discounted rate to plan members, are the most common type of health plan, enrolling 69 percent of all covered employees.
- High deductible health plans, which require a deductible of at least $1,100 (for individual coverage) to deposit tax-free money in a Health Savings Account (HSA) or Health Reimbursement Account (HRA), are spreading quickly as well. These plans, also known as consumer-directed health plans, were offered by 20 percent of large employers in 2008, up from 14 percent the year before. Employees might prefer HSAs because they cost less than PPOs. In addition, employers might choose these plans because as the PPO deductibles have risen so dramatically, choosing an HSA with a $1,100 minimum deductible is not significantly more expensive. Also, with HSAs and PPOs having similar minimum deductibles, the savings account aspect of a HSA plan might be attractive to employees.
- Due to the high cost of providing insurance, employers offer medical benefits for retirees much less than they did in the past decade.

[57] Mercer. (2008, November 19). *Mercer survey finds $1,000 health plan deductible was the norm in 2008* [Press release]. Retrieved May 7, 2009, from http://www.mercer.com/summary.htm?idContent=1328445

At the same time as employers are finding it increasingly difficult to offer affordable, comprehensive health coverage to their employees, the health insurance safety net for low-wage workers in Minnesota is being eroded.

To address these problems, The Institute of Medicine's 2008 report, *Retooling for an Aging America: Building the Health Care Workforce*, recommended that states improve direct service worker pay and benefits (Recommendation 5.2) through Medicaid rate increases or other mechanisms.[58] Yet, a current deep budget deficit has led to cuts in funding for health care programs in Minnesota, including elimination of the General Assistance Medical Care (GAMC) program.[59] GAMC is a state-funded program that provides health coverage for childless adults who earn less than 75 percent of the federal poverty level, currently $8,000 a year. The state will eliminate the program in mid-2010.

[58] Institute of Medicine (IOM), Retooling for an Aging America: Building the Health Care Workforce, 2008.

[59] National Conference of State Legislatures (NCSL), "Minnesota Budget Reflects Tough Economic Times," May 27, 2009.

2.0

Study Methods

This study examined costs and options for a Minnesota Medical Assistance rate increase to help employers purchase insurance for their employees in the private market. This involved three key study activities:

- Survey providers and workers to gather needed actuarial data and other employment related information
- Analyze actuarial data and develop cost estimates for the three coverage level options described in the legislation
- Develop implementation options and recommendations

Chapter 2: Study Methodology

The Minnesota Legislature mandated that this study develop cost estimates and recommendations for increasing Medicaid rates to help long-term care employers purchase employee health insurance in the private market.[60] The legislation specified that the study consider three levels of insurance coverage:

(1) the coverage provided to state employees (Minnesota Advantage plan);

(2) the coverage provided under MinnesotaCare, the State's health insurance program for low-income individuals and families; and

(3) the benefits provided under an 'average' private market insurance product, but with a deductible limited to $100 per person.

This involved three major tasks:

[60] Law of Minnesota for 2008, Chapter 358–S.F.No. 3780, Sec. 13. Long-Term Care Worker Health Coverage Study.
https://www.revisor.leg.state.mn.us/laws/?year=2008&type=0&doctype=Chapter&id=358

- First, to gather data needed for the actuarial analysis, Lewin surveyed all Minnesota Medical Assistance and state funded long-term care providers and a sample of their employees about current hours worked, health coverage, costs, and other needed information.
- Second, actuarial staff from Lewin's sister company Ingenix Consulting (IC) developed cost estimates and projected participation rates for the various potential plans and funding scenarios.
- Finally, with consultation from our sub-contractor, PHI (formerly Paraprofessional Healthcare Institute), we developed implementation options and considerations for the three coverage options, including examples and lessons learned from other states, and recommendations for Minnesota.

Research on Health Insurance and Worker Retention

Research findings have found a strong positive link between health insurance coverage for direct service workers and worker retention.[61] For example in the National Nursing Assistant Survey, 36 percent of certified nursing assistants told interviewers they continued to work at their current job because of the benefits.[62] Bolstered by these findings an increasing number of states have been considering policy strategies to make health insurance more accessible and affordable for this population. Examples of these state initiatives are discussed in ***Chapter 5*** of this report.

A) Provider and Worker Surveys

The first task was to collect data through surveys of all Minnesota Medical Assistance and state funded providers and a large sample of their employees. Although existing studies and data sources provide some information about health coverage for long-term care workers in Minnesota, no existing data sources were available that provided the level of detail needed for the actuarial analysis component of this study.

Minnesota's Health Insurance for Long-Term Care Workers Workgroup, which includes representatives from the Department of Human Services, Department of Health, and Department of Commerce, provided input on and approved both the provider and worker surveys. In addition, the DHS Institutional Review Board (IRB) approved the worker survey. We also pre-tested the surveys with a small group of long-term care providers and workers before finalizing them.

61 PHI. *Health Insurance Vital to Job Retention*, Health Care for Health Care Workers Fact Sheet (October 2007)

62 Marie R. Squillace, Anita Bercovitz, Emily Rosenoff, and Robin Remsburg, *An Exploratory Study of Certified Nursing Assistants' Intent to Leave*, Office of Disability, Aging and Long-Term Care Policy, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, September 2008. Accessed April 24, 2009 from http://aspe.hhs.gov/daltcp/reports/2008/intent.htm.

i) Provider Surveys

In March and April, 2009—one month prior to announcing the employee survey to ensure uniform methodology—we asked all of the 5,153 Minnesota long-term care providers in the listing provided to us by DHS (***Table 2.1***) to complete a confidential web-based survey. The DHS list included 5,153 providers identified as eligible for the study because they received the Cost of Living Adjustment (COLA). In accordance with the legislation, this study defined long-term care providers as all providers that received the COLA from DHS in 2008.[63] Of the 5,513 providers, 4,677 were in DHS's billing system for Minnesota Health Care Programs (MHCP) claims and other transactions, known as MN-ITS[64] (pronounced "minutes") (http://mn-its.dhs.state.mn.us/), and 476 were state grant providers such as Meals on Wheels that are not in MN-ITS. As shown in ***Table 2.1***, diverse provider types were eligible to participate in the study.

However, estimating the number of providers of each type respondents was complicated by the fact that providers who operate more than one type of Medical Assistance service (e.g., a nursing home and a home care agency) may use a single provider number for all members of their organization in MN-ITS. In these cases MN-ITS only classifies the agency as providing one service type.

Table 2.1: Estimated Number of Minnesota Long-Term Care Providers Eligible for the Provider Survey[65]

Provider Types	Number of Providers
Nursing facilities	381
Intermediate care facilities –MR	217
Home and community-based services, including waivers, home care and Alternative Care, and semi-independent living services (SILS)66	3,437
Day training and habilitation (DT&H)	234

63 For simplicity, this group of providers is referred to in this report as "long-term care providers," although some categories of providers in the study might be categorized as acute care, human services, or other types of service providers.

64 According to the MN Department of Human Services, MN-ITS is not an acronym. MN DHS, Disability Services Program Manual, Jan 15, 2004, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_017996

65 This is the listing included in the legislative language for the long-term care worker health insurance study, including the detailed list in the COLA statute.

66 This category does NOT include all individual PCAs registered as providers with the state in provide enrollment.

Table 2.1: Estimated Number of Minnesota Long-Term Care Providers Eligible for the Provider Survey[65]	
Provider Types	**Number of Providers**
Mental health programs (adult and child)	45
Rehab agencies	49
Chemical health services	304
Managed care organizations	10
TOTAL	**4,677**
State Grant Contracts	
Deaf and hard of hearing grants	10
Epilepsy service grant	1
HIV case management services	10
Group residential housing (GRH) rate 2	265
Living at home/block nurse programs	41
Eldercare development partnerships (EDPs)	7
Counties (receive state funds to provide mental health and screening services)	87
Community service/service development grants (CSSD)	41
Minnesota Board on Aging volunteer and nutrition grants (Title III OAA and related state grants)	14
TOTAL	**476**
GRAND TOTAL	5,153

Lewin developed the online survey and made it available for providers to complete at ZipSurvey.com. Minnesota DHS staff reported that service providers use an online system to submit claims (MN-ITS) and that this would be the most efficient and effective method to reach employers.

The primary focus of the Provider Surveys was to collect as much information as possible on Minnesota employees and their current insurance coverage. In particular, it was important to collect information on coverage types, amount of coverage, and employee take-up rates. The survey also elicited providers' recommendations for improving worker recruitment and retention, their thoughts about the health insurance proposal, and other information to help inform policy recommendations for ensuring successful implementation of the program across provider types.

For efficiency, the Lewin study team combined the provider survey with another survey that Lewin was conducting as part of a separate study for the Minnesota Department of Human Services, Division of Disability Services, to identify improvements to the Medical Assistance (MA) State Plan Personal

Care Assistance (PCA) program. We programmed the survey such that, after asking a question about whether the agency provides PCA services, the survey branched into two parallel surveys. PCA providers received a longer version of the survey incorporating questions for both studies and other providers received the survey questions for this study only. The two versions of the survey are provided in ***Appendices F and G***.

As an incentive, providers who completed the survey by the deadline were entered into a drawing to win one of three $500 cash prizes for their organizations.

The study team examined response rates daily. The study team also used multiple approaches to alert providers to the survey and encourage their participation:

- First, DHS alerted providers to the survey through a bulletin and message posted via the MN-ITS system (https://mn-its.dhs.state.mn.us/login.html), Minnesota DHS's billing system for electronically submitted Minnesota Health Care Programs claims and other transactions.
- As another outreach effort, DHS staff personally contacted representatives of several provider organizations in the state and asked them to announce the survey to their members, including, in some cases, through the organizations' newsletters.
- For additional outreach, the Lewin team emailed all providers for whom DHS could supply email addresses (525 of the 5,153 providers) and asked them to complete the survey.
- The response for the methods above were lower than expected, so Lewin also mailed hard copy letters to all provider groups eligible for the study. Response rates significantly improved after the mailing, but remained lower than expected.

A major challenge to eliciting responses was the length of the survey and the time involved to gather the requested information. Although the study team made efforts to make the survey as concise as possible, the actuarial analysis required that we ask respondents for detailed data on the number of employees, the wages and benefits they provide, expenditures on health benefits, and other numbers that may not be readily available. The survey cover letter suggested that respondents may need to gather their organization's tax records and Human Resources files before completing the survey. Our analysis of responses showed that many of the respondents who

started the survey stopped when they reached the questions asking for details about their organization's health insurance benefits.

In addition, although combining the two surveys eliminated the need to ask PCA providers to complete a separate survey for the other study, it resulted in a lengthy survey for PCA respondents, which may have resulted in "survey fatigue."

Another issue was that the survey used the term "long-term care providers" and some providers thought that the survey did not pertain to them because they did not consider their services to be "long-term care." To address this issue, we revised the survey language, changing "long-term care providers" to "service providers."

ii) Worker Surveys

We conducted an anonymous mail survey of long-term care workers to gather information about employees, including the type of provider they work for, type of coverage they have, their opinions and preferences, and demographic data. A copy of the worker survey is included in ***Appendix E***. We used a paper survey to gather information from workers because previous studies of long-term care workers suggest that many of these workers may not have access to the Internet.

Because we did not have the information needed to mail the survey directly to workers, we relied on provider facilities and agencies to distribute the survey to their employees. This is typical of surveys of long-term care workers (***Appendix A***), which generally rely on provider organizations or worker professional organizations to reach workers. While some states have databases with contact information for workers in some segments of the workforce (e.g., nurse aide registry of CNAs in nursing homes or data on consumer-directed workers through a public authority program), no state has a database on all long-term care workers.

To obtain a representative sample of workers in Minnesota, The Lewin Group used a mixture of ***stratified random sampling*** and ***simple random sampling*** to mail 5,203 surveys to diverse types of long-term care providers who agreed to distribute the survey to their employees (***Table 2.2***).

Table 2.2: Worker Surveys Mailed to Providers	
Provider type	**Number of Surveys Mailed to Providers**
Nursing Facilities	1754
Intermediate care facilities for persons with developmental disabilities (ICF/MR)	332
Home and Community Based Services (HCBS)	304
Chemical Health	110
Personal Care Assistance (PCA Agency)	685
Rehabilitation	260
Day Training & Habilitation	56
Home Health Agency	715
Public Health Nursing	223
Aging and Epilepsy Grant	580
HIV	64
Community	15
Continuing Care Facilities	9
Mental Health Rehabilitation	96
Total	**5203**

- ***Stratified random sampling group***: For provider groups where more detailed data were available, employer groups were stratified based on number of beds, ownership type, and provider type. The advantage of a stratified random sample is it has greater precision than that of a simple random sample and allows for stratum within each employer group to be measured separately. However, due to the limits in the available data, this stratification could only be done for nursing homes and intermediate care facilities for the mentally retarded (ICF/MRs). The number of employers within each stratum that were selected to participate in the survey was proportional to the size of each subgroup relative to the total number of employers in that employer group. Employers were then randomly selected from within each stratum to participate in the survey.

Simple random sampling group: For the other employer groups, only the provider name and contact information were available, so simple random sampling was the most appropriate method to select potential survey participants.

For each of the two methods, approximately 30 employers from each provider type were selected as potential participants, with the goal of reaching approximately 5,000 employees. The actual number contacted was proportional to the total number of providers within a provider type. The only exceptions were provider groups that had fewer than 30 providers in the State; in these cases all providers were included in the sample.

Staff from the Lewin Group telephoned these organizations describing the project and requesting their participation in the survey. In total, 61 organizations from among all 13 of the different facility types agreed to distribute the survey to their workers, representing 5,203 employees.

We sent employers a package containing a cover letter reminding them of the purpose of the study and enough surveys for all employees, prepaid return envelopes, and drawing entry forms for each of their employees. We sent an average of 83 surveys to each participating organization. Employers were asked to distribute the surveys, envelopes, and drawing entry forms to their employees. As a modest incentive, respondents were offered the opportunity to enter into a drawing for 40 $25 cash prizes.

iii) Review of other published surveys on health insurance for long-term care workers and other uninsured workers

To build on the information obtained from the surveys, our study also drew on the findings of previous research. Lewin and PHI reviewed results from 30 published studies on health care coverage for direct service workers and other uninsured workers. Fifteen of the studies were based on surveys of employers, and the other 15 studies surveyed employees. The summaries are included in ***Appendix A***. We gave particular attention to a 2002 study by the State of Minnesota, Department of Health, *Employer-sponsored health insurance in the Minnesota long-term care industry: Status of coverage and policy options.*[67] This study builds on the earlier Minnesota study by examining more detailed information about employers' health insurance costs and other information needed to explore costs and options for the three proposed insurance plan designs.

We also examined developments in Montana, which in 2009 became the first and to date the only state to implement a rate increase for long-term care providers dedicated to the purchase of employee health insurance. In addition to reviewing the literature, we held a telephone interview with Mike

67 Minnesota Department of Health. (January 2002). Employer-sponsored health insurance in the Minnesota long-term care industry: Status of coverage and policy options. Minnesota Department of Health. http://www.pascenter.org/state_based_stats/xml.php?state=minnesota

Hanshew, who is Director of Policy for a large personal assistance services agency in the state and was instrumental in the passage of Montana's rate increases to help employers purchase health insurance for home care workers.

In addition, the actuarial analysis component of the study used the Lewin Group Health Benefits Simulation Model (HBSM). Lewin developed the HBSM to model the effects of policies designed to increase access to health insurance.[68]

B) Actuarial Analysis of Data and Preparation of Cost Scenarios

Lewin's sister company, Ingenix Consulting (IC), performed an actuarial analysis to estimate costs for the three health insurance options listed in the Minnesota legislation and other plans that DHS requested we consider. The process was as follows:

1. ***Estimate claim costs.*** Using its propriety cost models and data from the surveys, IC estimated the single employee and family monthly claims costs for six different medical plan designs and two different dental plan designs for a plan year starting July 1, 2009. IC developed costs for eight locations within Minnesota: Twin Cities, Duluth, Fargo-Moorhead, Grand Forks ND area, St. Cloud, Rochester, Winona-La Crosse WI area, and non-MSA Minnesota.

2. ***Estimate non-benefit costs***. IC then estimated non-benefit, or overhead, costs, as a percentage of premium, for three coverage sources: 1) From the commercial health plan market; 2) from a new, dedicated, self-funded risk pool; and 3) directly from MinnesotaCare (i.e., these groups would be included in MinnesotaCare itself). The study considered modeling the option of enrolling workers in the Minnesota state employees' health plan, MinnesotaAdvantage. However, we learned that this option would not work for Minnesota, because the legal statute indicates that the state plan cannot be opened to new risk pools. The federal Employment Retirement Income Security Act (ERISA) ensures that state statutes regarding pensions and health plans are followed. Hence, opening the program to more people would be a violation of ERISA, per the head of ERISA in Minnesota.[69]

68 The Lewin Group, *The Health Benefits Simulation Model (HBSM): Methodology and Assumptions*, March 31, 2009, http://www.lewin.com/content/publications/HBSMDocumentationMar09.pdf

69 Correspondence with Julia Phillips, Minnesota DHS.

The non-benefit costs include administrative expense, stop loss or reinsurance costs, and for the commercial market scenario only, broker commission, premium tax, and the assessment to support the Minnesota Comprehensive Health Association (MCHA), the state's high risk pool. The preliminary premiums equal the projected claims costs divided by 100 percent minus the estimated overhead costs percentage. For example, if the overhead costs are is 9 percent of premiums, the preliminary premium equals the projected claims divided by 91 percent.

3. ***Estimate current statewide participation rates.*** From the survey results, IC estimated the current statewide employee participation rates for single and family coverage, by "small group" (50 or less eligible employees) and "large group" (51 or more eligible employees) employers. These estimates are on a statewide basis, because regional estimates would not be credible.

4. ***Estimate increased employee participation.*** Assuming that employee contributions under the proposed coverage will be the same as the current state employee contributions to the Minnesota Advantage plan, IC projected increased employee participation rates for single and family coverage due to lower employee contributions, for each of the proposed benefit plans, scenarios, and geographical locations. Because the proposed coverage will have no employee contributions for single coverage, IC assumed 100 percent employee participation for single coverage.

5. ***Apply selection factors and develop projected monthly premiums***. The various estimated current and projected employee participation rates imply selection factors that vary inversely with participation—the higher the level of employee participation, the lower the selection factor and therefore the lower the cost per employee. The reason is that, if participation is less than 100 percent, the healthier, lower utilizing employees are the ones more likely to opt out of coverage. IC applied the selection factors to the model premiums above to develop its projected single employee and family premiums by benefit plan, coverage scenario, and geographical location.

Based on the above analysis, the study team projected the total number of participants in each plan/funding source combination to develop an estimate of the cost to cover all eligible long-term care workers in Minnesota. Please refer to ***Chapter 4*** ("Actuarial Analysis of Data and Preparation of Cost

Issues Identified in Legislation

The legislation required that this study's recommendations include measures to:

- (1) ensure equitable treatment between employers that currently have different levels of expenditures for employee health insurance costs; and
- (2) enforce the requirement that the rate increase be expended for the intended purpose.

Scenarios") for more details on how IC developed the medical and dental rates.

C) Development of Implementation Options and Considerations

In the final task, project staff from PHI and Lewin developed implementation options and technical considerations for the state to implement the rate increase across the spectrum of providers. The legislation required that the recommendations address two key challenges in implementing a health insurance program: how to ensure fair treatment of providers that currently offer different levels of benefits, and how to ensure that the rate increase is used for the intended purpose, that is, to purchase health insurance coverage for employees. In addition, we identified other issues for the state of Minnesota to consider to make the health insurance initiative a success.

D) Limitations

Low response rates led to limited and cautious extrapolations and precluded analysis of responses by certain sub-groups of respondents.

In several instances, provider chains wanted to complete one survey that covered all of their individual entities, and the study team encouraged them to do so. Some providers with more than one National Provider Identifier (NPI) wanted to complete it on only one entity—they felt the burden to do more was unreasonable. Because specific employee information was critically important to us, we tried to accommodate providers in every possible way, regardless of provider type category. We wanted to be particularly sensitive to provider needs as the survey was long and complicated. We encouraged completion on any and every level. This precluded analyzing data by provider type for the provider surveys, but did not affect the main purpose of the survey, which was to gather information on coverage (or lack of coverage) for employees.

3.0

Survey Findings

- We surveyed long-term care workers and employees across all jobs and across diverse types of aging and disability services providers.
  - All facility based and all home and community based (HCBS) workers reported similar rates of uninsurance--20% of HCBS workers and 18% of facility workers were uninsured.
  - Disparities among workers in different occupations was much more striking, with 26% of direct service workers (DSWs), 19% of maintenance, housekeeping, dietary, and related staff, and 8% of professionals uninsured.
  - In addition, the results of this study and a separate study being conducted by Lewin on Minnesota's Personal Care Assistance (PCA) program point to important differences across provider types within facility and HCBS settings.

- A total of 923 long-term care workers participated in the employee survey. Key findings include:
  - 25% of all long-term care workers (34% of DSWs) have been uninsured within the past 12 months;
  - 46% of all workers had unpaid medical bills;
  - A third of workers work less than 32 hours per week, the amount needed to qualify for coverage under the Minnesota proposal. Fifteen percent work 32+ hours through more than one part-time long-term care job. Of workers without private health coverage, 33% said they would try to work 32+ hours a week so they could get health insurance and 47% said they already work 32+ hours a week.
  - In their comments, many workers described problems related to low pay and lack of health insurance and expressed strong support for efforts to make health insurance more affordable.

- A total of 772 long-term care providers completed at least some portion of the employer survey. Key findings include:
  - 72% of providers surveyed offer health insurance and 59% offer dental insurance.
  - The average turnover rate was 42%.
  - Employers named lack of health insurance as the second highest challenge in retaining direct service workers, after low pay.
  - The majority (56%) of providers said they support or strongly support the proposed rate increase for health insurance, 21% neither oppose nor support it, 17% were unaware of it, and 8% opposed it.

Survey Findings (Cont'd)

- To build on these findings, Lewin and PHI reviewed 30 previous surveys of long-term care employers or employees about health insurance. The literature supports our key findings, including that many long-term care workers decline health insurance because they cannot afford it, that many are not eligible for coverage because they work less than full time, and that health insurance benefits are an important factor that affects employee retention.

Chapter 3: Survey Findings

Lewin surveyed long-term care workers and employers from the entire state to gather information about health insurance coverage and related data and to hear the voices of workers and employers. This chapter describes key findings from the worker and employer surveys. The surveys included workers across all long-term care settings, because the legislation specified that the study examine health insurance for all long-term care workers.

To compare our findings with results of other studies, PHI and Lewin reviewed results from 30 previous studies that surveyed long-term care providers and/or workers about health insurance. ***Appendix A*** provides charts summarizing key findings from those studies. Although previous studies addressing health insurance for long-term care workers varied widely in their methods and the types of providers and workers included, our findings are consistent with the general trends.

