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85TH LEGISLATIVE SESSION
THE LEGISLATIVE
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ACCESS

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Health Care Access Commission Working Group Recommendation

Working Group Name: Health Care for Long-Term Care Workers

Working Group Recommendation: That the Legislature provide a rate increase to long-term care employers that would be dedicated to the purchase of employee health insurance in the private market.

Problem Issue:

Problem: The long-term care industry has three features that generally result in reduced health care coverage. First, many workers are relatively low-paid and are simply unable to afford coverage when it is offered. Many workers are part-timers, often not working enough hours to meet minimum qualifications for coverage. Finally, the industry is subject to high turnover, so at any one time a large percentage of employees are in the waiting period prior to qualifying for coverage.

The Work Group looked at a variety of data sources in an effort to quantify the extent of the problem. A 2002 report from the Minnesota Department of Health (MDH), entitled “Employer-Sponsored Health Insurance in the Minnesota Long-Term Care Industry” concluded that, while a large percentage of long-term care employees work for employers that offer health insurance benefits, a relatively small percentage of employees take advantage of this benefit. The study found that 81 percent of long-term care employers (that employ 94 percent of the workers in the industry) offer health insurance benefits. Comparative data from 1997 for all private industries indicated that 51 percent of employers (employing 87 percent of workers) offered insurance benefits.

But the data regarding actual insurance coverage reveal that the percentage of long-term care workers actually insured through employment is much lower than in private industry as a whole. According to the MDH study, 68 percent of eligible long-term care employees were enrolled (the take-up rate) and only 36 percent of all employees were covered (the coverage rate). For all of private industry, the take-up rate was 88 percent and the coverage rate was 62 percent. A non-scientific survey of long-term care employers conducted in September by the Work Group arrived at similar conclusions. It found that while 88 percent of employers responding to the survey offered health insurance benefits, the take up rate was only 47 percent and the coverage rate was just 25 percent.

One question not answered by the MDH study and the Work Group is how many long-term care workers actually are uninsured, regardless of where their coverage comes from. Holly Rodin, a senior field researcher at SEIU Local 113, provided to the Work Group an analysis of that issue. She analyzed Minnesota data from the

Current Population Survey (CPS) for 2006 and 2007. She found more similarities between long-term care employees and the rest of the work force than did the MDH study and the Work Group survey.

She concluded that 49.9 percent of long-term care workers received health insurance coverage from their employers, compared to 49.8 percent of other Minnesota workers. In addition, 41.1 percent of long-term workers received coverage from other sources (privately purchased coverage, group coverage as a dependent on another policy, or public programs), leaving 9 percent uninsured. Of other Minnesota workers, 39.4 percent were covered through other means, and 10.8 percent were uninsured.

Ms. Rodin did find substantial differences in coverage between long-term care management employees and other long-term care workers. Of management employees, 72.3 percent got coverage through their employer; none had privately purchased plans; 23.6 percent were dependents on another group plan; 6.1 percent were on a public program; and 0 percent were uninsured. Among non-management employees, 46.6 percent were insured through their employer; 5.3 percent had privately purchased coverage; 21.4 percent were dependents on another group plan; 16.2 percent received public program benefits; and 10.5 percent were uninsured.

Given the different data sources and different time frames, it is difficult to reconcile all of this data. It is clear that a significant percentage of long-term care workers are uninsured, and that the realities of the industry – low pay, the prevalence of part time work, and high turnover – make it unlikely that the remaining uninsured long-term care workers will be able to obtain employer-based coverage without some sort of state intervention.

Past Efforts at Solutions: Recent cost-of-living rate increases for long-term care employers have attempted to address this problem by requiring that a substantial percentage of these rate increases be spent on employee wages and benefits, including health care benefits. However, given the rapid increase in health care costs in recent years, it does not appear that this approach has done anything beyond helping employers pay ever-increasing health insurance premiums. It is doubtful that any money has been available through this mechanism to allow employers to improve coverage plans or expand coverage to more employees.

Legislation has also been introduced in recent years to address this problem by expanding MinnesotaCare eligibility for long-term care workers. This legislation has not been adopted.