A) Worker Surveys

Nearly 5,000 surveys were distributed to 61 long-term care employers in Minnesota who agreed to distribute the surveys to their employees. A total of 910 workers returned surveys (17.8% of the surveys sent to employers).[70] The response rate could not be calculated, because it is unknown how many of the surveys providers actually distributed to their employees.

i) Employment Characteristics

We asked employers to distribute the surveys to all their employees. Respondents represented workers in three categories of long-term care jobs (***Exhibit 3.1***):

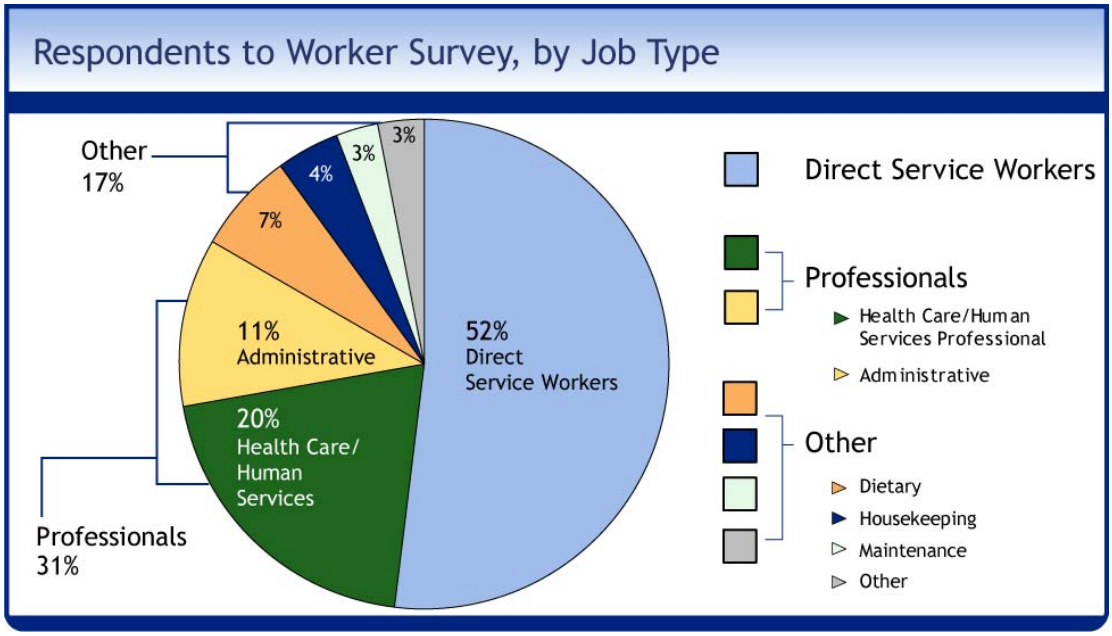
- Just over half (52%) of respondents were ***direct service/direct care workers (DSWs)***, who provide direct care and personal assistance to

[70] An additional 15 surveys were received late in the project. We included their responses in the anonymous data sent to Minnesota DHS, but were unable to incorporate their responses into this report.

people with disabilities and older persons. DSWs include certified nursing assistants, home health aides, home care aides, direct support professionals, personal care attendants, technicians, peer counselors, and similar workers.

- The next largest group of employees (31%) consisted of ***professionals***: these included health care/human service professionals, including nurses, physicians, physical therapists, social workers, psychologists, activity directors and similar personnel (20%), and administrative staff (11%).
- The remaining 14 percent of respondents were ***other long-term care employees***. These included dietary (7%), housekeeping (4%), maintenance (3%) and other staff (3%).

Exhibit 3.1: Respondents to Worker Survey, by Job Type



Our analysis of the worker survey data found many differences in wages, health insurance, and other job attributes for these three groups.

The place of employment for these job types also varied significantly (***Exhibit 3.2***). While just over half of the overall sample were direct service workers, in some settings two-thirds or more of respondents were direct service workers—ICF/MRs, home care/home health agencies, mental health providers, and PCA agencies. Respondents from nursing facilities and chemical health were more mixed between the three job types, and

respondents from hospitals and "other" settings were predominantly professionals.[71]

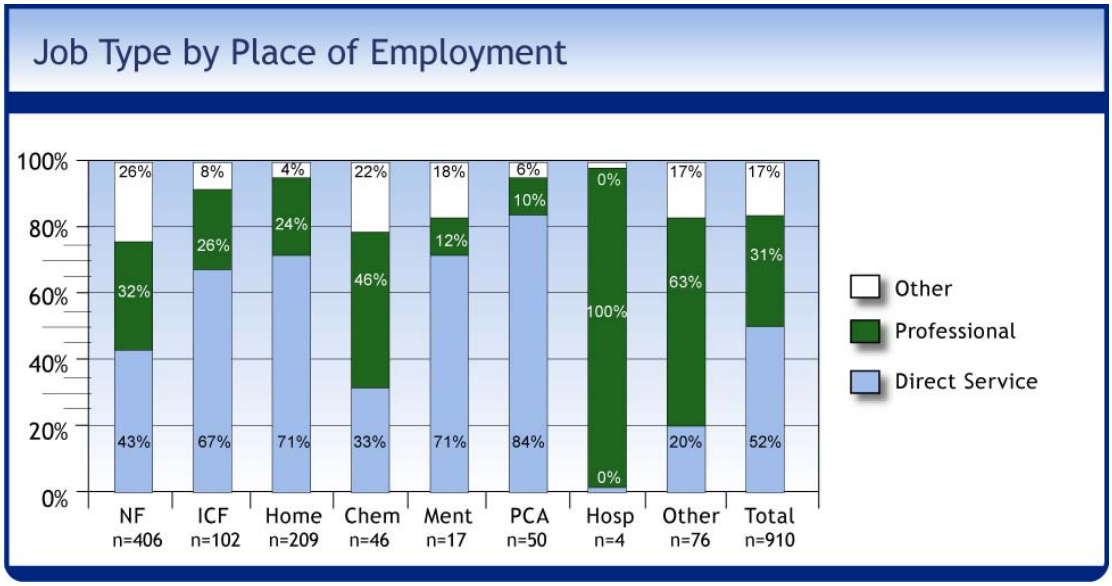
At the request of DHS, we also compared results from workers in institutional versus community settings in ***Appendix H***. The results show that workers in the community are somewhat less likely to have health insurance through their employer than workers in institutions (34% vs. 41%). However, it is important to recognize that HCBS workers and institutional workers are not monolithic groups. For instance, a good portion of workers in the HCBS category are in the chemical health (11.6%) and "other" fields (19.1%), which comprise mostly professionals, who are generally better paid and less in need of help getting health insurance.

A separate Lewin study on the Personal Care Assistance (PCA) program for the DHS Disability Services Division[72] suggests that PCAs face unique challenges. In focus groups of PCA workers, nearly all participants said that they were either not offered health insurance benefits, or that the insurance options they were offered were too expensive, and so they did not utilize them. Many were without insurance, and several said they just go to the emergency room when they are sick. Nearly unanimously, PCA workers expressed the need to have affordable health insurance. Another relevant finding from that study is that in the survey of PCA provider agencies, almost a third of agencies reported that they do not offer any benefits to full-time employees. Moreover, part-time employees received significantly fewer benefits than full-time employees, and approximately 75 percent of all PCAs worked only on a part-time basis. Approximately 45 percent of all responding PCA agencies reported that they offer health insurance to their PCA workers, with Traditional PCA agencies reporting that they offered health insurance benefits almost twice as often as PCA Choice agencies.

[71] We were not able to calculate response rates by provider setting, due to ambiguity about the denominator, as discussed in ***Chapter 2***.

[72] The Lewin Group, *Recommendations for Minnesota's Personal Care Assistance Program,* Report for Minnesota Department of Human Services, Disability Services Division, Draft July 2009.

Exhibit 3.2: Job Type by Place of Employment[73]



The survey asked workers in the "other" settings to describe the type of agency/facility they work for. Eighty workers reported being employed by diverse provider types, as shown in ***Table 3.1***. Note that the provider types are not mutually exclusive; for example, some workers described their place of employment as "non-profit," which could include many of the other setting types.

Table 3.1: "Other" long-term care employment settings[74]

Work setting	# of respondents
Public Health	16
Assisted Living	13
Rehab	12
Adult Foster Care	7
Senior Center / Community Center	6
Human Services	6
DT & Rehab / Habilitation and Training Center / Occupational Development Center	4
Group Home	3
Non Profit	3
Social Services	3
Waivered Services	2
Board and Care Home	1
Community	1

[73] Figures based on the 910 respondents who answered both the question on job type and the question on place of employment.

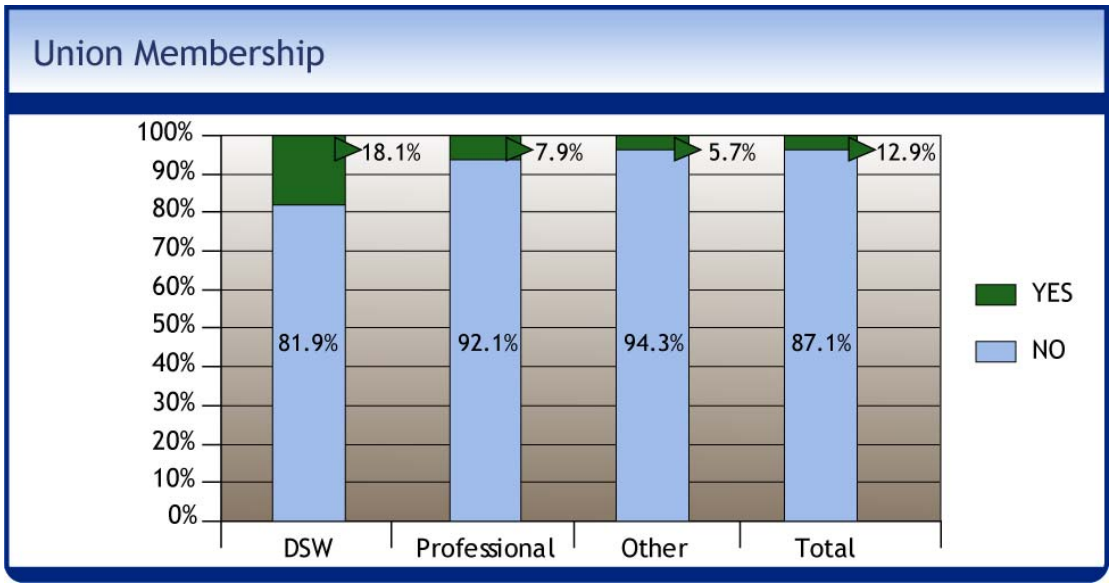
[74] Figures based on the 80 respondents who answered this question.

Table 3.1: "Other" long-term care employment settings[75] (Cont'd)

Work setting	# of respondents
Environmental Health Department	1
HUD	1
Physical therapy	1
Total	**80**

Seven percent of workers said they were in a union. Union membership ranged from 5 percent of professionals to over 11 percent of other employees (***Exhibit 3.3***).

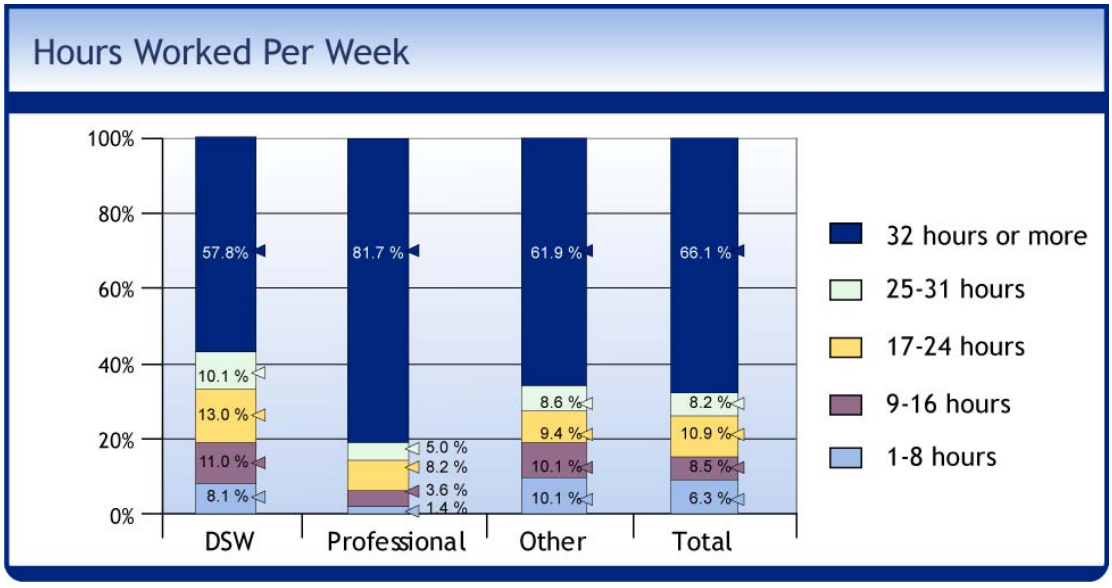
Exhibit 3.3: Union Membership by LTC Job



In the Medical Assistance rate increase being explored by Minnesota, eligibility criteria must be identical to that under the state employees' health plan, which defines full-time employees as those who work 32 hours or more per week. Two thirds of workers (66%) work 32 hours or more for the employer who gave them the survey, the amount needed to qualify for coverage under the Minnesota proposal (***Exhibit 3.4***). The remaining third work less than this amount. As ***Exhibit 3.4*** shows, direct service workers were least likely of the worker groups to work 32 or more hours per week, while professionals were most likely to work that amount of hours.

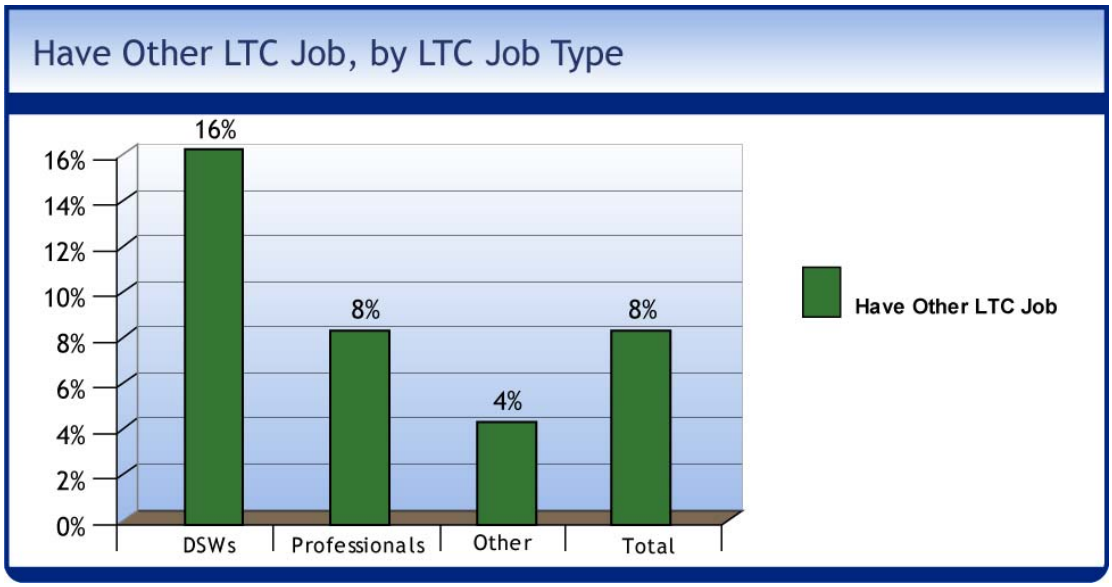
[75] Figures based on the 80 respondents who answered this question.

Exhibit 3.4: Hours Worked per Week with This Employer, by LTC Job



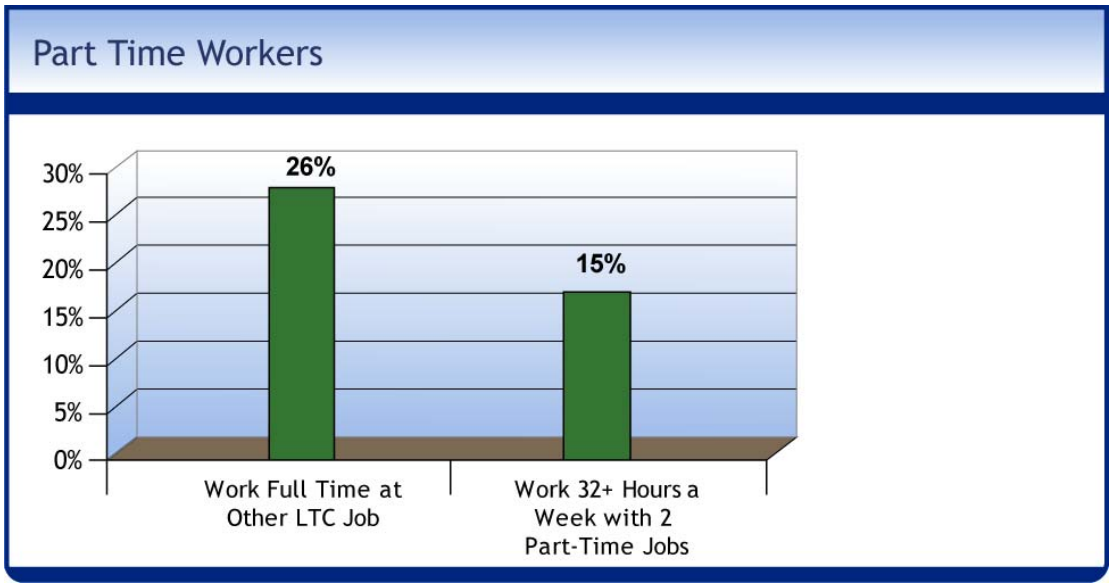
Eight percent of all respondents and 16 percent of direct service workers said they worked more than one job in long-term care (***Exhibit 3.5***).

Exhibit 3.5: Have Other LTC Job, by LTC Job Type



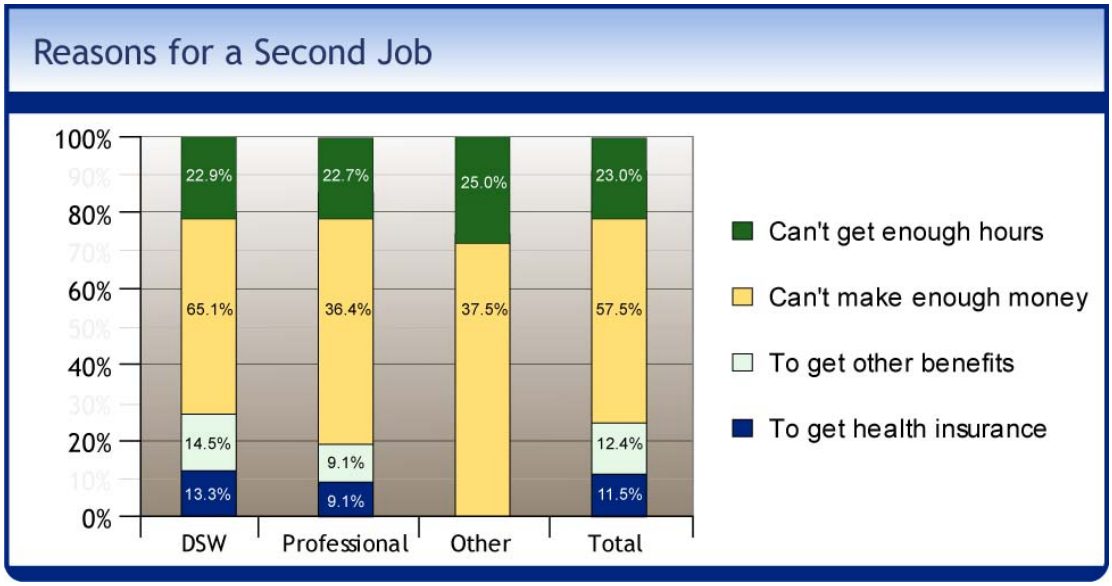
- Of respondents with more than one long-term care job, 26 percent indicated that they work full-time (32 or more hours) at their other long-term care job. In addition, another 15 percent of respondents worked part-time at both long-term care jobs, but worked full-time when hours from both jobs are added together (***Exhibit 3.6***).

Exhibit 3.6: Hours Worked by Part-Time Workers with Other Jobs



Of those working another job in long-term care, most stated their reason for working the second job was that they could not make enough money (58%) or could not get enough hours (23%) with the first employer. Twelve percent said they worked another job to get other health insurance (***Exhibit 3.7***).

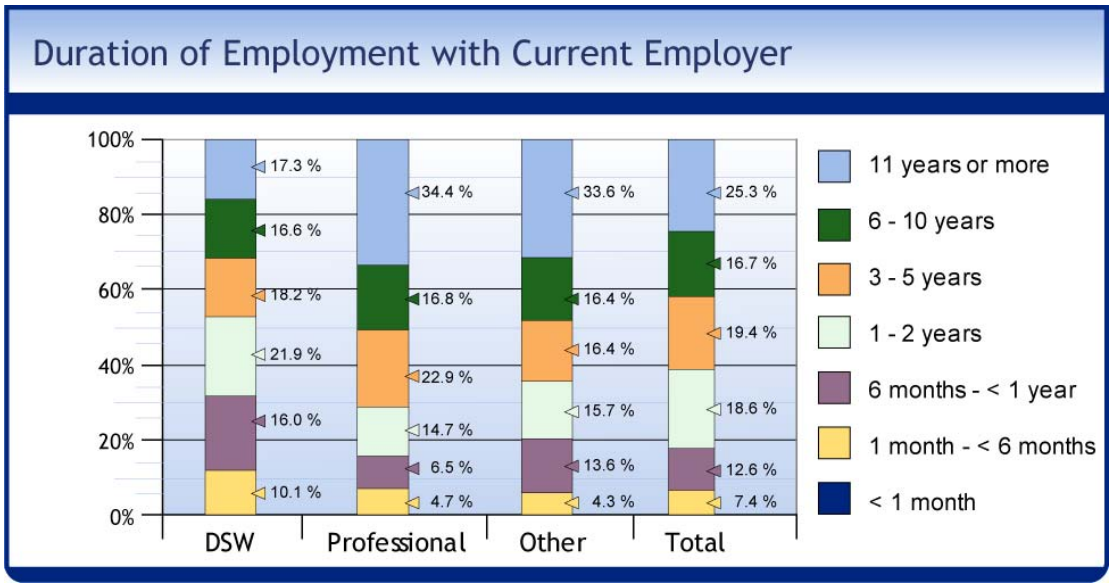
Exhibit 3.7: Reasons Why Workers Have a Second Job, by LTC Job Type



Eligibility for the state employees' health plan (the benchmark for the plan designs being considered by Minnesota) entails a waiting period for coverage of 35 days. Nearly all the workers who participated in the survey have worked for their current employer at least a month. Direct service workers had the least longevity of all long-term care job types, with the largest

proportion of workers on the job for 6 months or less, and the fewest with 3 or more years at the same job (***Exhibit 3.8***).

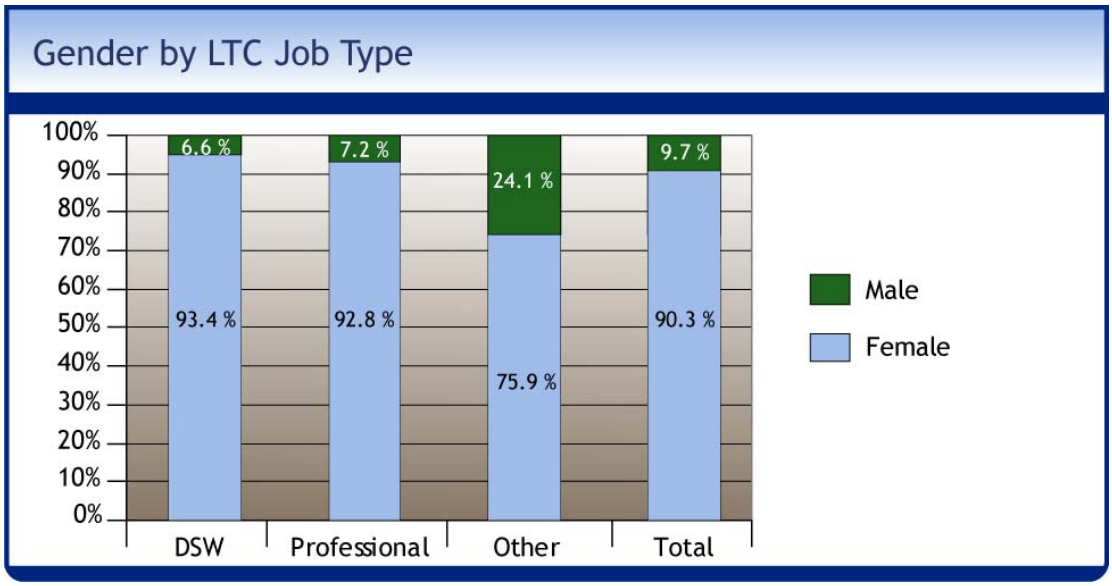
Exhibit 3.8: Duration of Employment with Current Employer, by LTC Job Type



ii) Worker Demographics

The vast majority (90%) of long-term care workers was female; this was especially true for direct service workers and professionals (***Exhibit 3.9***).

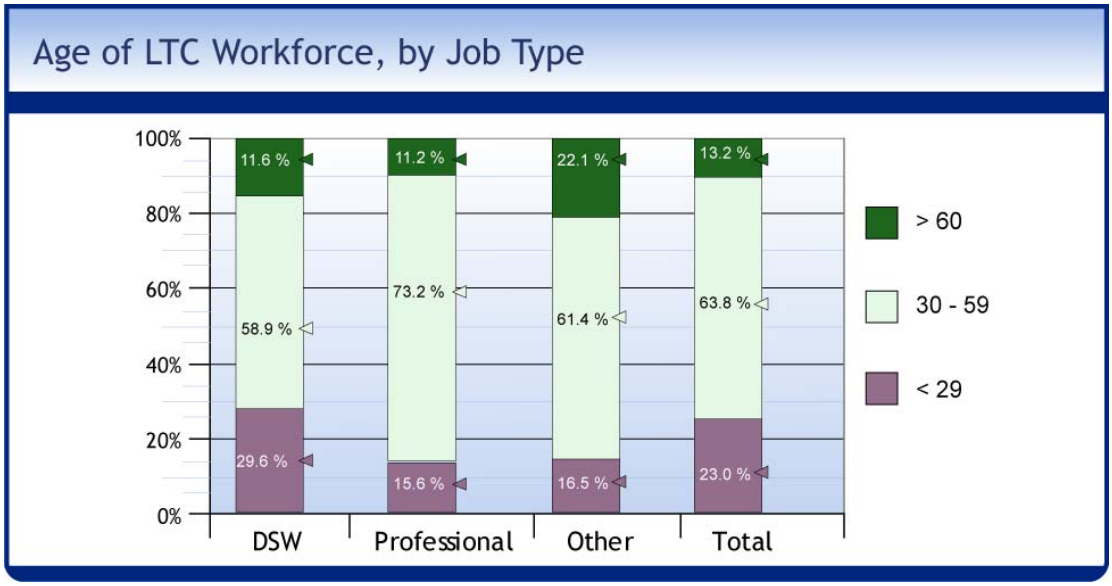
Exhibit 3.9: Gender by LTC Job Type



Employees' ages also varied by job type. Direct service workers included the greatest number of workers under age 30, while the "other" category (dietary,

housekeeping, and maintenance) included the greatest number of workers age 60+ (***Exhibit 3.10***).

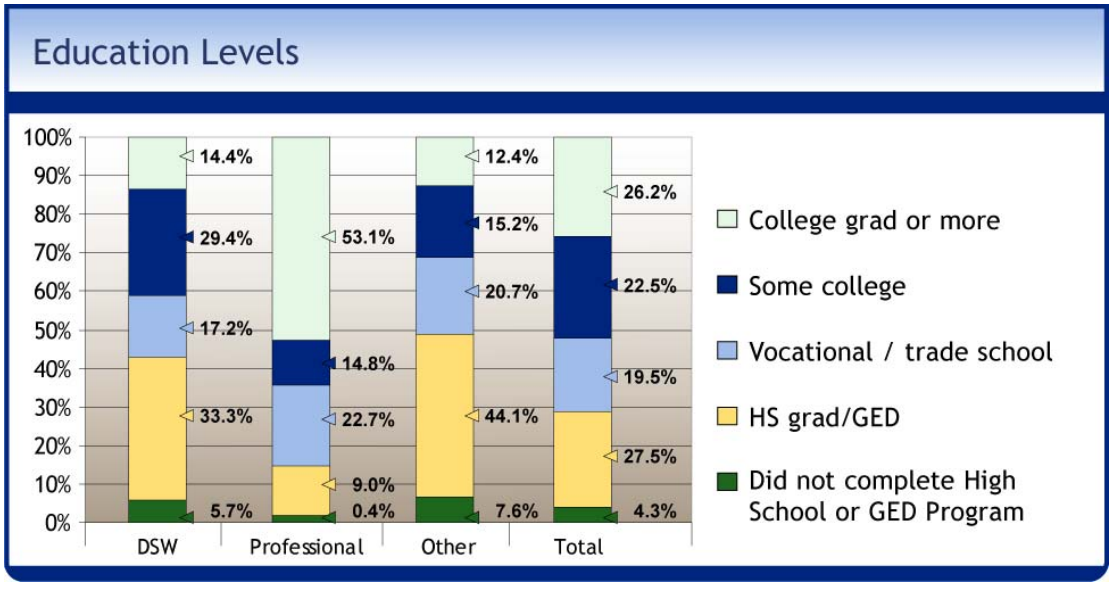
Exhibit 3.10: Age of LTC Workforce, by Job Type



The vast majority of long-term care employees were White (93%); and three percent of respondents were Hispanic or Latino. This was especially true of the Professionals category.

Level of education also varied greatly by type of job, with professionals having completed more education than direct service workers or other employees (***Exhibit 3.11***).

Exhibit 3.11: Highest Level of Education, by LTC Job Type

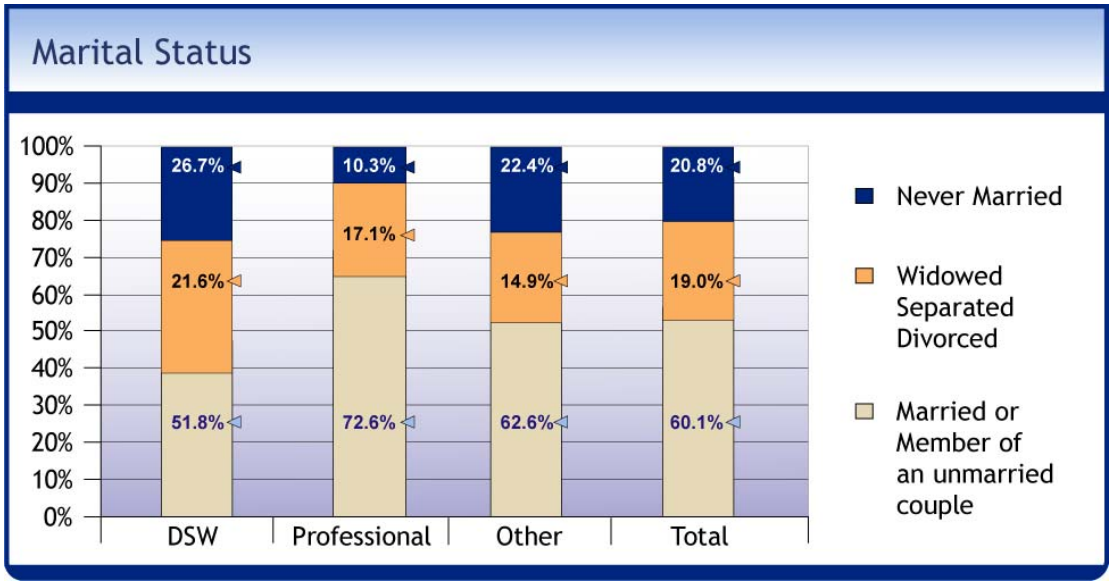


… We are very much under paid as a health care provider. People that work at a casino not far from us are making more than we are. There is something wrong here. We are providing care for human beings and giving them good care and work for hardly nothing. Someone needs to very much look into this.

– LTC Worker

Professionals were more likely to be married than other long-term care job types, while direct service workers were the least likely to be married (***Exhibit 3.12***).

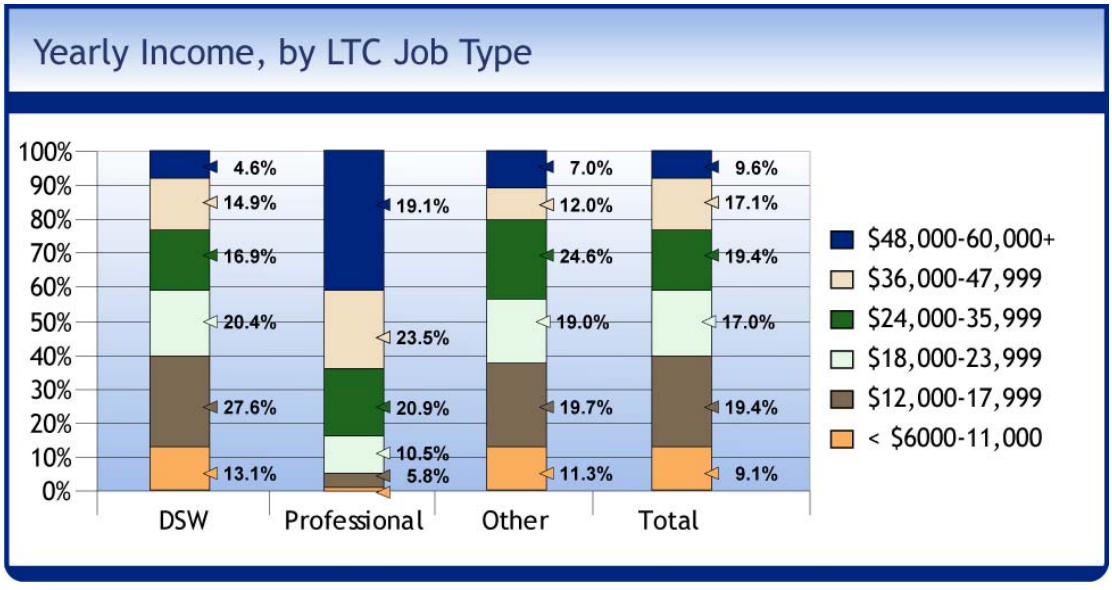
Exhibit 3.12: Marital Status by LTC Job Type



iii) Income and Benefits

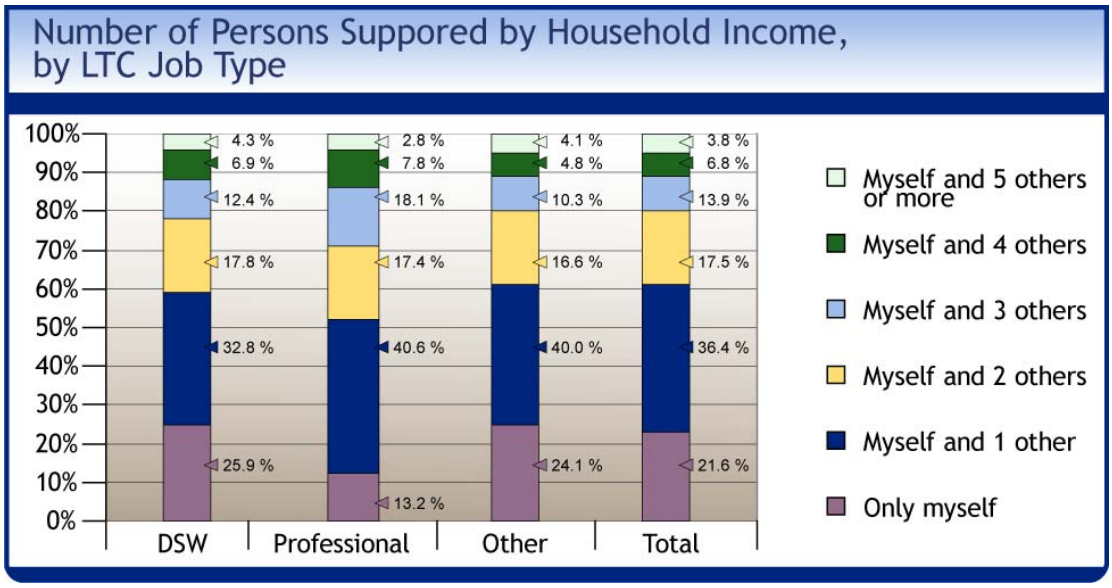
Direct service workers and other employees tended to have low household incomes, with most earning near 100 percent of the Federal Poverty Level for a family of four of $22,050 in 2009 (***Exhibit 3.13***).

Exhibit 3.13: Yearly Household Income by LTC Job Type



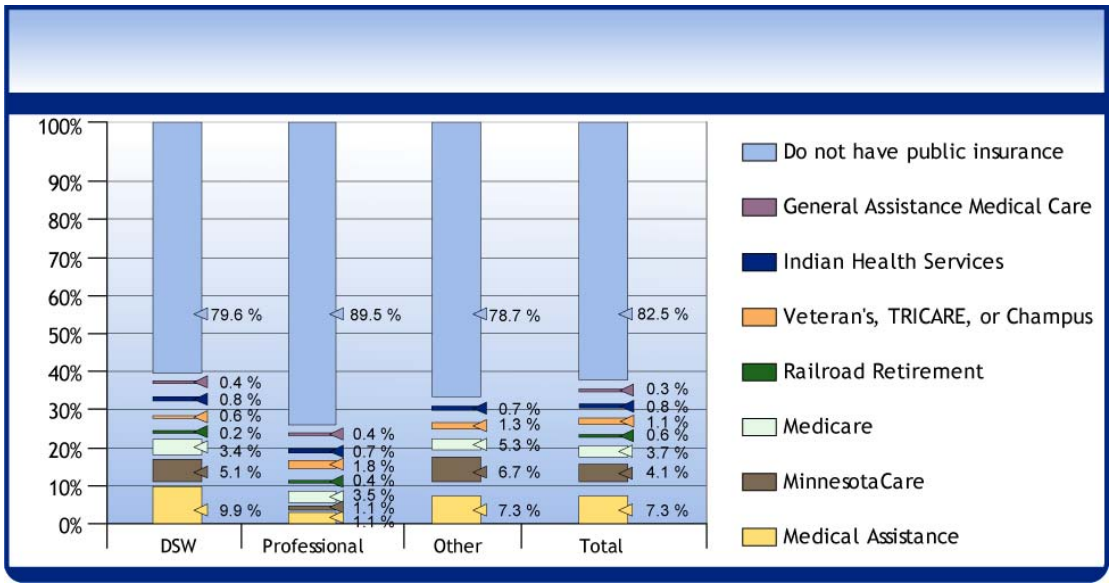
Most workers across all long-term care job types said that their household income was supporting at least one other person besides themselves (***Exhibit 3.14***).

Exhibit 3.14: Number of Persons Supported by Household Income, by LTC Job Type



Ten percent of direct service workers and 7 percent of "other" workers said they were covered by Minnesota Medical Assistance, and a number of workers reported receiving assistance from other public health insurance programs (***Exhibit 3.15***).

Exhibit 3.15: Have Public Insurance, by LTC Job Type

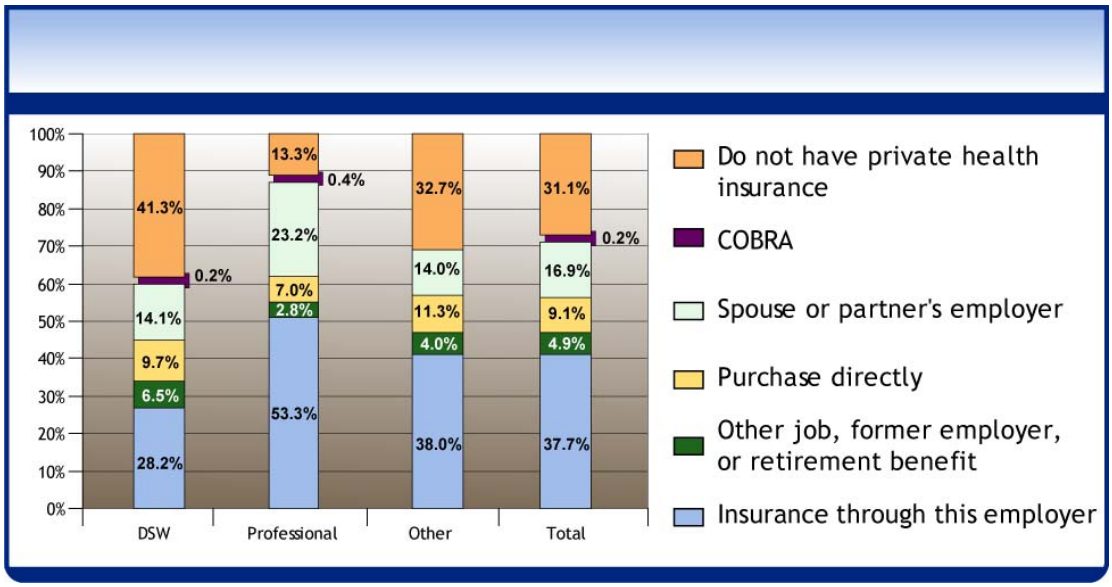


…We give up our time to help others on weekends, evenings and holidays with little to no benefits or wage compensation.

– LTC Worker

Direct service workers were least likely of all long-term care workers to have insurance through the employer who gave them the survey. Direct service workers were also the least likely to have any private insurance coverage, while professionals were the most likely to have private insurance (***Exhibit 3.16***).

Exhibit 3.16: Source of Private Health Insurance, by LTC Job Type



Although the survey included a definition of health insurance and descriptions of various insurance types, some respondents' answers suggested that they were unclear about what type of insurance they had. For example, some workers endorsed the statement "I have no public health insurance" and at the same time indicated that they had Medicare, Medical Assistance, or another type of public insurance. In these cases, Lewin re-coded their responses to indicate that they did have public insurance. Similar data cleaning was done for the questions about private insurance. This is not surprising, as other studies have found that many workers do not have a clear understanding of health insurance options.[76]

19 percent of long-term care workers and 26% of direct service workers surveyed were uninsured, that is, they had no public insurance and no private insurance (Exhibits 3.15, 3.16). By comparison, 10 percent of all working age Minnesotans are uninsured.[77]

[76] The Partnership for People with Disabilities at Virginia Commonwealth University, *Health Insurance and the Recruitment and Retention of Direct Service Workers in Virginia: Final Report*, Study for the Virginia Department of Medical Assistance Services, October 2007. http://hchcw.org/wp-content/uploads/2008/07/dmas_final_reportoct2007.pdf

Slightly more workers in HCBS settings (20%) than facility settings (18%) were uninsured (Appendix H). On the other hand, HCBS workers were somewhat less likely to have been uninsured for any period of time during the past 12 months (24% of HCBS workers and 27% of facility workers).

Much more striking differences were observed when comparing workers by occupation. Direct service workers were over three times more likely to be uninsured than professionals working in long-term care (8% vs. 26%). Direct service workers were also far less likely to have private coverage (54% vs. 82%), significantly more likely to have public health insurance (15% vs. 6%), and over twice as likely to have been uninsured during the past 12 months (***Table 3.2***).

Table 3.2
Health insurance status of Minnesota long-term care workers

	DSW	Professional	Other	Total
Public health insurance	15%	6%	14%	12%
Private health insurance	54%	82%	60%	54%
Uninsured	26%	8%	19%	19%
Both public and private health insurance	5%	5%	7%	5%
Uninsured during past 12 months	34%	14%	22%	25%

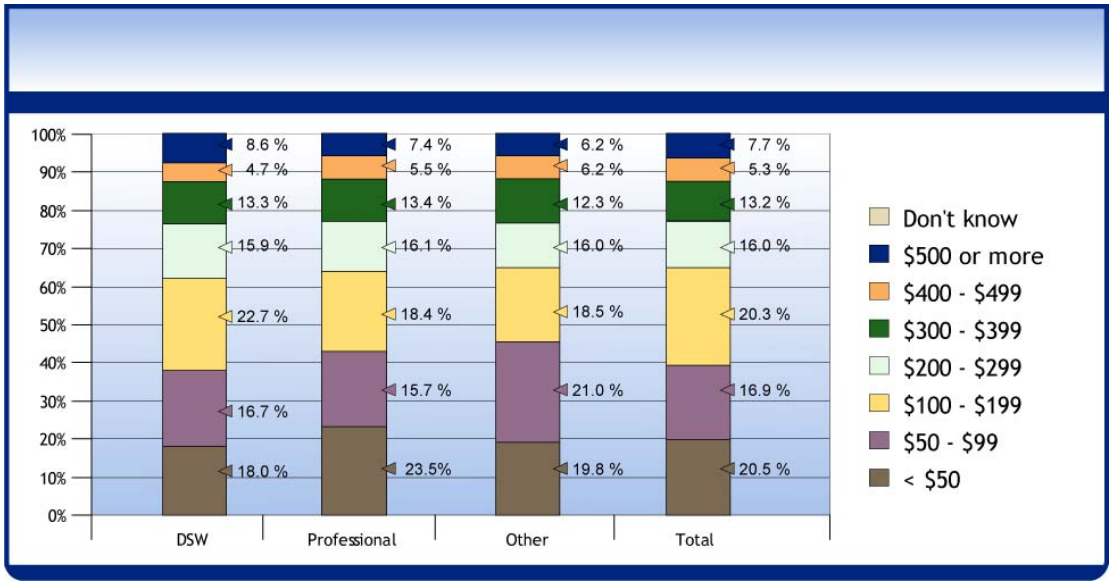
A few workers (5%) had both public and private health insurance coverage. These workers reported the following types of public coverage: Medicare, Veteran's Administration, and Indian Health.

Long-term care workers can be at risk of losing coverage when they change jobs or have inconsistent work schedules. A quarter of all respondents (25%) and over a third (34%) of direct service workers said there was a time during the past 12 months when they did not have health insurance.

Workers reported paying hefty amounts for their insurance policies, with most policies costing more than $50 a month (***Exhibit 3.17***).