Recommendation:

That the Legislature provide a rate increase to long-term care employers that would be dedicated to the purchase of employee health insurance in the private market. The majority of these rate increases would be paid by the Medical Assistance (MA) program. One-half of the MA payments would be paid by the federal government.

To qualify for reimbursement the insurance product would have to meet minimum criteria to be established in law. The Work Group discussed three options for a minimum level insurance product. The three options are:

(1) The benefit package provided to state employees. Employee coverage currently costs \$432.16 per month, or \$5,185.92 per year. Dependent coverage is \$838.70 monthly, or \$10,064.40 annually. The annual cost for employee and dependent coverage is \$15,250.32.

(2) The benefits provided to MinnesotaCare enrollees. These benefits currently cost \$350 per person per month, or \$4,200 per person per year. One shortcoming of this benefit package is the \$10,000 limit on hospital coverage for some adult enrollees.

(3) The benefits provided under an “average” private market health insurance product, but with a deductible limited to \$100 per person. The Commerce Department roughly estimated the costs of an average small group medical premium at \$300 to \$400 per person per month in 2006, ranging from a low of \$200 per month for a child up to \$750 per month for a person aged 60 or older. Limiting the deductible to \$100 would increase premiums by about 10 percent, and a rate increase of about 10 percent annually needs to be factored into these numbers, according to the department. An average plan might include a deductible of \$300 per person and \$900 per family, an out-of-pocket maximum of \$2,500 per person, and full coverage of most in-network services, with copayments for emergency room outpatient care and prescription drugs.

Premium cost sharing, waiting periods for eligibility, and other parameters under the three options would be identical to those under the state employees’ health plan. Full-time employees would pay zero percent of the individual premium and 15 percent of the dependent premium. Part-time employees would pay a higher percentage of premiums on a sliding fee scale according to the number of hours worked. Part-time employees would need to work at least 32 hours per pay period to be eligible for insurance benefits. The waiting period for new employees to qualify for coverage would be 35 days.

The Work Group also discussed incremental steps that should be considered if the lack of funding or other impediments prevent the adoption of this recommendation. The incremental steps include:

(1) a targeted but limited rate increase that would assist long term care employers with health insurance issues but would not be a broad solution to the problem. This rate increase could be modeled after the employee scholarship rate, which provided an upfront per diem payment to employers for scholarship costs for two years and now determines scholarship per diem payments based on actual facility expenditures;

(2) an expansion of the MinnesotaCare program to include more long-term care workers by enacting an industry-specific exemption from some of the program’s eligibility barriers, including the provision making an employee ineligible for MinnesotaCare if the employer contributes half or more of the cost of employer-sponsored health insurance; or

(3) an appropriation for a detailed fiscal note on the Work Group’s recommendation. Late in the Work Group process the Department of Human Services informed the Work Group that it could not complete a fiscal note on the recommendation because it needed specific data on the number of fulltime and parttime workers; their claim patterns and histories; the current levels of employer investment in health insurance; and a specific identification of which employers would be included. If this information cannot be obtained by DHS without an additional appropriation for needed analysis and data collection, this interim recommendation would ensure that in future years very specific data would be available on which to base a broad initiative to ensure long-term care workers.

Background Information Regarding Work Group Process

The charge to this work group was very specific: to utilize Medical Assistance funds to provide health insurance for long-term care workers. The Work Group quickly settled on approaching this objective through a provider rate increase dedicated to health insurance costs as the most effective way to leverage federal money to offset the proposal’s total costs.

The Work Group realizes that a variety of issues remain to be resolved before this proposal is enacted. One thorny issue stems from the fact that employers currently make widely different investments in health insurance versus other facility needs. Some have chosen to emphasize health coverage and hold down wages as a result. Others offer reduced health care benefits in order to provide better wages. Legislation will need to wrestle with the issue of fair treatment of providers who have made different prior decisions on this issue.

A larger issue, one hopefully being addressed in other work groups, is how to hold down the overall growth of insurance costs. A related issue, also not addressed by the work group, is whether a pooling mechanism of some sort would reduce premium growth rates in this industry, which is subject to higher rates, estimated by some industry representatives at 20 percent above average, possibly due to the preponderance of employees who are women of child-bearing age.