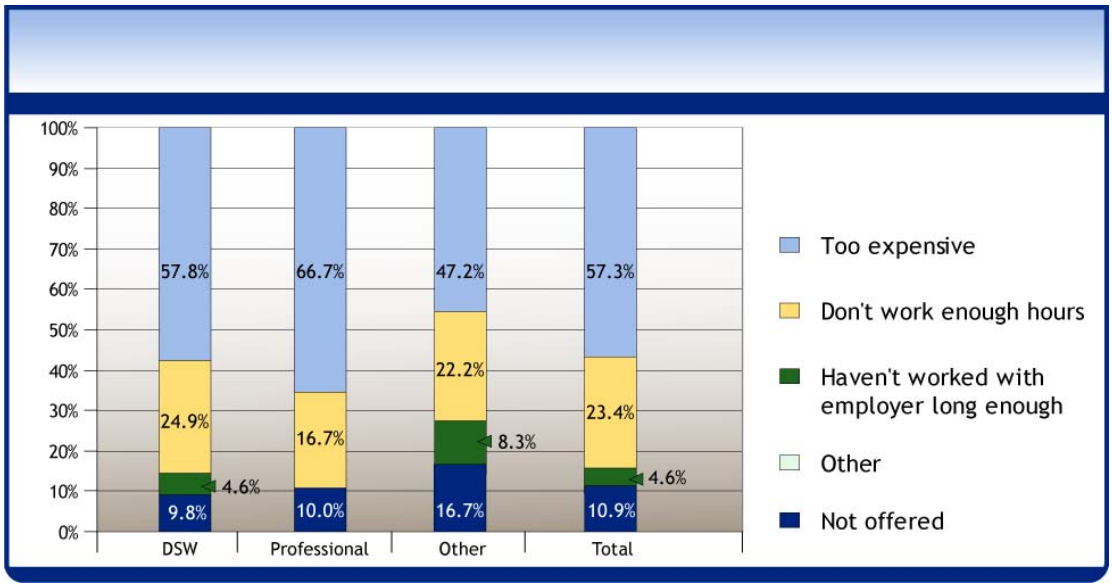
[77] Kaiser Family Foundation, "Minnesota: Health Insurance Coverage of Nonelderly 0-64, state (2006-2007), U.S. (2007) http://www.statehealthfacts.org/profileind.jsp?ind=126&cat=3&rgn=25

Exhibit 3.17: Monthly Premiums by Employee for Individual Coverage, by LTC Job Type



Of workers who were not covered by private health insurance, over half said they didn't have private health insurance because the cost of insurance was too expensive (***Exhibit 3.18***). The next most common reason workers cited for not having private health insurance was that they do not work enough hours with their employer to qualify for coverage.

Exhibit 3.18: Reason Cited for No Private Health Insurance, by LTC Job Type

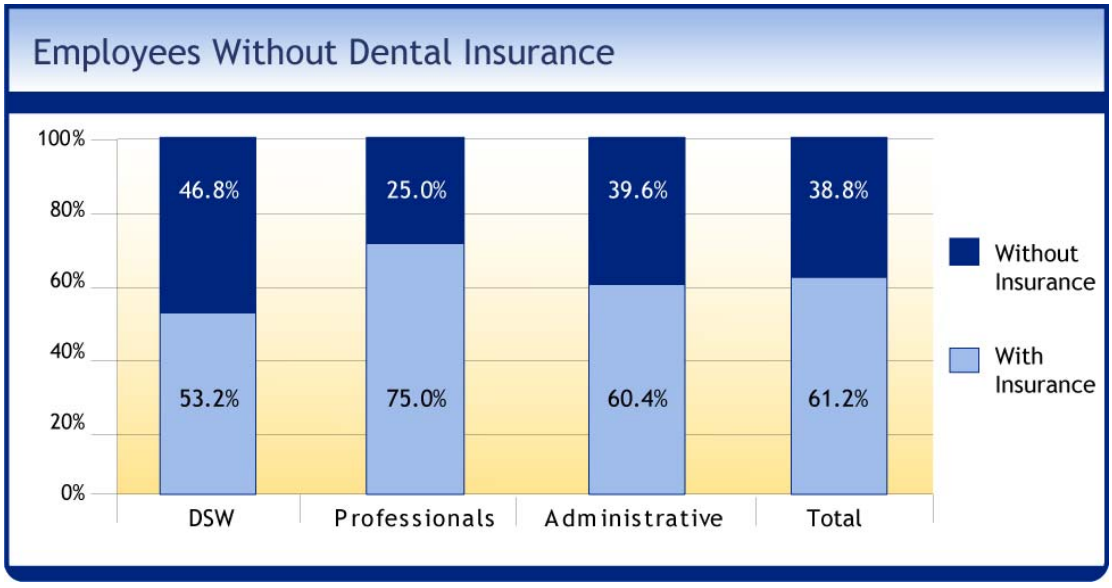


Direct service workers were least likely among long-term care employees to have dental insurance (***Exhibit 3.19***).

…We have a son with asthma and a daughter with chronic ear infections. We live a healthy life style and take care of ourselves, but some visits are unavoidable. The cost of these visits has had us in debt for 3 years and we have insurance. I can't imagine how people without coverage make it...

– LTC Worker

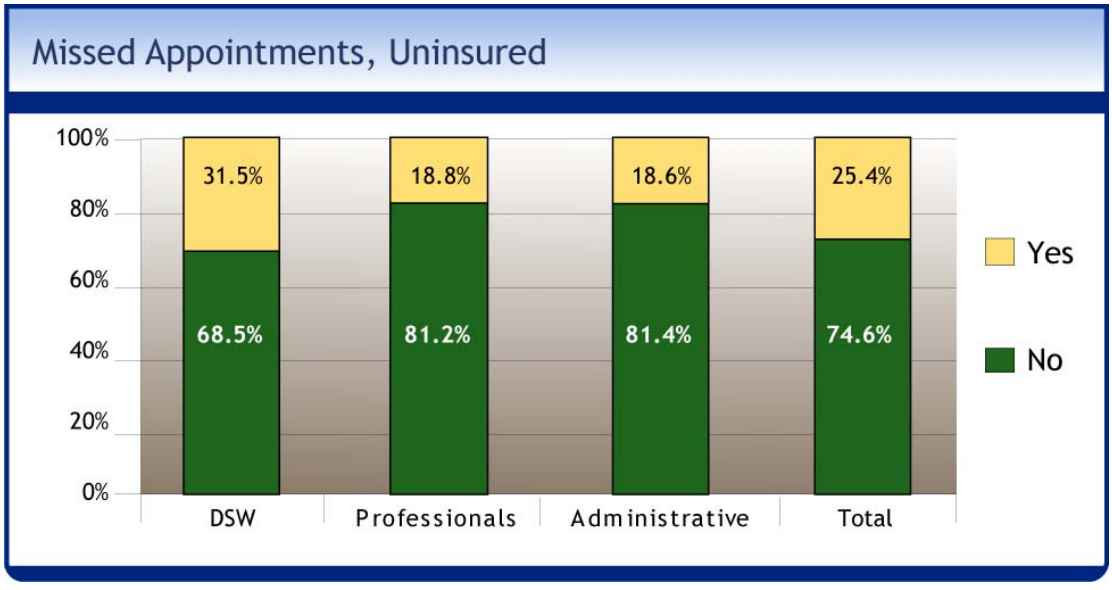
Exhibit 3.19: Long-Term Care Employees Without Dental Insurance



iv) Impacts of Uninsurance and Limited Insurance on Health Care Use and Expenses

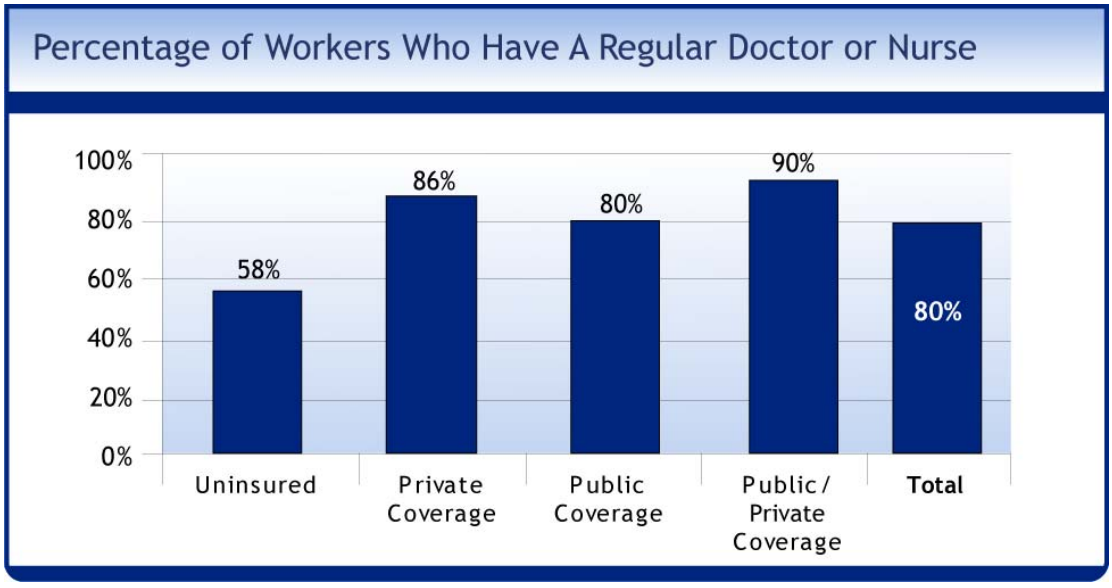
Lack of insurance can have significant consequences for workers' ability to get and pay for the health care they need. A quarter of all long-term care workers (25%) and a third of direct service workers (34%) said they had missed a health appointment within the past 12 months because they did not have health insurance (***Exhibit 3.20***). Workers who have insurance may also avoid going to the doctor if they have high deductibles and/or co-pays.

Exhibit 3.20: Missed Health Appointment in Past 12 Months Because Did Not Have Health Insurance



Uninsured workers were also less likely to maintain a relationship with a regular doctor or nurse (***Exhibit 3.21***).

Exhibit 3.21 Percentage of Workers Who Have a Regular Doctor or Nurse



Twenty-three percent of all respondents said they used the emergency room during the past 12 months. Thirteen percent said they spent time as a patient in the hospital during the same time period.

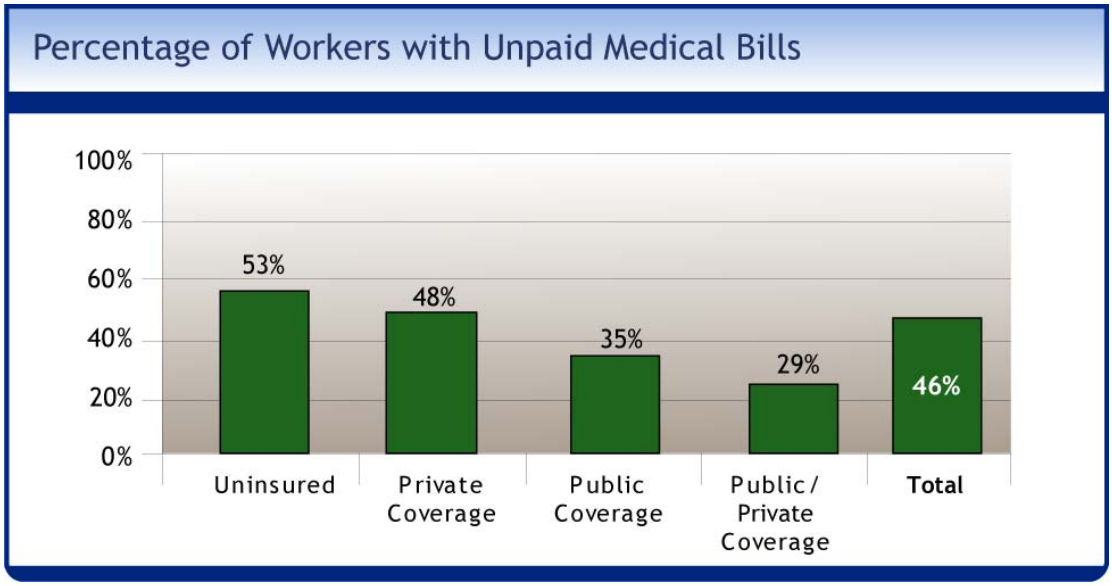
Workers with no insurance or inadequate coverage may face high medical bills when they get sick. Respondents to the Worker Survey reported medical expenses in 2008 ranging from less than $500 to over $5,000.

Although uninsured workers were the most likely to have unpaid medical bills, many of the insured also had medical debt, especially those with private coverage (***Exhibit 3.22***).

… I think that the Government should take a look at healthcare facility employees' wages and health insurance more closely. We take care of people's lives and take care of families loved ones and never get very good raises.

– LTC Worker

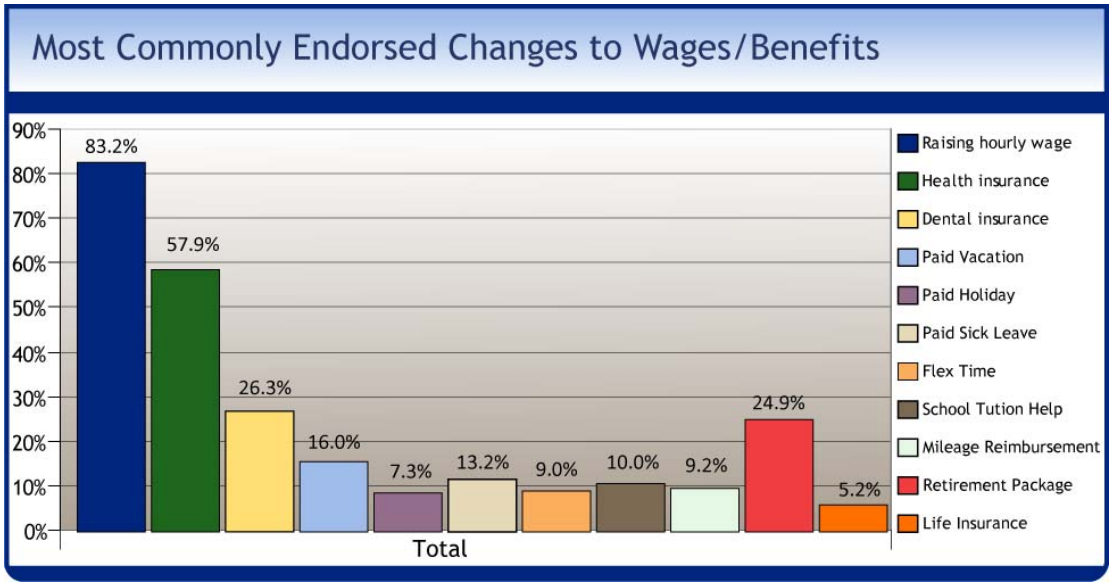
Exhibit 3.22 Percentage of Workers with Unpaid Medical Bills



v) Workers' Opinions and Recommendations

When asked, "What three changes at this job would be most important to you?" workers were most likely to include "raising my hourly wage," "health insurance," "dental insurance," and "retirement package" among the four most important changes (***Exhibit 3.23***).

Exhibit 3.23: Most Commonly Endorsed Changes to Wages/Benefits



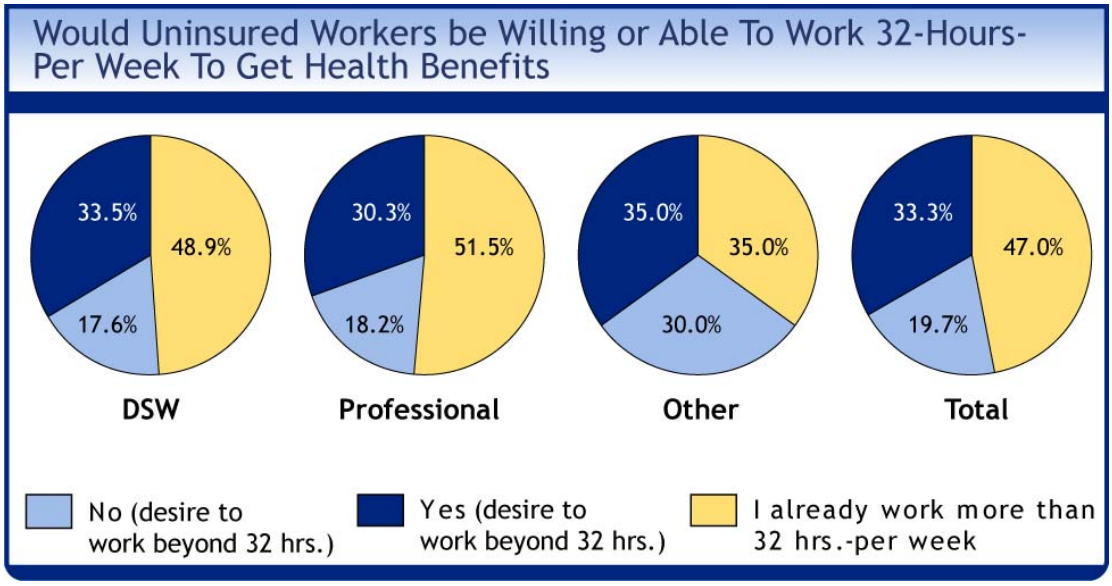
Those workers without private health coverage expressed a high level of interest in health insurance. A third (33%) of workers without private health coverage said they would try to work 32 or more hours per week so they

… It will take me 4 years or more to earn a $1.00 raise only on COLAs! Is this really the way someone should live? Only starting at $11/hr. who would want to go above and beyond for any company that isn't even give you a raise. Isn't this why personal care has such a turnover?

care and work for hardly nothing. Someone need to very much look into this.

could get health insurance. Nearly half (47%) of uninsured long-term care workers said they already work more than 32 hours a week. The remaining 20 percent they would not be able to or do not want to work 32 hours or more per week (***Exhibit 3.24***).

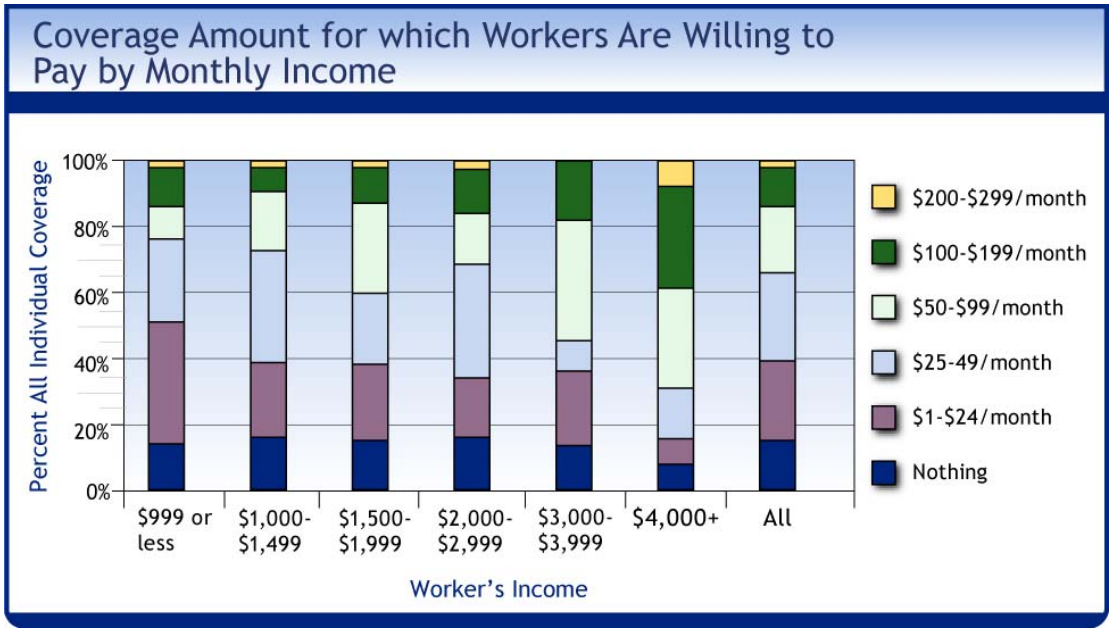
Exhibit 3.24 Would Uninsured Workers Be Willing or Able to Work 32 Hours-a-Week to Get Health Benefits?



This finding suggests that enhancing health benefits could help fill vacancies by providing an incentive for employees to work more hours.

Nearly all workers without private coverage said that if their employer offered health insurance at no cost to them they would participate in the coverage. While those with higher incomes were willing to pay more for health insurance, the majority of all workers said they would not pay more than $25-$49 a month (***Exhibit 3.25***). Many said that they would not pay more than $1-$24 or that they would pay nothing.

Exhibit 3.25: Maximum Premium Workers are Willing to Pay for Individual Coverage from Their Employer



When asked if they had any other comments, many workers described problems related to low pay and lack of health insurance and expressed strong support for efforts to make health insurance more affordable. Their responses are included in ***Appendix B***.

B) Provider Surveys

Sample Size and Response Rate

From the 5,153 total providers on the lists provided by DHS, 772 surveys were received. The actual response rate is unknown, because it is unclear how many providers received the notice about the survey. Also, the number of participating providers is understated for two reasons:

- Some providers that operate multiple types of services and have multiple provider numbers wanted to complete a single survey for all their operations. Given the length and complexity of the survey, we were as accommodating to provider preferences as possible and encouraged any level of participation. In these cases, we received a single survey with one provider number, although the survey also provided information on other employees working in other provider numbers operated by the same business.
- Similarly, in some instances, one chain would answer on behalf of several member providers. Several companies' corporate headquarters called and asked if they could complete a single survey for all their

providers, instead of having each of their facilities or agencies complete a separate survey. In these cases, we encouraged providers to complete the survey at whatever level would be most convenient for their organizations, because wages, health insurance, and other employee benefits tend to be the same across all providers within a chain. So in effect, data that would have been reported in multiple surveys were instead combined into a single survey for these chain organizations.

Of the surveys received, 65 respondents (9%) were ineligible for the study because they did not receive the COLA, leaving 666 respondents who were eligible for the study. The survey immediately terminated after the COLA screening question.

Of the providers who were eligible for the study, 391 respondents provided data on how many employees they had, covering a total of 70,769 employees. Although the exact number of long-term care workers in Minnesota is unknown, a 2002 study by the state Department of Health estimated that the industry as whole included 77,000 to 181,000 employees, depending on the definition of long-term care employees and the data source used.[78] Hence, the survey appears to represent a large segment of the industry.

As can be expected with a lengthy online survey, many of the providers did not complete every survey question. Anecdotally, some providers called and said that they were not able to provide certain financial and human resources data on their organizations, such as the numbers of employees eligible for health insurance and health insurance costs. In these cases, we encouraged providers to answer as many of the survey questions as they were able.

i) Ownership and Payment Sources

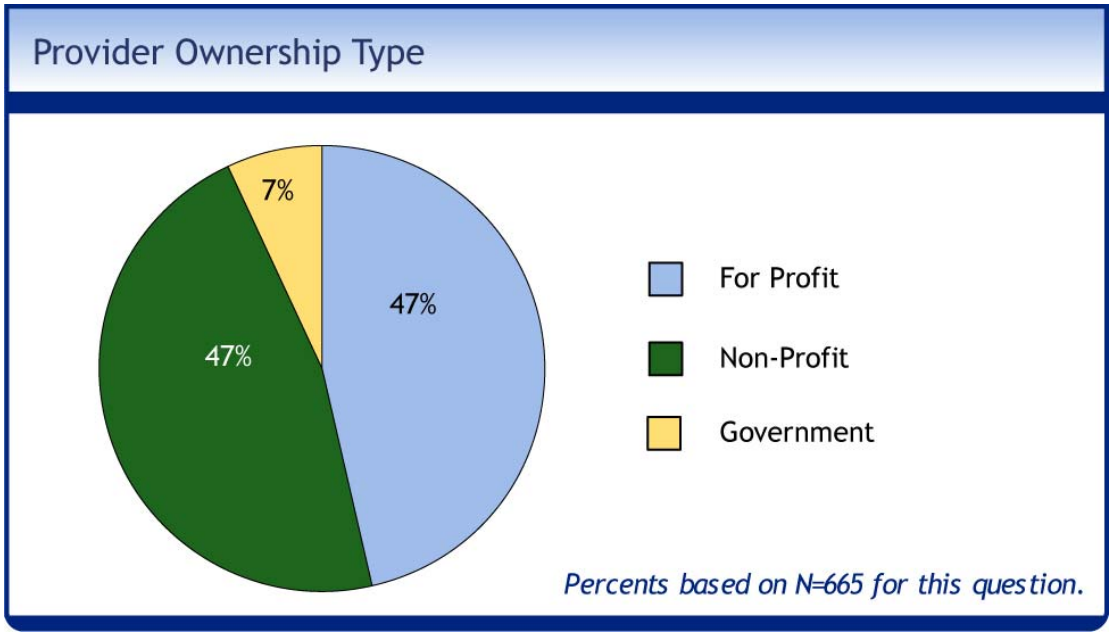
Facilities were equally split between for-profit (47%) and non-profit (also 47%). Seven percent were government operated. About a quarter (24%) of providers said they were part of a chain (***Exhibit 3.26***).

[78] Minnesota Department of Health, 2002.

… In rural areas that are within a 50 mile radius of a Metro area, it is hard to compete for licensed nurses. We are not able to pay the salaries that the Metro does and therefore do not get the best qualified candidates. A wage incentive for licensed staff would be most helpful to the rural areas.

– Provider

Exhibit 3.26: Provider Ownership Type



Lewin matched data on respondents' reported zip codes with U.S. Census categories for Metropolitan Statistical Areas (MSA) to categorize respondents by the MSA where they were located. Of the 603 respondents that provided valid zip codes, 253 (42%) were from non-metro areas, the same proportion were from the Twin Cities, and the remaining 16 percent were from smaller metro areas in Minnesota (***Table 3.3***). Five respondents (1%) said they were out-of-state providers serving Medical Assistance clients residing in Minnesota (***Exhibit 3.27***).

Exhibit 3.27: Metro Minnesota Statistical Area

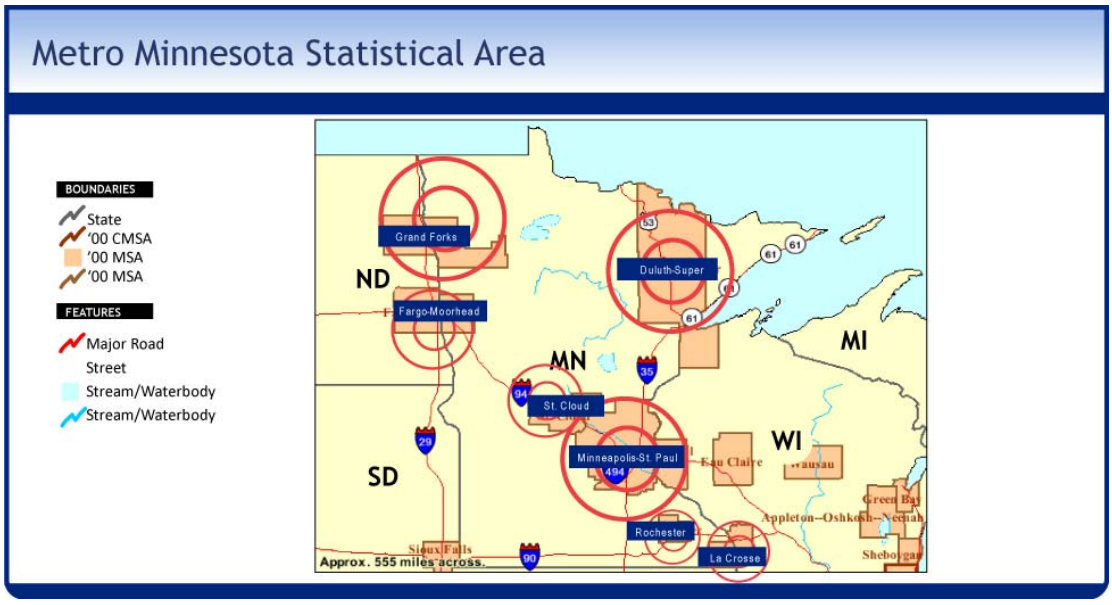


Table 3.3: Respondents by Minnesota Metro Region / Non-Metro[a]

# of Respondents among each Metropolitan Statistical Area (MSA)	N	Pctg
Non-metro	253	42%
Minneapolis-St. Paul	251	42%
Duluth-Superior	38	6%
St. Cloud	28	5%
Fargo-Moorhead	13	2%
Rochester	9	1%
Grand Forks	6	1%
La Crosse	5	1%

[a]*Percents based on N=603 for this question.*

Medicaid was the primary revenue source for most of the providers. Other sources of revenue included private insurance, private pay, and Veteran's Administration resources.

Uffda,, where does one begin?

– Provider

ii) Employment, Vacancies, and Turnover

The number of employees per provider ranged from zero (6 providers) to 22,154. The average number of total employees was 167, and the median was 75 (***Table 3.4***).

Table 3.4 Number of Employees[a]

	Range	Median	Average	Total
Full-time	1 - 12,560	30	82	33,137
Part-time	1 – 9,594	43	92	37,632
All employees	1 – 22,154	75	167	70,769

[a]*Numbers based on N = 391 for this question.*

Of the 603 employers who provided information on employees eligible for insurance, 556 were "small group" employers (under 51 eligible employees) and 47 were "large group" employers (51 or more eligible employees).

Respondents reported an average of three direct care worker vacancies per provider (Table 3.5).

Table 3.5 Direct Service Worker (DSW) Vacancies[a]

DSW Vacancies	
Total	1,224
Average	3

[a] *Percents based on N = 514 for this question.*

Organizations varied in the number of hours an employee needs to work to qualify as a full-time employee. Less than half (41%) of organizations said they currently provide benefits to employees who work 32 or fewer hours a week.

iii) Wages and Benefits

Most of the providers reported hourly wages for direct service workers in the range of $10 to $13 an hour (***Table 3.6***).

Table 3.6: Average Hourly DCW Wages

	Less than $7.00 per hour	$7.00 - $8.49 per hour	$8.50 - $9.99 per hour	$10.00 - $11.49 per hour	$11.50 - $12.99 per hour	$13.00 - $14.99 per hour	$15.00 or more per hour	Not Applicable	Total
Amount	2	3	78	228	99	49	46	81	503
Percentage	0.3%	0.5%	13.3%	38.9%	16.9%	8.4%	7.8%	13.8%	

Percents based on N = 586 for this question.

72 percent of employers responded that they offer health insurance and 59 percent said they provide dental coverage (Table 3.7). This is a somewhat lower percentage than the 2002 Minnesota Department of Health survey, in which 81 percent of long-term care providers reported that they offer health insurance.[79] In other studies, the percent of long-term care employers offering coverage has ranged from 32 percent to 99.5 percent, with percentages being lowest among home-based and smaller providers and highest in nursing homes (***Appendix A***).

… We treat our employees with respect and we talk with them about issues. When doing the hiring and interviewing we take our time, ask a lot of questions, watch how they are answered and how the residents would be referred to, it gets to be a long process but in the end we get the kind, caring individual we were looking for.

– Provider

Table 3.7: Health and Dental Insurance Offered

Health Insurance Offered	
Percentage	72%

Percent based on N = 305 for this question

Dental Insurance Offered	
Percentage	59%

Percent based on N = *236* for this question.

Survey data on employee contribution to health insurance premiums, participation levels, take-up rates, and employee contributions to premiums are discussed in ***Chapter 4***.

iv) Employee Recruitment and Retention

Using reported data on the number of direct service workers currently employed and those who left during the past 12 months, Lewin calculated the ***average annual turnover rate*** (the ratio of the number of terminations to the total number of workers employed) for direct service workers in long-term care to be 42 percent. In other terms, for every 100 DSWs currently

[79] Minnesota Department of Health, 2002.

… The people we have working for us are very dedicated, compassionate individuals who work hard caring for Minnesota's disabled population. It would be nice if they could earn a wage to support themselves and have good health insurance. At the wage they make now their monthly salary would not even cover the most basic health insurance plan. We have checked into this and the cheapest plan I found for the employees is $600 per person. That is not including families, which most of them have.

– PCA Provider

employed, 42 DSWs have left their position in the last twelve months.[80] This is comparable with findings from national studies that have found turnover rates between 40 and 71 percent for direct service workers across the aging and disability service sectors.[81]

Lewin used survey data to calculate an ***average provider retention rate*** of 67 percent, calculated as the number of DSWs employed by a provider for at least 12 months divided by number of DSWs on payroll.[82]

About 47 percent of respondents reported "medium" or "high" difficulty retaining DCWs (***Table 3.8***).

Table 3.8: Difficulty Recruiting and Retaining DCWs

	Level of Difficulty PCA Agencies Have Recruiting PCA Choice Workers	Level of Difficulty PCA Agencies Have Recruiting Traditional PCAs	Level of Difficulty Clients Have Retaining PCA Choice	Level of Difficulty Non-PCA Provider Has Recruiting DCWs	Level of Difficulty Non-PCA Provider Has Retaining DCWs	Level of Difficulty Retaining - Total
High	7%	13%	17%	25%	14%	17%
Medium	20%	42%	44%	40%	46%	40%
Low	19%	19%	27%	23%	26%	24%
No Difficulty	23%	21%	11%	5%	6%	8%
Not Applicable	31%	5%	*Not a response option for this question*	7%	7%	10%
N	**96**	**112**	**70**	**282**	**282**	**782**

Forty-one percent of providers rated health insurance benefits as a "high" challenge in recruiting DCWs, next to the challenges of low pay (70%) and

[80] Dorie Seavey, "Collecting Turnover Data from a Provider Survey." Memo dated December 8, 2006. National Direct Service Workforce Resource Center, http://www.dswresourcecenter.org/tiki-index.php?page=Data+Collection

[81] Hewitt et al, *A Synthesis of Direct Service Workforce Demographics and Challenges across Intellectual/ Developmental Disabilities, Aging, Physical Disabilities, and Behavioral Health*, November 2008, http://www.dswresourcecenter.org/tiki-download_file.php?fileId=12

[82] Steven Edelstein and Dorie Seavey, *The Need for Monitoring the Long-Term Care Direct Service Workforce and Recommendations for Data Collection*, National Direct Service Workforce Resource Center, February 2009. http://www.dswresourcecenter.org/tiki-index.php?page=Data+Collection

…There needs to be a way to provide part-time employees with health/dental and time-off options…

– Provider

lack of available and qualified workforce (63%). A total of 82 percent ranked lack of health insurance as a "high" or "medium" challenge (***Table 3.9***).

Table 3.9: Challenges in Recruiting DCWs

	High	Medium	Low
Low pay	70%	23%	7%
Lack of available and qualified workforce	63%	27%	8%
Lack of health insurance benefits	41%	41%	10%
Lack of transportation or transportation reimbursement	20%	36%	23%
Disqualifying background checks	10%	32%	32%
Lack of childcare/eldercare options	13%	43%	22%
Lack of paid time off	6%	39%	32%

Lack of health insurance ranked even higher as a challenge in *retention of* DSWs, with 49 percent ranking lack of health insurance as a high challenge in retention, second only to low pay (80 percent) (***Table 3.10***).

… Health care is a BIG issue. It needs to be available and affordable for our employees. Our company has health care but is EXTREMELY expensive. It is cost prohibitive for most employees at PCA wages.

– PCA Provider

Table 3.10: Challenges in Retaining DCWs

	High	Medium	Low
Low pay	80%	16%	4%
Lack of available and qualified workforce	36%	29%	11%
Lack of health insurance benefits	49%	32%	8%
Lack of transportation or transportation reimbursement	20%	33%	18%
Disqualifying background checks	4%	26%	32%
Lack of childcare/eldercare options	14%	36%	18%
Lack of paid time off	8%	38%	25%

v) Employer Opinions and Recommendations

The majority of providers (56%) said they supported or strongly supported the proposal to provide a rate increase to long-term care employers dedicated to the purchase of employee health insurance. Seventeen percent were unaware of the initiative, and 8 percent opposed or strongly opposed it (***Table 3.11***).

… Our facility was unable to keep health insurance due to the cost and we lost employees for the specific reason that they found a comparable paying job WITH health insurance.

- Provider

Table 3.11: Support of Initiative

Support of Initiative	
Strongly Support	36%
Support	20%
Neither Oppose nor Support	21%
Oppose	3%
Strongly Oppose	5%
Unaware of the initiative	17%
Total	**100%**

We also asked providers to share any thoughts, issues, or concerns they thought the State should consider as it develops it proposal, as well as their recommendations for improving the recruitment and retention of direct service workers. Their responses are summarized in ***Appendices F and G***.

4.0

Actuarial Analysis of Projected Participation and Costs

- Ingenix Consulting (IC) projected coverage impacts and costs and for six levels of coverage: 1) MinnesotaCare+2 (parents); 2) MinnesotaCare+1 (non-parents); 3) a plan like MinnesotaCare+1 but without the $10,000 in-patient hospital limit; 4) the benefits provided by the state employees' health plan (Minnesota Advantage); and 5) sample low deductible ($100) and 6) higher ($500) deductible commercial plans. IC also projected three scenarios for how employers obtain the insurance: 1) through the commercial market; 2) through a new risk pool; and 3) directly through MinnesotaCare. IC also projected dental insurance participation rates and costs for both stand-alone (dental can be chosen separately from medical) and tied to medical dental (requires medical) coverage. Based on the above analysis, the study team projected the total number of participants in each plan/funding source combination to develop an estimate of the cost to cover all eligible long-term care workers in Minnesota.
- The highest projected participation rates are with the two MinnesotaCare benefit packages without the $10,000 annual inpatient max. These plans provided the best benefits and highest total plan costs (and hence highest plan "values"), for the same employee contribution amount as the lesser model plans.
- Model rates for the combined medical and dental premium costs, minus employee contributions, ranged from an average of $315 to $879 per long-term care employee per month. Total projected costs for the state of implementing the proposed rate increase for employer health insurance ranged from $16 to $105 million per month, depending on the benefit plan design, the avenue for how employers obtain insurance, and the estimated number of long-term care workers.
- The lowest costs were for the options in which the plans are actually part of MinnesotaCare itself. This is because the non-benefit costs and provider reimbursement levels of MinnesotaCare are much lower than under typical commercial plans.
- For the options where insurance is purchased commercially, the lowest cost plan was the $500 deductible commercial plan, purchased through a new dedicated risk pool ($586 per member per month for the employer portion). The MinnesotaCare plans were by far the most expensive plans. The Minnesota Advantage plan provides reasonable coverage and has a total cost that is about 2.5 percent higher than the $100 deductible commercial plan, but has a better chance of controlling cost increases in the future due to its tiering structure.
- For all plan designs, stand-alone dental plans, in which people have the option of enrolling in dental insurance without medical, cost somewhat more than plans in which dental was tied to medical.

Chapter 4: Actuarial Analysis of Projected Participation and Costs

A) Plan Designs

The actuarial staff of Ingenix Consulting (IC) simulated participation rates and costs for six model health insurance benefit plan designs:

Plan 1: MinnesotaCare Basic Plus Two (parents) benefit package (a model commercial plan with the same deductibles, co-pays, benefits, and other elements as the MinnesotaCare Basic Plus 2 plan)

Plan 2: MinnesotaCare Basic Plus One (non-parents) ($10,000 annual inpatient max.) benefit package

Plan 3: MinnesotaCare Basic Plus One (same as Plan 2, but with unlimited inpatient maximum) benefit package

Plan 4: Minnesota Advantage (the plan for state employees) benefit package

Plan 5: A sample low deductible commercial plan

Plan 6: A sample higher deductible commercial plan

The legislation mandated that the study project costs for three health insurance plan designs, providing the level of benefits provided by MinnesotaCare, MinnesotaAdvantage (the state employees' health plan), and a sample commercial plan, but with a $100 deductible. Because MinnesotaCare includes a number of different plans, IC projected outcomes for three model MinnesotaCare plans. Plans 1 and 2 represent plans with costs and coverage identical to MinnesotaCare plans for parents and non-parents. The MinnesotaCare plan for non-parents (Plan 2) includes a $10,000 annual limit on hospital stays, while Plan 1 has no limit on hospital stays. Hence, this plan would leave workers responsible for paying costs over $10,000, unless the employer chose to provide an additional benefit to help cover that. At the request of Minnesota Department of Health, we also modeled Plan 3, which is not a MinnesotaCare plan that actually exists, to estimate results for a plan resembling the plan for non-parents, but without the $10,000 limit on hospital stays.

Plan 6, the sample commercial plan with a $500 in-network (INN) deductible, does not meet the requirements of the legislation that authorized this study. However, this deductible or even higher deductibles are typical of the coverage that most employees now receive from non-government employers. Indeed, a study by a large national benefits firm showed that the median PPO plan deductible in 2008 was $1,000. For comparison purposes and at the request of DHS, IC provided the rates for the $500 deductible plan (Plan 6), to

measure how the cost of that plans compared to one that's more common among the groups that this initiative is intended to serve.

The commercial plan design assumes that in-network (INN) office visit, prescription drug, and emergency room copayments in addition to the deductible are allowed, as well as an out-of-network (OON) deductible higher than $100. MinnesotaCare and Minnesota Advantage are more complicated plans. Fuller descriptions for these plans are included in ***Appendices J and K***. Highlights of the six model plans are described in ***Table 4.1***, below.

Table 4.1
Comparison of Insurance Plans

	MinnesotaCare + 2		MinnesotaCare + 1, $10,000 In Patient Maximum	MinnesotaCare + 1, No In Patient Maximum		Minnesota Advantage	Commercial, $100 Deductible		Commercial, $500 Deductible	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	$0		$0	$0		See table 4.2	$100	$400	$500	$1,000
Coinsurance	0%		10% In Patient Only	10% In Patient Only		See table 4.2	20%	40%	20%	40%
Out-of-pocket max [1]	None		None	None		See table 4.2	$2,000	$4,000	$2,500	$4,500
Copayments										
ER	$6 Copay for Non Emergency Visits		$6 Copay for Non Emergency Visits	$6 Copay for Non Emergency Visits		See table 4.2	$150	Deductible/ coinsurance	Deductible/ Coinsurance	Deductible/ coinsurance
Primary care	$3/Copay non-preventative visits		$3/Copay non-preventative visits	$3/Copay non-preventative visits		See table 4.2	$15 [2]	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance
Specialist	$3/Copay		$3/Copay	$3/Copay		See table 4.2	$30 [2]	Deductible/ coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance
Preventive	100% covered		100% covered	100% covered		See table 4.2	100% covered	Not covered	100% covered	Not covered
Eye exam	$3/Copay		$3/Copay	$3/Copay		See table 4.2	No	No	No	No
Rx copays										
Generic	$3		$3	$3		See table 4.2	$10		$10	
Brand-Preferred	$3		$3	$3		See table 4.2	$25		$35	
Brand-Non-preferred	$3		$3	$3		See table 4.2	40% with $40 minimum		40% with $50 minimum	

[1] Includes deductible and office visit copays (not Rx copays).

[2] Surgical procedures, laboratory, radiology, etc performed during an office visit are subject to the deductible and coinsurance.

[3] MinnesotaAdvantage Plans vary by provider level

Table 4.2
Minnesota Advantage Plan Summary of Key Benefit Features
Out-of-Pocket Expense

	Provider Level			
	1	2	3	4
Deductible [1]	$50	$140	$350	$600
Office Visit Copay [2]	$17	$22	$27	$37
ER Copay	$75	$75	$75	25%
Inpatient Hospital Copay	$85	$180	$450	25%
Outpatient Surgery Copay	$55	$110	$220	30%
DME	20%	20%	20%	30%
Preventative Services	$0	$0	$0	$0
Hospice & Skilled Nursing Facility	$0	$0	$0	$0
Lab, Pathology, Radiology	5%	5%	10%	30%
Other	5%	5%	10%	30%
Rx	← ← ←$10/$16/$30 for all levels → → →			
Out-of-Pocket Max: Non-Rx [1]	$1,100	$1,100	$1,100	$1,100
Out-of-Pocket Max: Rx [1]	$800	$800	$800	$800

[1] 2 times for family. Deductible applies prior to all copays & coinsurance

[2] Office visit copay is $5 more if employer does not complete health assessment and does not agree to a follow-up call from a health coach. Convenience clinics: $10 copay all levels, and deductible does not apply.

i) Dental Plan Designs

IC also projected the cost for two dental insurance benefit plan designs:

- A model dental benefit that provides the benefits of MinnesotaCare dental insurance—This plan pays 100 percent of all expenses with no deductible or coinsurance and a $5,000 maximum annual benefit.

- A typical commercial dental PPO plan with benefits as follows:
  - Preventive services paid at 100 percent
  - Basic services paid at 80 percent (60 percent out of network)
  - Major services paid at 50 percent
  - $100 deductible ($200 out of network) on basic and major services
  - No orthodontia coverage
  - $2,000 annual maximum benefit

B) Plan Availability and Funding Sources

The legislation specified that the study develop estimates assuming that the health insurance would be purchased in the commercial market. For comparison purposes and at the request of DHS, IC developed costs under

three sources of how these plans would be made available to long-term care employers: 1) through the commercial market, 2) through a dedicated risk pool, and 3) directly through MinnesotaCare (for the three MinnesotaCare benefit levels). The main difference between the three options was the proportion of premium devoted to expenses other than benefits.

Funding Source A: ***Providers purchase plans in the commercial market***. IC estimates that the total non-benefit, or overhead, cost for medical plans under this funding source would be approximately 22.5 percent of premium for small groups (fewer than 51 eligible employees) and 17.0 percent of premium for large groups. IC based these percentages on information from the Minnesota Department of Commerce and from information gathered from several Minnesota health carriers. These non-benefit costs include administrative expenses, broker commission, premium tax, and the assessment for the Minnesota Comprehensive Health Association (MCHA).

For dental plans, the overhead costs vary by whether the plan is tied to medical (i.e., members can get the dental plan only if they enroll in the medical plan) or whether the dental plan is stand-alone (members can get the dental plan even if they do not enroll in the medical plan). The commercial dental plan overhead costs, expressed as percentages of premium, are as follows:

- Tied to medical: 20 percent for small groups (50 or fewer eligible employees) and 14.5 percent for large groups (51 or more eligible employees)
- Stand-alone: 29 percent for small groups and 22 percent for large groups

Funding Source B: Coverage is available to providers through a dedicated self-funded risk pool managed by the state. Based on a prior IC study of the feasibility and cost of a statewide health insurance plan for school districts, IC estimates that the total non-benefit cost, primarily administrative and catastrophic claim reinsurance costs, of this funding option would be approximately 10.25 percent of premium. This cost includes start-up costs and an amount to build up a stabilization reserve of 10 percent of premium over a 4 year period that would protect the pool in years of adverse experience. Because this pool would be self-funded, there are no premium tax and no MCHA assessment.

Funding Source C: ***Providers obtain coverage directly through MinnesotaCare.*** IC estimates the non-benefit, or administrative cost, of this funding source at 9 percent of premiums. In addition, provider reimbursement in all plans would be at current MinnesotaCare levels, which

is similar to reimbursement under Medical Assistance and significantly less than the provider reimbursement level of commercial plans.

… It would greatly help in keeping/obtaining direct care workers if long term care employees could be eligible for state health insurance benefits, which premiums would be payable by the employer.

– Provider

For a comparison of non-benefit costs, see ***Table 4.3***.

Table 4.3
Non-Benefit Costs of Model Plans

	Percent of Premium for Non-Benefit Costs	Types of Non-Benefit Costs Included
Funding Source A – Commercial Market	For health insurance: 22.5% for small group 17.0% for large group	Administrative costs Broker commission Premium tax Assessment for MCHA
	For dental insurance tied to medical: 20% for small group 14.5% for large group	
	For stand-alone dental: 29% for small group 22% for large group	
Funding Source B – Risk Pool	10.25% for all plans	Administrative costs Catastrophic claim reinsurance costs Start-up costs Costs to build up stabilization reserve
Funding Source C – Minnesota Care	9% for all plans	Administrative costs

C) Current and Projected Employee Participation

With the proposed, lower employee contributions, IC projects significantly higher participation in both medical and dental plans. IC estimated the new medical plan participation levels for each plan design/funding source combination, based on the calculations and assumptions described below.

i) Current and Projected Employee Contributions

Based on the results of the employer survey, the current plans offered by LTC and PCA providers require relatively high average employee contributions (***Table 4.4***).

Table 4.4 Current Employee Contribution Levels Based on Employer Survey				
	Small Group		Large Group	
	Single EE	Family	Single EE	Family
Medical Coverage				
Average employee monthly contributions	$ 144.38	$ 483.95	$ 109.06	$ 503.77
as % of total plan cost	27.3%	48.2%	22.8%	39.7%
Dental Coverage				
Average employee monthly contributions	$ 23.66	$ 70.57	$ 16.43	$ 54.94
as % of total plan cost	43.7%	55.7%	41.2%	54.1%

Our findings on employee contributions are very similar to the findings from the Minnesota Department of Health's 2002 study, which reported average employee contributions of 24 percent for individual coverage and 45 percent for family coverage. In other studies examining long-term care employee health insurance, employee contributions for individual coverage have ranged from 23.5 percent to 65 percent, or between $50 and $193.

One reason these contributions are high may be that there is a larger percentage of employees who work less than full-time (66 percent of worker survey respondents said they work 32 hours or more per week). Most employers typically require a larger contribution from these workers.

The proposed plan requires that employee contributions be no higher than those of state employees. Therefore, IC modeled the impact on employee participation of these monthly employee contributions (***Table 4.5***):

Table 4.5 Proposed Monthly Employee Contribution Rates				
	Small Group		Large Group	
	Single EE	Family	Single EE	Family
Medical	$ 0.00	$ 130.20	$ 0.00	$ 130.20
Dental	$ 5.00	$ 34.16	$ 5.00	$ 34.16

ii) Current Participation Rates

IC started with the adjusted current participation levels and assumed that these reflect an average current in force plan that has a $500 deductible.

Based on the employer survey, the **current participation rates in medical and dental plans**, expressed as percentages of employees eligible for coverage, are approximately:

- Small group (50 or fewer eligible employees): 50% for single coverage; 18% for family coverage
- Large group (51 or more eligible employees): 53% for single coverage; 28% for family coverage

For dental plans, the current participation rates are approximately:

- Small group: 67% for single coverage; 20% for family coverage
- Large group: 71% for single coverage; 34% for family coverage

The dental participation levels are higher than the current medical levels for several reasons. First, it is much less likely that employees have spousal, public, or other dental coverage. Second, fewer employers—only 59 percent—offer dental coverage. Finally, dental coverage provides immediate benefits to all members, in the form of regular routine examinations, cleaning, and X-rays paid 100 percent by the plan.

Based on the employee survey, a significant number of these employees are covered by plans other than the one offered by the surveyed employer. A commercial carrier underwriting a group would consider these employees to have "other valid coverage" and not count them in the minimum participation requirement. IC therefore adjusted the current medical plan participation levels to reflect only those employees without other valid coverage, and the **adjusted current medical participation rates** are approximately:

- Small group: 73% for single coverage; 26% for family coverage
- Large group: 77% for single coverage; 41% for family coverage

Other dental coverage is probably less common. Individual dental coverage is rare, and COBRA dental is unlikely given its cost. Even among the seven percent of long-term care employees with a public plan, much of this is Medicare, which does not include dental. Therefore, the only place IC used the adjusted participation was to set the medical selection rating factors, and dental coverage providers use a different method to set this factor.

iii) Projected Participation for Individual Coverage

The proposed single employee contribution is $0. Because this is non-contributory coverage, **the single employee participation rate for employees with single coverage is always assumed to be 100 percent.**

In actuality, a small percentage of employees might choose not to enroll in the free plan, because many groups, including many public entities, offer a benefit usually referred to as "cash in lieu of coverage." If an employee can prove that she or he has other valid coverage, usually through a spouse, then the employer will increase the employee's pay by a portion of the cost of single coverage if the employee waives coverage from the employer's plan. According to the legislation, the rate increase would be designated for health insurance only. Hence any cash in lieu of coverage benefit would be paid for by the employer, and not by the state through a rate increase, at the discretion of the employer.

iv) Projected Participation for Family Coverage

IC increased or decreased the family participation for the relative richness of the new medical benefit plan compared to the average in the assumed current plan. **For family coverage, IC estimates the participation change as half of the difference between the value of the benefits of the new plan and the value of the benefits of the assumed current in force plan.**

Our cost models start by calculating **per member per month (PMPM)** claims costs for each of the plan designs**.** In the PMPM costs, a "member" is anyone in the health plan: the person who obtains the coverage (in a group setting, this is typically an employee, but it could be a retiree or COBRA-eligible ex-employee; in an individual policy setting, this is the policyholder or subscriber); his/her dependent spouse; his/her dependent children. In this report, we use the term "PMPMs" to mean the PMPM claim costs. Because costs for children are much less than costs for adults, the cost per single employee or per spouse is higher than the PMPM cost. Hence, the medical cost per single employee is 1.068 times the PMPM cost—i.e., 6.8 percent higher than the PMPM. The PMPM cost is the average across all members, both adults and children.

For example, the model PMPM claims cost of the $500 deductible plan in the Twin Cities is $232.28. The model PMPM claims cost of the MinnesotaCare Basic + 2 benefit package plan is $260.79. The difference is a 12.3 percent "richer" benefit plan. IC therefore assumes that participation will increase by 6.1 percent from current levels, because employees are more likely to take coverage if the benefit is better. The participation change factors are:

- MinnesotaCare Basic+2 benefit package: +6.1% points
- MinnesotaCare Basic+1 benefit package: -4.8% points (note that this plan has a $10,000 inpatient annual maximum benefit)
- MinnesotaCare Basic+1 with no inpatient maximum: +6.8% points
- Minnesota Advantage benefit package: +0.7% points
- Commercial Plan 5 ($100 deductible): +0.8% points
- Commercial Plan 6 ($500 deductible): no change

This factor was not used for dental coverage, because IC assumed that the participation would not vary much between the two dental plans. Although the MinnesotaCare dental plan is a richer plan, both this plan and the commercial plan pay 100 percent for all preventive services, which are the only benefit that a large percent of employees and their dependents will use. Even the commercial plan's next level "basic" benefits pay 80 percent of costs after a $100 deductible.

v) Projected Participation Rates with Elasticity Factors

Next, to project participation in the model plans, IC calculated an *elasticity factor*, the amount by which projected participation increases or decreases for every 1 percent increase or decrease in employee contributions. For this study, IC determined a single elasticity factor as the weighted average of the Lewin Health Benefits Simulation Model (HBSM) elasticity factors by employee income only, with the weights being the number of surveyed employees in all groups by income bracket. The resulting elasticity factor is 0.4 percent.

The employee survey indicates a very high level of price sensitivity among these workers. Only 18 to 20 percent of employees eligible for family coverage take it. One reason for this low take-up is the relatively high employee contribution rates for family coverage. In addition, even with the reduced employee contribution ($130) for family medical coverage under the model plans, the projected family medical plan participation is still less than 50 percent for small group employers and less than 60 percent for large groups.

Only 41 percent of surveyed employees said that they are willing to pay $100 per month or more for family medical coverage. The employer survey indicates somewhat better actual participation with higher monthly contributions than responses to the willingness to pay question imply. Regardless, the projected increase in family coverage over current rates from the proposed lower family contribution rate of $130 is still quite limited. Previous studies have also reported relatively low take-up rates among long-

term care employees, unless premiums are very low, due to the low wages of these workers (***Appendix A***).

The projected participation rates vary by plan and by location (except for single employee medical, where 100 percent participation is assumed everywhere). The ranges and projected participation rates are as follows (***Table 4.6***):

Table 4.6
Projected Participation Rates, Ranges

	Small Group		Large Group	
	Low	High	Low	High
Medical: single employee	100.0%	100.0%	100.0%	100.0%
Medical: family	34.7%	48.2%	45.7%	59.4%
Dental: single employee	78.3%	81.8%	80.3%	83.9%
Dental: family	23.8%	37.3%	35.7%	50.0%

Table 4.7 displays projected participation rates for each of the model plans for the Metro region. While participation rates vary by region, the patterns are the same. As the chart shows, participation would be lowest for the plan with the most limited benefits—the $10,000 in-patient limit MinnesotaCare plan. Projected participation is highest for the MinnesotaCare plans without the $10,000 limit, which provide the fullest set of benefits.

Table 4.7
Projected Increased Employee participation rates - Medical*

Metro	Small Group (<51 eligible employees)		Large Group (51+ eligible employees)	
Medical Plan	Single Employee	Family	Single Employee	Family
MinnesotaCare Basic+2	100.0%	47.5%	100.0%	58.7%
MinnesotaCare Basic+1, $10K IP limit	100.0%	35.8%	100.0%	46.9%
MinnesotaCare Basic+1, no IP limit	100.0%	48.2%	100.0%	59.3%
Minnesota Advantage	100.0%	41.6%	100.0%	52.7%
Commercial Plan, $100 ded	100.0%	41.6%	100.0%	52.7%

Table 4.7 Projected Increased Employee participation rates - Medical*				
Metro	**Small Group (<51 eligible employees)**		**Large Group (51+ eligible employees)**	
Commercial Plan, $500 ded	100.0%	40.6%	100.0%	51.7%
Dental Plan				
Tied to Medical Coverage				
MinnesotaCare Plan	82.4%	35.7%	84.6%	48.5%
Commercial Plan	80.5%	30.2%	82.6%	42.6%
Stand-alone				
MinnesotaCare Plan	82.9%	37.3%	85.1%	50.0%
Commercial Plan	81.4%	32.8%	83.5%	45.1%

The family coverage participation rates vary as shown above in ***Table 4.7,*** above. As one would expect, the highest projected participation rates are with the two MinnesotaCare benefit package Plans 1 and 3, the plans with the best benefits and highest total plan costs (and hence highest plan "values"), but at the same employee contribution amount as the lesser plans. Projected participation is higher for large groups, because the base current plans' participation rates, from IC projected the new plans' participation, are higher to begin with.

D) Projected Model Rates

IC actuarial staff projected the model rates for each health and dental plan/funding source combination using the calculations and assumptions described below.

i) Provider Reimbursement and Network Utilization

To project the costs of commercial Plans 5 and 6, IC assumed in its cost model provider discounts on billed charges that IC considers to be typical in Minnesota. IC assumed that 93 percent of medical services will be performed by in-network providers.

To project the costs of the Minnesota Advantage benefit package Plan 4, IC assumed provider discounts on billed charges that are highest for Level 1 providers and progressively decrease for provider Levels 2, 3, and 4 (i.e., Level 1 has the lowest provider charges, and Level 4 has the highest). These discounts were based on actual experience data received from the state, showing Per Member Per Month (PMPM) costs by level, as well as utilization

by provider level from recent experience of the state employees plan: 16 percent in Level 1, 65 percent in Level 2, 17 percent in Level 3, and 2 percent in Level 4. IC estimated the provider discounts by level so that the overall average Plan 4 discount was consistent with the discount assumed for the commercial plans.

To project the costs of the MinnesotaCare benefit package Plans 1-3, IC assumed that 100 percent of utilization would be INN at the discounts assumed for the commercial plans.

For Funding Source C (the plan would actually be part of MinnesotaCare), IC performed another set of cost model runs that assumed provider reimbursement at the level that the state pays providers for current MinnesotaCare members. IC assumed that this reimbursement level is approximately the same as the Medical Assistance level, which is considerably less than the reimbursement under commercial plans. This resulted in total monthly premiums that are less than half the level of corresponding benefit plans in the commercial market, dedicated risk pool, and state employee plan scenarios. IC modeled this funding source for the three plan designs that match the MinnesotaCare benefits.

ii) Cost Variations by Location

IC developed model costs for the following locations within Minnesota:

1. Minneapolis-St. Paul area
2. Duluth
3. Grand Forks ND area
4. Moorhead
5. Rochester
6. St. Cloud
7. Winona-La Crosse WI area
8. Other areas that are outside of MSAs

The relative costs by location vary from medical to dental and by medical plan. The average allowed costs differences are as follows (***Table 4.8***):

Table 4.8
Allowed Cost Variations by Location

Cost Relative to Twin Cities			
Location	Medical/Rx	Dental	Distribution of Employees *
Twin Cities	1.00	1.00	51%
Duluth	0.88	0.68	5%
Grand Forks Area	0.79	0.65	1%
Moorhead	0.85	0.65	5%
Rochester	0.93	0.72	1%
St. Cloud	0.93	0.68	3%
Winona-La Crosse	1.01	0.66	1%
Non-MSA	0.81	0.72	33%
Average relative to Twin Cities	0.92	0.85	100%

* From employer survey

The cost relativities in ***Table 4.8*** assume that prescription drug costs are the same throughout the state. The weighted costs for each region were then added together to produce the total blended costs.

iii) Other Assumptions Used to Develop Model Rates

IC developed model claims costs for a plan year starting 7/1/2009. It used the survey results to develop a distribution of employees by age, gender, and single-family coverage for input into its cost model. This distribution differs in several respects from the average commercially-insured group distribution:

- Among organizations surveyed, only 9.7 percent of employees are male, compared to 57 percent in the average commercially insured group. This is consistent with other research on the long-term care workforce, which has reported that between 9 percent and 35 percent of direct service workers are male, depending on sector.
- Long-term care employees are on average older than the typical commercially insured group. Sixty percent of full-time employees are between the ages of 40 and 64 and 34 percent are age 50 to 64, compared to 52 percent and 24 percent in the typical average commercially insured group. National data estimate that the average age is 38 for direct care workers in nursing facilities, 43 for home health care workers, and 49 for those who are self-employed or working directly for households.

iv) Selection Factors

Selection factors modify projected claims costs for the impact on utilization due to employee choice and employees' knowledge of their health and the health of their family members. The various current and projected employee participation rates imply selection factors that vary inversely with participation—the lower the level of employee participation, the higher the selection factor and therefore the higher the cost per employee. The reason is that, if participation is less than 100 percent, the healthier, lower utilizing employees are the ones most likely to opt out of coverage. If employees or their dependents have chronic health conditions, they are likely to obtain coverage and stay covered. Considering that 80 percent of all non-Medicare medical expenses come from less than 19 percent of all non-Medicare eligible members, and that 20 percent of non-Medicare eligible members have no claims, employee selection has a very large impact on the costs of the underlying plans.

IC developed medical and dental selection factors using its claims continuance tables—basically claims probability distributions. For example, for medical, IC assumed that half of the members not taking coverage would be among the lowest cost members in the continuance table, and the other half would have average claims. IC also assumed that the average participation level underlying the data in its model is 85-90 percent.

The table below shows the selection factors at selected participation levels ***(Table 4.9***):

Table 4.9
Selection Factors at Selected Participation Levels

Participation	Medical	Dental
25%	2.00	1.20
35%	1.63	1.12
45%	1.42	1.08
55%	1.27	1.08
65%	1.16	1.04
75%	1.07	1.00
85%	1.00	1.00
95%	0.94	1.00
100%	0.94	0.90

The dental selection factors do not get as high as the medical factors, because the dental cost variance is not as large as the medical variance, and the dental maximum benefit ($2,000 is typical of commercial plans) is low.

v) Projected Premium Rates

The **projected monthly premium** rates for each model health plan for the year 7/1/2009 through 6/30/2010 equal:

- The PMPM claims costs from the IC model, assuming 1.00 selection factor, times:
- For medical: 1.068 for single coverage and times 2.815 (1.068 * 2.636) for family coverage, and for dental: 1.117 for single coverage and times 2.601 (1.117 * 2.329) for family coverage, divided by 100 percent minus the administrative and other non-benefit costs as a percentage of premium discussed above, times the selection factor based on the projected participation level.

Because the current low employee participation rates imply large selection factors, there is an additional factor of 0.95 applied to the small group rates projected at the current participation levels. Minnesota small group rate regulations limit the extent to which an insurer can increase rates for factors that are not considered to be "group characteristics." IC therefore reduced the small group rates with the highest selection factors. This regulatory rating restriction does not apply to large groups, and the selection factors of other scenarios are in the range where IC felt that no rate adjustment was needed.

Table 4.10 shows the projected model rates for the model health plans, for all regions blended together, with the projected increased employee participation levels. This is the total premium (i.e., employer plus employee portions of cost).

As shown in the table, rates are generally higher for small group employers (those with fewer than 51 eligible employees). Even in a dedicated risk pool, rates would be higher for small group employers because the family participation level is higher in large group employers. Note that, in the risk pool scenario, single employee rates are the same, because both small and large group are at 100 percent participation. For families, where there is a contribution, the "base line" current participation rate is higher for large group, so IC projected higher large group family participation (54 percent versus 43 percent for small group) and therefore lower rates due to lower selection factors.

Table 4.10
2010 Total Projected Monthly Premiums for Health Insurance for LTC Workers: Weighted average of all regions with projected increased employee participation levels

	Small Group (<51 eligible employees)		Large Group (51+ eligible employees)	
Funding Source & Benefit Plan	Single Employee	Family	Single Employee	Family
A. Coverage from market				
MinnesotaCare Basic+2	$ 443.89	$ 1,539.09	$ 414.70	$ 1,328.42
MinnesotaCare Basic+1, $10K IP limit	369.94	1,454.31	345.61	1,197.31
MinnesotaCare Basic+1, no IP limit	440.14	1,526.08	411.19	1,317.18
Minnesota Advantage	390.81	1,415.11	365.10	1,212.62
Commercial Plan, $100 ded	381.38	1,380.99	356.30	1,183.39
Commercial Plan, $500 ded	363.80	1,348.95	339.88	1,128.83
B. Coverage from dedicated risk pool				
MinnesotaCare Basic+2	$ 383.30	$ 1,327.91	$ 383.30	$ 1,227.85
MinnesotaCare Basic+1, $10K IP limit	319.44	1,254.74	319.44	1,106.67
MinnesotaCare Basic+1, no IP limit	380.06	1,316.68	380.06	1,217.47
Minnesota Advantage	337.46	1,220.92	337.46	1,120.82
Commercial Plan, $100 ded	329.33	1,191.48	329.33	1,093.80
Commercial Plan, $500 ded	314.15	1,163.86	314.15	1,043.37
Funding Source & Benefit Plan	**Single Employee**	**Family**	**Single Employee**	**Family**
C. Coverage directly from MinnesotaCare				
MinnesotaCare Basic+2	$ 210.51	$ 729.27	$ 210.51	$ 674.32
MinnesotaCare Basic+1, $10K IP limit	189.53	744.45	189.53	656.60
MinnesotaCare Basic+1, no IP limit	208.14	721.06	208.14	666.73

Table 4.11 shows model rates for the dental plans. The commercial dental plan—with coinsurance and a deductible applied to basic and major procedure costs and a $2,000 annual benefit— has a total cost (employer plus employee contributions) that is 44 percent less expensive than the MinnesotaCare look-alike plan that provides 100 percent coverage without a deductible and a high, $5,000 benefit maximum.

Stand-alone dental plans are more expensive than those tied to medical plans for several reasons:

- Claims costs are 12 to 14 percent higher. The IC model assumes that members in a stand-alone plan are more likely to be those that need basic and major dental work.
- Charges for non-benefit costs are 7.5 percent to 9.0 percent of premium higher, because the stand-alone plan must absorb all of the member services administrative expense. When dental is tied to the medical plan, the latter absorbs these expenses. In addition, for Scenario A (dental coverage purchased in the commercial market) IC assumes that commissions and profit margins will each be 1 percent higher for a stand-alone plan.

Because the proposed plan has an employee contribution for single coverage, the projected single participation level is less than 100 percent. For this group of employees with generally modest incomes, even the proposed low $5 monthly contribution for single coverage may be enough to dissuade many employees from taking dental coverage.

Table 4.11
2010 Projected Monthly Premiums for Dental Insurance for LTC Workers: Weighted average of all regions

	Small Group (<51 eligible employees)		Large Group (51+ eligible employees)	
Funding Scenario & Benefit Plan	Single Employee	Family	Single Employee	Family
A. Coverage from market				
Tied to Medical Coverage				
MinnesotaCare Plan	$ 69.84	$ 173.83	$ 65.38	$ 159.65
Commercial Plan	40.31	102.11	37.74	93.94
Stand-alone				
MinnesotaCare Plan	89.81	223.53	81.75	199.13
Commercial Plan	50.91	128.98	46.34	113.92
B. Coverage from dedicated risk pool				
Tied to Medical Coverage				
Commercial Plan	35.94	91.02	35.94	89.44

Table 4.11 2010 Projected Monthly Premiums for Dental Insurance for LTC Workers: Weighted average of all regions				
	Small Group (<51 eligible employees)		Large Group (51+ eligible employees)	
Stand-alone				
MinnesotaCare Plan	71.05	176.84	71.05	173.06
Commercial Plan	40.28	102.04	40.28	99.01
C. Coverage directly from MinnesotaCare				
Tied to Medical Coverage				
MinnesotaCare Plan	$ 30.70	$ 76.41	$ 30.70	$ 74.96
Stand-alone				
MinnesotaCare Plan	35.04	87.20	35.04	85.34

E) Projected Total Participants and Total Costs

i) Projected total number of participants

The study team then projected the total number of participants in each plan/funding source combination using the following steps.

First, the **total number of LTC employees** was derived from low and high estimates of the number of long-term care workers in the state (71,000 and 181,000), taken from a report from the Minnesota Department of Health in 2002 entitled *Employer-Sponsored Health Insurance in the Minnesota Long-Term Care Industry: Status of Coverage and Policy Options*. A mean estimate was added based on the average of the two figures (129,000). Based on the employee survey, we estimated 66 percent of employees work enough hours to be eligible for benefits.

The model assumes that all employers in the state will participate in the rate increase and offer health and dental insurance that provide the coverage level of the model plan. In reality, this would only be the case if participation were mandatory or if the state could somehow persuade all employers to voluntarily participate. If participation is voluntary, many employers would likely choose not to participate and total costs to the state would be lower.

The number of eligible employees is based on the employee survey for respondents who said they work 32 or more hours a week with the employer who gave them the survey. This is the amount of hours an employee would need to work to qualify for coverage under the health insurance pass-through described in the legislation.

The number of eligible employees in the large group category was calculated by multiplying each of the low, mid, and hi eligible employee figures by 84 percent, which is the number of employees working at establishments with more than 50 employees reported in "Employer-Sponsored Health Insurance in the Minnesota Long-Term Care Industry: Status of Coverage and Policy Options." **Small group** employees were simply the difference between the two figures (16%).

The number of single / no dependents employees were based on survey results received through the worker survey. Twenty-two percent of respondents indicated they did not have any other individuals in their household supported by their total monthly household income. We multiplied the number of eligible employees in large and small group to arrive at estimates of the number of eligible employees in small and large group who were single/no dependents and who had dependents.

To calculate participation in the proposed plans, first the **estimated number of single employees w/ no dependents who would elect employee only coverage** was calculated by:

(number of eligible employees that are single/have no dependents) x (percentage of employees at a small/large group employer) x (single coverage participation rate)

Next the **number of employees who were not single and/or had dependents who would decline family coverage but elect single coverage** was calculated:

(number of employees that are not single/have dependents) x (percentage of employees at a small/large group employer) x (1 – family coverage participation rate*)

Employees who would elect family coverage was calculated by:

(number of employees that are not single/have dependents) x (percentage of employees at a small/large group employer) x (family participation rate*)

The sum of 4a and 4b was used to calculate the **"total statewide employees who would enroll in *employee only* coverage."** The model assumes that 100 percent of individuals that would decline family coverage would enroll in employee only coverage. These calculations were done for each of the projected statewide employee populations for each combination of medical plans, funding sources and dental plans.

The projected participation rates for medical and dental insurance are shown in ***Tables 4.12*** and ***4.13,*** below.

Table 4.12
Total Projected Participation in Medical Insurance
(Combined Metro & Non-Metro, Small and Large Group)

Medical Plan		Low Estimate	Med Estimate	Hi Estimate
Minnesota Care Basic +2	Individual Coverage	28,336	47,471	66,607
	Family Coverage	22,484	37,669	52,853
	Total Enrolled	50,820	85,140	119,460
Minnesota Care Basic +1 $10k In-Patient Limit	Individual Coverage	33,031	55,338	77,645
	Family Coverage	17,789	29,802	41,815
	Total Enrolled	50,820	85,140	119,460
Minnesota Care Basic +1 No In-Patient Limit	Individual Coverage	28,093	47,065	66,037
	Family Coverage	22,727	38,075	53,423
	Total Enrolled	50,820	85,140	119,460
Minnesota Advantage	Individual Coverage	30,729	51,481	72,233
	Family Coverage	20,091	33,659	47,227
	Total Enrolled	50,820	85,140	119,460
Commercial $100	Individual Coverage	30,741	51,500	72,260
	Family Coverage	20,079	33,640	47,200
	Total Enrolled	50,820	85,140	119,460
Commercial $500	Individual Coverage	31,137	52,164	73,191
	Family Coverage	19,683	32,976	46,269
	Total Enrolled	50,820	85,140	119,460
Minnesota Care - Tied to Medical	Individual Coverage	27,585	46,215	64,844
	Family Coverage	17,883	29,960	42,037
	Total Enrolled	45,469	76,175	106,881
Minnesota Care - Stand Alone	Individual Coverage	27,184	45,541	63,899
	Family Coverage	18,602	31,165	43,728
	Total Enrolled	45,786	76,706	107,627
Commercial - Tied to Medical	Individual Coverage	28,949	48,500	68,050
	Family Coverage	15,318	25,662	36,006
	Total Enrolled	44,267	74,161	104,056
Commercial - Stand Alone	Individual Coverage	28,350	47,496	66,642
	Family Coverage	16,475	27,601	38,726
	Total Enrolled	44,825	75,096	105,368

ii) Projected Total Costs

Medical and Dental per member per month costs for employee only/family and small/large group were taken from Ingenix Consulting's calculations. These figures were multiplied by the projected number of participants in each plan taken to arrive at a cost for each plan expressed in terms of small/large group and population estimate. Small and Large group costs within each

medical plan were added together with dental plan costs to produce a total cost figure for each plan, including both employer and employee portions of the cost. We then subtracted the employee portion to derive the **total cost figures excluding employee contributions**. The projections assume that the rate increase will fully cover just the employer portion of the premium.

The projections of total costs for the plans are the costs of the health and dental plan combination, based on IC's projections for increased participation. These include costs to cover claims and overhead costs—claims and member administration, provider network development and upkeep, and the cost of catastrophic claims insurance. For coverage purchased from the commercial market, the overhead cost also includes marketing expense, broker commissions, premium tax, and the assessment to support the Minnesota Comprehensive Health Association, (MCHA) the state's high-risk pool.

We present the projected per member per month cost for the 6 plans, 3 funding scenarios, and stand-alone and tied to medical dental insurance, for small and large group and for individual and family coverage.

Total costs for the employer portion of the premium varied widely, depending on the plan design and funding approach selected, from an average of $340 to $879 per insured worker per month, or a total of $17.3 million to $105.1 million a month, depending on the number of workers and the model plan and funding source selected by the state (Table RS.11). For the mid-range estimate of the number of workers, total monthly costs ranged from $28.9 million to $74.9 million. The total costs include the employer plus employee share. The employer share would be paid through a combination of Federal Medical Assistance match, state funds, and any required employer contributions. The employee share could be paid by the employee, or by a subsidy provided by the employer or the state.

A mid-cost option is a plan modeled after Minnesota Advantage, with commercial dental insurance tied to medical insurance. This plan would cost $698 per insured worker per month, or $59.5 million a month to cover all participating workers and their families, using the medium estimate for the number of workers in the commercial market. A new dedicated risk pool could lower costs to an estimated $634 per insured worker per month, or $54.1 million total monthly costs

The lowest costs were for the option in which the plan is actually part of MinnesotaCare itself, with a cost per insured worker from $340 to $396. While the MinnesotaCare plan with the $10,000 limit on in-patient hospitalizations yielded the lowest costs of any option, the MinnesotaCare

plans without in-patient limits also cost less than plans purchased through the commercial market. This is because the average provider reimbursement in MinnesotaCare is assumed to be at the Medical Assistance level, which is far less than provider reimbursement under commercial plans. Also, MinnesotaCare has much lower non-benefit costs than typical commercial plans.

For the options where insurance is purchased in the commercial market, the lowest cost plan was the $500 deductible commercial plan, purchased through a new dedicated risk pool, with dental tied to medical ($586 per member per month). The $100 deductible plan cost somewhat more, at $618 per member per month if purchased through a dedicated risk pool. The coverage levels of MinnesotaAdvantage and MinnesotaCare purchased through the commercial market were the most expensive options ($673 to $877 per member per month). ***Table 4.13*** shows the projected total costs for each plan, excluding employee contributions.

Table 4.13: Combined Medical and Dental Insurance Monthly Costs Excluding Employee Contributions

Medical Plan & Dental Plan	Funding Source	Dental Plan Type	Average Cost per Insured Worker per Month	Estimated Total Monthly Cost (In Millions)		
				Low Estimate	Med Estimate	Hi Estimate
MinnesotaCare +2 / MinnesotaCare Dental	Market	Tied to Medical	$854	$43.4	$72.8	$102.1
		Stand Alone	879	44.7	74.9	105.1
	Dedicated Risk Pool	Tied to Medical	777	39.5	66.2	92.9
		Stand Alone	791	40.2	67.4	94.6
	MinnesotaCare	Tied to Medical	389	19.8	33.2	46.6
		Stand Alone	396	20.1	33.7	47.3
MinnesotaCare Basic +1 10k IP with MinnesotaCare Dental	Market	Tied to Medical	$673	$34.2	$57.3	$80.4
		Stand Alone	716	36.4	60.9	85.5
	Dedicated Risk Pool	Tied to Medical	629	31.9	53.5	75.1
		Stand Alone	642	32.6	54.7	76.7
	MinnesotaCare	Tied to Medical	340	17.3	28.9	40.6
		Stand Alone	346	17.6	29.5	41.4
MinnesotaCare Basic +1, No IP with MinnesotaCare Dental	Market	Tied to Medical	$834	$42.4	$71.0	$99.6
		Stand Alone	877	44.6	74.7	104.7
	Dedicated Risk Pool	Tied to Medical	775	39.4	66.0	92.6
		Stand Alone	789	40.1	67.1	94.2
	MinnesotaCare	Tied to Medical	387	19.6	32.9	46.2
		Stand Alone	393	20.0	33.5	47.0

Table 4.13: Combined Medical and Dental Insurance Monthly Costs Excluding Employee Contributions (cont'd.)						
Medical Plan & Dental Plan	**Funding Source**	**Dental Plan Type**	**Average Cost per Insured Worker per Month**	**Estimated Total Monthly Cost (In Millions)**		
Commercial Plan, $100 Ded with Commercial Dental	Market	Tied to Medical	$670	$34.1	$57.2	$80.2
		Stand Alone	693	35.3	59.1	83.0
	Dedicated Risk Pool	Tied to Medical	618	31.5	52.7	74.0
		Stand Alone	625	31.8	53.3	74.8
Commercial Plan, $500 Ded with Commercial Dental	Market	Tied to Medical	$634	$32.3	$54.1	$75.9
		Stand Alone	658	33.5	56.1	78.7
	Dedicated Risk Pool	Tied to Medical	586	29.8	49.9	70.1
		Stand Alone	592	30.1	50.5	70.8
MinnesotaAdvantage with Commercial Dental	Market	Tied to Medical	$698	$35.5	$59.5	$83.5
		Stand Alone	711	36.2	60.6	85.0
	Dedicated Risk Pool	Tied to Medical	634	32.3	54.1	75.9
		Stand Alone	641	32.6	54.6	76.7

Low Estimate: Assumes 77,000 employees; 50,820 eligible for coverage
Med Estimate: Assumes 129,000 employees; 85,140 eligible for coverage
Hi Estimate: Assumes 181,000 employees; 119,460 eligible for coverage

F) Other Considerations

One question for this study is how much reliance on publicly funded plans by these employees and their dependents would decrease as a result of this proposal. From the employee survey, approximately 18 percent of the employees said they were covered by a public plan; included in this group are 4 percent of employees covered by Medicare. Some employees said they were also covered by both a public and a private plan; most of these are probably covered by Medicare and also have a Medicare supplement. IC estimates that approximately 12 to 13 percent of employees have coverage exclusively from a public plan that is not Medicare. If these employees get free (non-contributory) coverage from the proposed plan, then they will not need to be in public plans, although if given the option some might prefer to stay in the public plan if they could keep their doctor or if the workplace plan has co-pays and a deductible.

The dependent side is more complicated. Considering the survey results showing only 41 percent of employees willing to pay more than $100 per month for family coverage, there will likely be little desire to move dependents from low or no cost public plan coverage.

In addition, the proposed rate increase is likely to have other benefits that are important for the state to consider, although projecting the amount of these potential benefits was beyond the scope of this study. These include increased income tax revenue due to employee wage growth (assuming that reductions in employers' health insurance costs are passed on to workers as increased wages), savings from reduced worker turnover, and improved access to services for people with disabilities.

5.0

Conclusion, Recommendations, and Implementation Considerations

- Low wages, part-time and fluctuating hours, and eroding employer benefits lead to many long-term care workers lacking access to affordable health insurance. At the same time, the small size, rising insurance costs, and heavy dependence on public funding make it difficult for many long-term care employers to offer comprehensive, affordable coverage to their employees without increased public support. This chapter provides recommendations for implementing a rate increase to expand coverage for the long-term care workforce, based on study findings and examples from other states.
- The legislation specified that the insurance be obtained in the commercial market. While employee contributions would be the same for all plans, the plans differ in the total costs and the level of benefits provided to employees. The $500 deductible plan and the MinnesotaCare Basic+1 plan with the $10,000 in-patient limit are the least expensive plans. However, we do not recommend these plans because even if the premiums are affordable, co-payments and deductibles beyond a nominal amount are unaffordable for low-wage workers and may discourage them from seeking health care. The plan modeled after Minnesota Advantage, with commercial dental insurance tied to medical coverage, offers the best combination of low cost and reasonable coverage. To lower costs, we recommend establishing a risk pool, after the first five years of operation, when the plan would have enough experience on which to base premiums.
- For comparison purposes, the study also projected participation and costs for if the insurance was actually part of MinnesotaCare. This option yielded significantly lower costs than commercially purchased health insurance, but this approach may be unrealistic due to the very low provider reimbursement levels of MinnesotaCare.
- Based on the experience of other states, we suggest the following recommendations for successfully implementing the rate increase:
    - To ensure equitable treatment of providers, make participation voluntary and do not base eligibility on previous expenditures for health insurance.
    - Consider impacts of the initiative on equity across long-term care workers.
    - Build and maintain accountability systems to ensure that the rate increase is spent for the intended purpose.
    - Explore options for making insurance more accessible to part-time workers or ensuring full-time work.
    - Conduct outreach efforts to increase awareness of the health benefit and encourage participation.
    - Ensure that the rate increase is adequate to make insurance affordable to employers.
    - To ensure sustainability over time, build in mechanisms to ensure that funding keeps pace with escalating health insurance costs.

- In conclusion, implementing the proposed rate increase for health insurance in Minnesota will require careful planning and investment. However, given the growing need for a strong, stable workforce to support Minnesota's growing population of older persons and people with disabilities, the link between health coverage and retention, and the importance of a stable qualified workforce to quality of care, we believe that the results of undertaking this endeavor will be well worth it.

Chapter 5: Conclusions, Recommendations, and Implementation Options

The results of the long-term worker survey show that many workers do not consistently work enough hours to qualify for benefits, or do not enroll because they cannot afford the premiums, deductibles, or co-pays. In addition, the employer surveys show that the small size and dependence on Medical Assistance and state funds make it difficult for many long-term care employers to offer affordable health coverage that covers workers' health expenses. These findings support giving priority to long-term care workers in efforts to expand health insurance to working families in Minnesota.

The good news is that solutions do exist. Over the past ten years, state policymakers, employers, clients and their advocates, and unions have been engaging in a variety of strategies to make health care for long-term care workers more affordable.

This chapter describes core design issues and provides recommendations for insuring Minnesota long-term care workers across the spectrum of providers. We discuss key conclusions from the survey data and actuarial analysis and their implications for a model plan design and avenues for obtaining insurance.

The chapter also provides examples of related strategies that have been implemented in other states to provide health insurance to long-term care workers. The initiatives vary greatly in scope, approaches for how employers obtain coverage, and the strategies for making private market insurance more affordable. While approaches from other states do not mirror exactly the three design options in Minnesota, key factors in each are relevant to choices the state will make and highlight important issues for Minnesota to consider when designing a health insurance plan.

Particular attention is focused on Montana, the first and so far only state to provide a rate increase to providers dedicated to the purchase of health insurance in the private market, as is being considered in Minnesota. We compare these options with what is under consideration in Minnesota and draw conclusions about lessons learned from these models that apply to Minnesota.

Several of the examples were funded by the Demonstration to Improve the Direct Service Community Workforce (DSW Demonstration). In 2003, the Federal Centers for Medicare & Medicaid Services (CMS) launched the DSW Demonstration to respond to the need to improve the quality of direct service jobs and stabilize this workforce to improve the quality of care and meet the caregiving needs of the future. Through this demonstration program, six grantees received funds to provide health coverage and test the impact on recruitment and retention.[83]

A) Recommendations for Benefit Plan Design and Funding Options

The legislation mandated that this study develop estimates for a rate increase designated for the purchase of health insurance for employees. Most of the respondents to the Employer Survey reported receiving most of their revenue from Minnesota Medical Assistance (Minnesota's Medicaid program). Although long-term care is financed through a combination of public and private sources, the Medicaid program is by far the single largest payer of long-term care services, financing 49 percent of long-term care services in 2005 nationwide.[84]

Limited Medicaid reimbursement rates are an obstacle for employers who want to provide health care coverage for their employees. These reimbursement rate structures, which vary by state and sector, typically do not entirely cover the cost of health insurance or other benefits for workers. A recent study found that most states set reimbursement rates for Medicaid-funded personal care services in a relatively ad hoc manner and without knowledge of whether the provider agencies they contract with provide health care coverage.[85]

The Minnesota Department of Health's 2002 study suggested that the Department of Human Services, which is already heavily involved in the financing and regulation of long-term care services, could administer such a program.[86] An advantage of administering the program as a Medicaid rate increase is that it creates an opportunity to obtain significant federal matching funds (60.19% for FY09) to help offset total costs, whereas direct subsidy payments would likely require the use of state-only funds.

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[83] PHI, Emerging Strategies for Providing Health Coverage to the Frontline Workforce in Long-Term Care: Lessons from the CMS Direct Service Community Workforce Grants, January 2007.

[84] Komisar, Harriet L. and Lee Shirey Thompson, 2007. "National Spending for Long-Term Care," Washington, DC: Georgetown University Long Term Care Financing Project.

[85] Seavey, Dorie PhD and Vera Salter PhD., "Paying for Quality Care: State and Local Strategies for Improving Wages and Benefits for Personal Care Assistants,", AARP Public Policy Institute, 2006

[86] MDH, 2002.

i) The Plan Modeled after Minnesota Advantage, with Commercial Dental Insurance Tied to Medical, Provides the Most Cost Effective Plan with Reasonable Coverage for this Workforce

This study compared six health benefit plan designs and two dental benefit designs in terms of projected costs and projected individual and family enrollment. Because the premium for individual medical coverage would be $0, enrollment for single persons and people without children was projected to be 100 percent. Hence, the important areas in which the plans differ are in projected costs and projected enrollment in family coverage, which varies depending on the richness of the plan:

- The MinnesotaCare+2 plan and the model plan of MinnesotaCare+1 without the $10,000 in-patient limit are the most expensive plans (***Table 5.1***), but also result in higher enrollment in family coverage, due to the better benefits. These may not be the most advantageous plans for covering all long-term care employees because of the very high cost.
- We recommend the plan modeled after Minnesota Advantage. This plan has a total cost that is about 2.5 percent higher than the $100 deductible plan, but has a better chance of controlling future cost increases due to its tiering structure, in which providers are grouped into levels with costs and benefits varying by provider level. Our recommendation assumes that a commercial carrier or third party administrator (TPA)—usually a claims processor[87]— can develop a tiered provider network for the plan.
- We do not recommend the $500 sample commercial plan or the MinnesotaCare+1 plan with the $10,000 in-patient limit, because these plans would not provide adequate coverage for this workforce.

[87] A TPA is essentially an entity that doesn't take insurance risk but just pays claims, arranges the provider network, and performs disease management, and similar functions.

Table 5.1: Projected Combined Medical and Dental Insurance Costs

Medical Plan	Funding Source	Dental Plan	Cost per Member per Month	Federal Match PMPM	Total PMPM Cost To State
MinnesotaCare +2	Market	Tied to Medical	$854	$514	$340
		Stand Alone	879	529	350
	Dedicated Risk Pool	Tied to Medical	777	468	309
		Stand Alone	791	476	315
	MinnesotaCare	Tied to Medical	389	234	155
		Stand Alone	396	238	158
MinnesotaCare Basic +1 $10k IP	Market	Tied to Medical	$790	$475	$314
		Stand Alone	833	501	332
	Dedicated Risk Pool	Tied to Medical	736	443	293
		Stand Alone	749	451	298
	MinnesotaCare	Tied to Medical	369	222	147
		Stand Alone	376	226	150
MinnesotaCare Basic +1, No In-Patient Limit	Market	Tied to Medical	$735	$442	$292
		Stand Alone	777	468	309
	Dedicated Risk Pool	Tied to Medical	684	412	272
		Stand Alone	698	420	278
	MinnesotaCare	Tied to Medical	315	190	126
		Stand Alone	322	194	128
Commercial Plan, $100 Ded	Market	Tied to Medical	$670	$403	$267
		Stand Alone	693	417	276
	Dedicated Risk Pool	Tied to Medical	618	372	246
		Stand Alone	625	376	249
	MinnesotaCare	Tied to Medical	268	161	107
		Stand Alone	271	163	108
Commercial Plan, $500 Ded	Market	Tied to Medical	$634	$382	$253
		Stand Alone	658	396	262
	Dedicated Risk Pool	Tied to Medical	586	352	233
		Stand Alone	592	356	236
	MinnesotaCare	Tied to Medical	260	156	103
		Stand Alone	263	158	105
MinnesotaAdvantage	Market	Tied to Medical	$698	$420	$278
		Stand Alone	711	428	283
	Dedicated Risk Pool	Tied to Medical	634	382	252
		Stand Alone	641	386	255

Assumes Minnesota's current Federal match of 60.19% for the scenarios in which insurance is purchased in commercial market or through risk pool. This is the state's temporary enhanced Federal match through Dec 31, 2010, under the American Recovery and Reinvestment Act (ARRA);. Assumes 31% Federal match for scenario in which the insurance is part of MinnesotaCare.

For all plans, employee contributions are $0 for individual health insurance, $130.20 for family health insurance, $34.16 for family dental, and $5.00 for single dental.

Because of the generally low-wages of the long-term care workforce, premiums and co-pays must be minimal in order to encourage take-up. In

developing Massachusetts' health care reform program, the state analyzed what people pay for employer-sponsored insurance across income levels and determined that if a premium is greater than 2.1 percent of income for people at 200 percent of poverty or 4.1 percent of income for people at 300 percent of poverty, then it is unaffordable.[88] Even if the premiums are affordable, co-payments and deductibles beyond a nominal amount are unaffordable for low-wage workers and may discourage them from seeking health care. Some experts suggest using sliding fee scales that set premiums based on percentage of wages or family income.[89]

For a dental plan, we recommend the commercial plan tied to medical. As with medical, the MinnesotaCare dental plan is very costly. Tying dental to medical can increase participation in the initiative. One of the stated goals is to reduce the number of employees and their families who are now in public plans. If stand-alone dental is offered, some employees may stay in the public medical plan but take the separate dental plan. This would result in employees and their dependents remaining in the more costly public medical plans, and dental costs would be higher due to anti-selection by employees choosing to participate in dental insurance not tied to medical insurance.

ii) Montana Provides an Example of the Feasibility of a Rate Increase to Cover Health Insurance

Montana's model, called Health Care for Montanans who Provide Health Care and passed in 2007, is of particular interest because although many states have implemented Medicaid rate increases for the purpose of increasing compensation for direct service workers over the years (known as "pass-throughs"), Montana approved one for health benefits.

Montana's plan was launched in January 2009 for employers delivering Medicaid-funded personal assistance or private duty nursing services. The coverage is for individuals only. Employers may choose their own plan as long as it meets the state's "benchmark" criteria for an insurance plan, which stipulates a maximum $1,000 individual and $3,000 family deductible, 70 percent co-insurance, individual premium no greater than $25/month, and other plan design requirements.[90] The program is voluntary and as of April

[88] PHI, "Expanding Coverage for Caregivers: A Checklist for State Health Reform," 2007.

[89] E. Neuschler and R. Curtis, 2003, "Use of Subsidies to Low-Income People for Coverage through Small Employers," *Health Affairs,* Web Exclusive, May. http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.227v1, cited in Better Jobs Better Care, *Health Insurance Coverage for Direct Care Workers: Riding Out the Storm*, March 2004.

[90] Montana Department of Public Health and Human Services, "Department's Benchmark Standards," http://www.dphhs.mt.gov/sltc/services/communityservices/HCWorkers/Index.shtml

2009, covers 900 workers.[91] In the first round of funding for the Montana program, 20 of the 28 Medicaid personal assistance service agencies (71%) participated in the rate increase for insurance.[92] Seven of the 20 Medicaid private duty nursing (PDN) agencies participated, and these 7 agencies provide approximately 71 percent of the total PDN services in Montana. Montana's health insurance program is more limited in scope in several respects than the plan under consideration in Minnesota (***Table 5.2***).

Table 5.2
Montana and Minnesota Health Insurance Initiatives Designs

	Montana Health Insurance Rate Increase	Minnesota Proposed Rate Increase
Employees covered	Direct care workers in Medicaid-funded personal assistance and private duty nursing service providers only. The state is studying how the program would work for nursing homes and developmental disability service providers.	All long-term care employees
Coverage type	Individual coverage only Dental coverage is optional if employer funding allows	Individual and family coverage Dental coverage is included
Key features of plan design	Max $1,000 individual and $3,000 family deductible 70% co-insurance Individual premium no greater than $25/month	$100 deductible for model commercial plan Co-pays vary by model plan design Individual premium $0

The allocation of funds for the Montana program is fairly complex. The amount of the total funding pool is determined based on the total number of agencies participating in the rate increase and the percentage of each provider's business from Medicaid, subject to an annual cap of $5.6 million (including state and federal funds). The pool of funds is then divided among the agencies participating based on the percent of revenue each agency receives from Medicaid. The average total monthly premium is $450, and the employee shares are capped at $25 a month. The employer has to attest to the fact that they will use the money for the appropriate benchmark coverage. The payment to the employer is advanced monthly, and every quarter the employer

[91] Conference call with staff at Montana Department of Health and Human Services, Senior Long-Term Care Division, April 2009.

[92] Montana Department of Public Health and Human Services, "Health Care for Direct Care Workers Application 1 Report." http://www.dphhs.mt.gov/sltc/services/communityservices/HCWorkers/Index.shtml

must send in reports attesting to their actual costs. These lump-sum payments will eventually be factored in the Medicaid rate.

Concurrent to launching this program, the state was required by legislation to survey other non-home care sectors for which data was not available at the time the legislation was passed in order to assess how a similar reimbursement strategy would work for nursing homes and developmental disability service providers. That research work is currently underway.

Although the Montana plan differs in scope from the Minnesota proposal, we recommend keeping abreast of developments in Montana for potential ideas and lessons learned that may be helpful for Minnesota.[93]

iii) Pooling Risk through Purchasing Pools Can Significantly Reduce Costs

Sharing the risk is essential for lowering insurance premiums. That is why it is easier for large companies with multiple facilities that share a single health plan to make insurance affordable. In the employer survey, several employers commented that their small size made it difficult for them to obtain affordable health insurance benefits for their employees.

In Ingenix Consulting's (IC) actuarial analysis, projected costs for commercially purchased insurance were significantly lower when purchased through a new dedicated risk pool. This is primarily due to the lower non-benefit costs of a risk pool.

IC estimates that the total non-benefit cost, primarily administrative and catastrophic claim reinsurance costs, for a risk pool would be approximately 10.25 percent of premium. This is significantly lower than the non-benefit costs of other commercially purchased insurance (22.5% for small group, 17% for large group). For the risk pool, non-benefit costs include start-up costs and an amount to build up a stabilization reserve of 10 percent of premium over a 4-year period that would protect the pool in years of adverse experience. Because this pool would be self-funded, there are no premium tax and no assessment for the Minnesota Comprehensive Health Association (MCHA), as is required for other commercially purchased plans.

We recommend that coverage be obtained from carriers in the commercial market for the first five years of the program. After the first five years of

[93] For more information, contact Mike Hanshew, Montana Health Solutions, LLS mikeh@consumerdirectonline.net, PHI, *Coverage Models from the States*, 2007. See also the Montana Department of Health and Human Services' Health Care for Health Care Workers web page at http://www.dphhs.mt.gov/sltc/services/communityservices/HCWorkers/Index.shtml.

operation, the plan would have enough experience on which to base premiums and to build a dedicated risk pool. This is ultimately the better approach, provided that all long-term care employers that accept the rate increase from the state would have to get their benefit plan from the dedicated risk pool.

A few states have considered risk pools to help small long-term care employers purchase insurance for their employees. Montana has an insurance pool for small businesses (2 to 9 employees) called "Insure Montana," which is not specific to healthcare workers.[94] However, this program did not affect most long-term care workers because most home care agencies had 10 or more employees.

In Wisconsin, the Wisconsin Regional Training Partnership, the nonprofit training organization affiliated with the Wisconsin AFL-CIO, established an innovative purchasing arrangement—a union-sponsored Professional Employer Organization (PEO).[95] A PEO is a co-employment strategy that allows multiple employers to purchase human resource services from a single entity, reducing costs for individual agencies. Workers employed by participating agencies have two employers: the PEO for purposes of payroll, benefits, and other HR services, and the home care agency for hiring and daily supervision. Although the risk pool reduced costs, in the absence of a subsidy, coverage was still unaffordable to many employers.

iv) MinnesotaCare, while a less expensive funding source, is challenged by low provider reimbursement rates.

This study also projected participation and costs for the option of insurance being obtained directly through MinnesotaCare. The MinnesotaCare plans without the $10,000 in-patient limit provide the most generous benefits of the six model plans. This option yielded significantly lower projected costs than commercially purchased health insurance, due to the much lower provider reimbursement rates and non-benefit costs of MinnesotaCare compared with the typical commercial plan. IC estimates that the non-benefit, or administrative cost, of this funding source is 9 percent of premiums. Provider reimbursement in all plans would be at current MinnesotaCare levels, which is similar to reimbursement under Medical Assistance and significantly less than the provider reimbursement level of commercial plans. The result could be that many providers, particularly those outside the Twin Cities, would refuse

[94] PHI Health Care for Health Care Workers, Case Study: Montana, "Healthcare for Montanans Who Provide Healthcare," http://www.dswresourcecenter.org/tiki-download_file.php?fileId=27

[95] PHI, *Subsidizing Health Insurance Coverage for the Home Care Workforce in Two Wisconsin Counties: An Analysis of Options*, February 2007, http://www.directcareclearinghouse.org/download/HealthInsCovWIreport.pdf

to accept the plan's reimbursement, and members would be left with a very limited provider network.

In addition, this approach would leverage less federal funds, because the federal matching percentage is lower for MinnesotaCare than for the rates paid to providers for long-term care services, because there is no federal match for adults without children in MinnesotaCare.[96] In 2007 (the most recent year for which data were available), the federal share for MinnesotaCare was 31 percent. This figure was based on federal funds matching 65 percent for MinnesotaCare caregivers with incomes between 100 and 200 percent of Federal Poverty Level. Since February 1, 2009, this group receives the regular MA federal match of 50 percent, and the enhanced match is applied to MinnesotaCare children age 18 or younger with incomes greater than 150 percent but not exceeding 275 percent of FPG. This compares with a federal match for Medical Assistance rates paid for services of 60.19 percent.

Maine, New York, and Michigan provide examples of states that expanded coverage to long-term care workers by allowing long-term care employers to "buy into" publicly funded health insurance programs for people with low incomes.

In **Maine**, small businesses with 2 to 50 full-time employees, self-employed individuals, sole proprietors, and uninsured individuals are eligible to participate in the state-subsidized Dirigo Health plan.[97] Employers pay 60 percent of the premium cost; workers receive a sliding scale subsidy to cover their share, with the state paying for the employee premium discounts.

Maine used its CMS Demonstration grant to conduct outreach to home care agencies to promote DirigoChoice.[98] The state found that employers lacked reliable information about coverage options, and when presented with options, believed premium costs were unaffordable for their businesses. In response, Maine refocused the outreach work to provide employers with a broader range of options for providing health coverage. While a small number of agencies decided to offer coverage through DirigoChoice and other plans, many more agreed to circulate information to their employees about health plans they

[96] Minnesota House of Representatives, December 2008, "MinnesotaCare," http://www.house.leg.state.mn.us/hrd/pubs/mncare.pdf

[97] PHI, January 2007. For more information on the Maine plan, go to www.dirigohealth.maine.gov Eligibility is capped for uninsured individuals.

[98] Paraprofessional Healthcare Institute (now PHI), 2006, "Health Insurance Coverage Initiatives for the CMS Direct Service Workforce demonstration Grants 2003 and 2004," http://www.dswresourcecenter.org/tiki-index.php?page=Health+Care+Coverage

might be able to purchase themselves and/or provided referrals to community-based organizations for assistance.

There are important lessons from Maine. The benefit package for DirigoChoice is viewed as a good comprehensive plan that includes preventive care, prescription drugs, and mental health services, all key benefits for this workforce. So, while the costs were considered unaffordable by many agencies in Maine, the plan itself is considered comprehensive and affordable to DSWs. The premiums for individual coverage for DSWs are approximately $350 per month, a typical price for this insurance plan. The workers' premium share was discounted based on income, and with a sliding fee scale, deemed to be affordable for most direct service workers if their employer would participate. Another significant benefit of this plan for low-income workers is that there are no out-of-pocket costs for those who earn less than 200 percent of the Federal Poverty Level. Nonetheless, with the employers' share at 60 percent, many employers—particularly those heavily dependent on Medicaid—could not afford even that amount. Hence, a lesson learned from Maine is that, to be a success, a rate increase for health insurance must be sufficient to make health insurance affordable to employers.

New York's Family Health Plus Buy-In program, created in 2007, allows employers and unions to "buy into" the Family Health Plus program.[99] Family Health Plus program is New York's no-cost, public health insurance option for low-income individuals (age 19-64) and families that have income/assets above Medicaid's resource limits.[100] The program replaces an earlier state-funded Home Care Workers Health Insurance Demonstration that funded the New York City-based 1199/SEIU National Benefit Fund (see below).

PHI identified several obstacles to employers participating in the Family Health Plus Buy-In option. One primary obstacle is that the state requires employers to pay at least 70 percent of the premium (estimated at around $4,000 annually). Survey results suggested that this cost would exclude an estimated half of all employers. This is consistent to the problem encountered in Maine—few employers enrolled because the subsidy was insufficient to enable them to afford health insurance for their employees.

Michigan's Access Health Plan is a county-based, publicly funded community-based health plan that divides premium costs between the employer, the employee, and the county.[101] The program is considered community-based

[99] PHI Health Care for Health Care Workers, *Is New York Prepared to Care? A Comprehensive Coverage Solution for Home Care Workers*, May 2009. http://www.nyshealthfoundation.org/content/document/detail/1679/

[100] http://www.health.state.ny.us/nysdoh/fhplus/

[101] PHI, Coverage Models from the States.

because Access Health takes an approach of working with each community, including employers and workers, to mutually fund the program and tailor the program to the community's specific health needs. This can be contrasted with approaches that apply the same health plan, benefits, and approach to different communities with different needs. The program is funded by contributions from the employer, the employee, and local community. These contributions are matched by the state's Medicaid Disproportionate Share Hospital (DSH) funds, which provide federal funds to hospitals that serve a disproportionate share of indigent patients. The plan is open to employers in Muskegon and Ottawa Counties who employ workers earning $12.00 an hour or less and who do not already offer employer-sponsored insurance. Participants include adult foster care homes, home care agencies, and nursing homes. Outreach efforts are underway to reach more long-term care employers and direct service workers. A disadvantage of this program is that the state would have difficulty continuing it if this funding stream were eliminated or significantly reduced.

B) Implementation Recommendations, Options, and State Examples

Several criteria are critical to ensuring the success of the proposed Minnesota long-term care workforce health insurance initiative. The 2008 Minnesota health reform legislation identified two key criteria that the proposal should meet:

- Ensures equitable treatment between employers that currently offer insurance and those who do not, and those with differing insurance costs and plans,
- Ensures the requirement that the rate increase be expended for the intended purpose.

In addition, a 2007 PHI report about the experiences of the CMS DSW Demonstration grantees identified 5 key design elements for this workforce:[102]

- Accessible to all long-term care workers,
- Affordable for workers and employers,
- Adequate benefit plan,
- Simple, easy to understand and enroll in, and
- Sustainable over time.

This section provides recommendations for how the Minnesota initiative can meet these goals, based on the results of the surveys, actuarial analysis, and review of other states' experiences.

[102] PHI, Emerging Strategies for Providing Health Coverage to the Frontline Workforce in Long-Term Care.

i) Ensure Equitable Treatment of Providers by Not Basing Payments on Previous Expenditures for Health Insurance and By Making Enrollment Voluntary

As the Minnesota Health Care Access Commission Working Group noted, some employers have emphasized health coverage and held down wages as a result, while others have offered reduced health care benefits in order to provide better wages.[103] Other employers might reduce health insurance benefits but provide more paid time off. Hence, the Working Group recommended that the state address fair treatment of providers who have made different prior decisions on the issue of better health insurance benefits versus better wages.

Montana's initiative provides an example of how to meet the goal of equitable treatment of providers. As discussed above, the rate increase amount for health insurance each provider receives is based on the percentage of revenue received from Medicaid.[104] The funding must be used to pay for employee health insurance that meets Montana's benchmark criteria.[105] A dental plan is optional if employer funding allows. Participation in the rate increase is voluntary, and employers may apply. If an agency's current plan meets the benchmarks, the agency can use the enhanced rate to offer the current plan to their uninsured workers.[106] If the agency's plan does not meet the benchmarks, they will need to enroll in a different plan to obtain the enhanced rate. The difference in reimbursement must go to pay insurance premiums. Of the 20 personal assistance agencies that applied for the first round of health insurance funding, 30 percent were currently offering insurance, and none of the agencies offered a plan to the majority of their workers that met the benchmark.[107]

New York's Health Care Enhancement Initiative, which targeted providers of services for people with intellectual/developmental disabilities, is designed to reward employers who are already offering comprehensive coverage, while also creating an incentive for employers that provide a lower level of benefits. The state identifies organizations that have historically offered health coverage above a benchmark level and provides the funding to help offset health

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[103] The Legislative Commission on Health Care Access, Health Care for Long-Term Care Workers working group, 2007.

[104] Telephone conversation with Mike Hanshew.

[105] "Health Insurance Benchmarks: Final Draft", http://www.dphhs.mt.gov/sltc/services/communityservices/HCWorkers/benchrmaks.pdf, accessed June 24, 2009 .

[106] "Health Insurance for Health Care Workers: Frequently Asked Questions," http://www.dphhs.mt.gov/sltc/services/communityservices/HCWorkers/Index.shtml

[107] Montana Health Care for Direct Care Workers, Application 1 Report.

insurance costs to those providers without their applying.[108] Providers who have not historically offered such insurance can receive the same funding, but must go through an application process. Such a strategy that involves assessing the health insurance benefits of all providers would be less feasible for the proposed Minnesota initiative, which would target a much larger group of providers from diverse service sectors.

ii) Consider Impacts of the Initiative on Equity across Long-Term Care Workers

The legislation directed the study to examine a rate increase for insurance for the entire long-term care workforce. However, given limited state funds, beginning with one sector of the workforce with the highest rates of uninsurance and expanding to other sectors – as is the Montana plan – may be a viable strategy for Minnesota. Montana is beginning with home care and private duty nursing workers and studying how the rate increase would work in other settings. Most other states with long-term care health insurance initiatives have target them for workers in specific sectors, particularly individual providers, home care workers, and workers supporting people with intellectual/developmental disabilities. If this option is considered, funding should be targeted to sectors with the greatest need, to improve balance across provider types.

Although the survey found small differences between workers in institutional and home and community based settings, our findings indicate much larger differences by workplace setting *within* home and community based or institutional settings, with lower-paid direct service staff at the greatest disadvantage. In particular, a related study by Lewin on Minnesota's Personal Care Assistance program found exceptionally high uninsurance rates among PCAs.[109]

iii) Build Accountability Systems to Ensure that Rate Increases Are Spent for the Intended Purpose

Another key issue identified in the legislation is the importance of developing mechanisms to ensure that rate increases are spent for the intended purpose.

Minnesota has already developed an accountability system for previously enacted rate increases (COLAs) for long-term care providers earmarked for employee wage increases and benefits. On most recent COLAs, 75 percent of

[108] PHI Health Care for Health Care Workers, *Coverage Models from the States,* 2007.

[109] The Lewin Group, *Recommendations for Minnesota's Personal Care Assistance Program,* Report for Minnesota Department of Human Services, Disability Services Division, Draft July 2009.

the rate increase is designated for compensation costs, two-thirds of which (50 percent of the total increase) is for wage increases, according to Minnesota officials consulted for this study.

Within six months after the effective date of each rate adjustment, providers must provide a Provider Statement of Assurance letter to the Department of Human Services Commissioner and those counties with which they have a contract. The letter provides assurances that the provider has developed and implemented a compensation plan that estimates the amounts of money that must be used to meet compensation and wage requirements and details the distribution plan for the money. The Provider Statement of Assurance is an on-line form available on the DHS 2008 COLA Web page at: http://www.dhs.state.mn.us/dhs16_138858.

Nursing home providers do not complete a Provider Statement of Assurance, but must submit a compensation plan application instead.[110] For self-employed workers and individual practitioners with no employees, the Department considers the acceptance of the rate increase by the individual practitioner to be an increase to the wages and compensation for that individual. These individuals must complete the Provider Statement of Assurance and check the box indicating that they are self-employed or individual practitioners with no employees.

However, Minnesota officials consulted for this study commented that this has not really worked, as many providers have not returned this statement. In addition, a few survey respondents commented that their employer had not used the COLA for wage increases as required. Research in other states has found that even when accounting mechanisms have been specified, providers have not always passed on rate increases to employees.[111]

Hence, Minnesota should also ensure a system is in place to track and monitor outcomes of the rate increase on employee health insurance. For example, in Montana's program, payments are advanced to employers monthly, and every quarter the employer must send in reports attesting to their actual costs.

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[110] Minnesota Department of Human Services, "2008 COLA: Frequently Asked Questions," http://www.dhs.state.mn.us/main/groups/disabilities/documents/pub/dhs16_142199.pdf ,a accessed June 26, 2009.

[111] Dorie Seavey and Vera Salter, *Paying for Quality Care: State and Local Strategies for Improving Wages and Benefits for Personal Care Assistants*, Washington, DC: AARP Public Policy Institute, 2006, http://www.aarp.org/research/longtermcare/quality/2006_18_care.html

Research on the experiences of these states suggests several possible approaches to enforcement of a rate increase designated for wages or benefits:[112]

- Surveying providers after the rate increase to determine whether and how they participated;
- Requiring providers to submit expanded cost reports;
- Random audits; and
- Tracking employer deductions for health insurance on business tax returns.

iv) Make Insurance Accessible to More Workers by Expanding Coverage to Part-Time Workers and/or Supporting Initiatives to Ensure Full-Time Work.

Many long-term care workers, particularly direct service workers, do not qualify for health insurance benefits because they work part-time or irregular hours, particularly those in home care. A third of workers reported working less than 32 or more hours per week for the employer who gave them the survey. Potential strategies for expanding coverage to part-time workers include:

- **Ensure full-time work—** Of the 33 percent of workers who indicated they do not have private health insurance, 33 percent said they would try to work at least 32 hours if that would qualify them for coverage. Another 47 percent said they already work 32 or more hours. This suggests that ensuring full-time work could be a promising strategy for Minnesota to encourage. For example, Cooperative Home Care Associations (CHCA) in New York has developed a guaranteed hours program that blends regular hours with replacement hours worked and "on-call" hours not actually worked.[113] The program guarantees participants 30 hours of paid work a week. In addition, ensuring guaranteed continuous eligibility for 12 months would significantly reduce the administrative burden on the state caused by workers churning in and out of employer and public coverage.[114]

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[112] PHI and IFAS, State Wage Pass-Through Legislation: An Analysis," Workforce Strategies No. 1April 2003. http://www.directcareclearinghouse.org/download/WorkforceStrategies1.pdf.

[113] PHI, The Guaranteed Hours Program, Workforce Strategies No. 4, http://www.directcareclearinghouse.org/download/WorkforceStrategiesNo4.pdf

[114] This has been a significant issue in New York State. See Berliner, H.S. *Home Care Workers Health Insurance Demonstration Project: Final Evaluation*, June 28, 2004.

- **Design the premium structure to ensure part-time workers are eligible for the full employer contribution—** Under the Minnesota Advantage plan, employees receive the full employer contribution to premium if they work more than 30 hours a week, partial contribution (50% or 75%) if they work 20 to 29 hours, and no contribution if they work less than 20 hours (***Table 5.3***).[115]

Table 5.3: Monthly Employee Contributions to Premiums for Minnesota State Employees' Plan[116]

Monthly Rate	Employee Coverage	Dependent Coverage	Family Coverage
Full Employer Contribution	$0	$130.20	$130.20
75% Employer Contribution	$111.82	$314.66	$426.48
50% Employer Contribution	$223.64	$499.12	$722.76
0% Employer Contribution	$447.28	$868.06	$1,315.34

Similarly, Cooperative Home Care Associates in New York addressed this issue by paying all of the premium costs for full-time staff and a prorated share for part-time employees.[117]

However, based on the results of the worker survey, few workers would be able to afford premiums of over $100 a month for insurance, so it is unlikely that many part-time employees would enroll unless the cost of premiums were fully subsidized or very low.

- **Create an alternative plan for those workers who are working part-time for multiple employers and not eligible for any single employer—** In the worker survey, 15 percent of respondents indicated they work 32 or more hours a week through more than one part-time job. This suggests that another strategy for Minnesota may be to develop a way to count workers as full-time if they work a total of 32 hours through multiple part-time long-term care jobs.

[115] Email from Beth Arntson, Workforce Planning Consultant, Minnesota Department of Human Services, June 19, 2009.

[116] "2009 Rate Guide for Health, Dental, Life, and Disability Insurance - State Employee Group Insurance Program," http://www.mmb.state.mn.us/doc/ins/adv-ee/ee-rates.pdf

[117] Better Jobs Better Care, Health Insurance Coverage for Direct Care Workers: Riding Out the Storm, Issue Brief No. 3, March 2004.

In California, many public authorities set the minimum hours per month (e.g., 35 hours) to expand eligibility to more workers; New York City and Oregon require 80 hours per month.

v) Conduct Outreach Efforts to Increase Awareness of the Insurance Benefit and Encourage Participation

The experiences from Maine and Washington states' CMS grantees,[118] and most recently from New York's Family Heath Plus Buy-in,[119] stress the need for concerted outreach efforts. It will be important to ensure that long-term care workers are aware of the insurance benefit, the benefits of insurance and how it works, and how to enroll.

Minnesota might consider mechanisms to gain direct access to workers, either with the permission of their employers or independently through direct service worker associations or labor unions representing the direct service workforce.[120] Community organizations where many workers participate are another potential way to reach workers.

vi) Ensure that the Rate Increase Is Enough to Make Health Insurance Affordable for Employers.

For the initiative to have significant impact, the payment made would need to be of sufficient size to provide an incentive for employers to participate.[121] In Montana, several of the providers who did not participate said the reason was because the Medicaid rate increase was insufficient to cover the cost of an insurance plan that meets the state's criteria. [122]

As discussed above, **Maine** conducted outreach to encourage employers to provide DirigoChoice in which the state subsidized up to 40 percent of employees' premiums and employers paid 60 percent. Maine's experience illustrates the difficulty of subsidizing employees in the long-term care sector when the employers themselves have a hard time paying premiums, especially when they are funded primarily with public dollars.

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[118] PHI, CMS Direct Service Workforce Demonstration Grants: Overview and Discussion of Health Coverage Interventions, 2006.

[119] PHI, Coverage Models from the States, 2007.

[120] PHI, Emerging Strategies for Providing Health Coverage to the Frontline Workforce in Long-Term Care: Lessons from the CMS Direct Service Community Workforce Grants, January 2007.

[121] Minnesota Department of Health, 2002.

[122] Montana Department of Public Health and Human Services, "Health Care for Direct Care Workers Application 1 Report." http://www.dphhs.mt.gov/sltc/services/communityservices/HCWorkers/Application1Summary.pdf

vii) To Ensure Sustainability Over Time, Build in Mechanisms to Ensure that Funding Keeps Pace with Escalating Health Insurance Costs.

Due to lack of a steady financing source, several of the long-term care worker health insurance initiatives undertaken by other states were short-lived demonstration programs that were unsustainable when the grant period ended. In some cases, rising health care costs led employers to increase costs or reduce benefits for employees.

To be sustainable, the Minnesota initiative should build in mechanisms to ensure that funding keeps pace with escalating health insurance costs.

C) Conclusion

In conclusion, implementing the proposed rate increase for health insurance in Minnesota will require careful planning and investment. However, given the growing need for a strong, stable workforce to support Minnesota's growing population of older persons and people with disabilities, the link between health coverage and retention, and the importance of a stable qualified workforce to quality of care, we believe that the results of undertaking this endeavor will be well worth it.