UNHEALTHY STATE:
Health Care Costs Put Connecticut's Private Providers, Caregivers and Services at Risk

Report presented to

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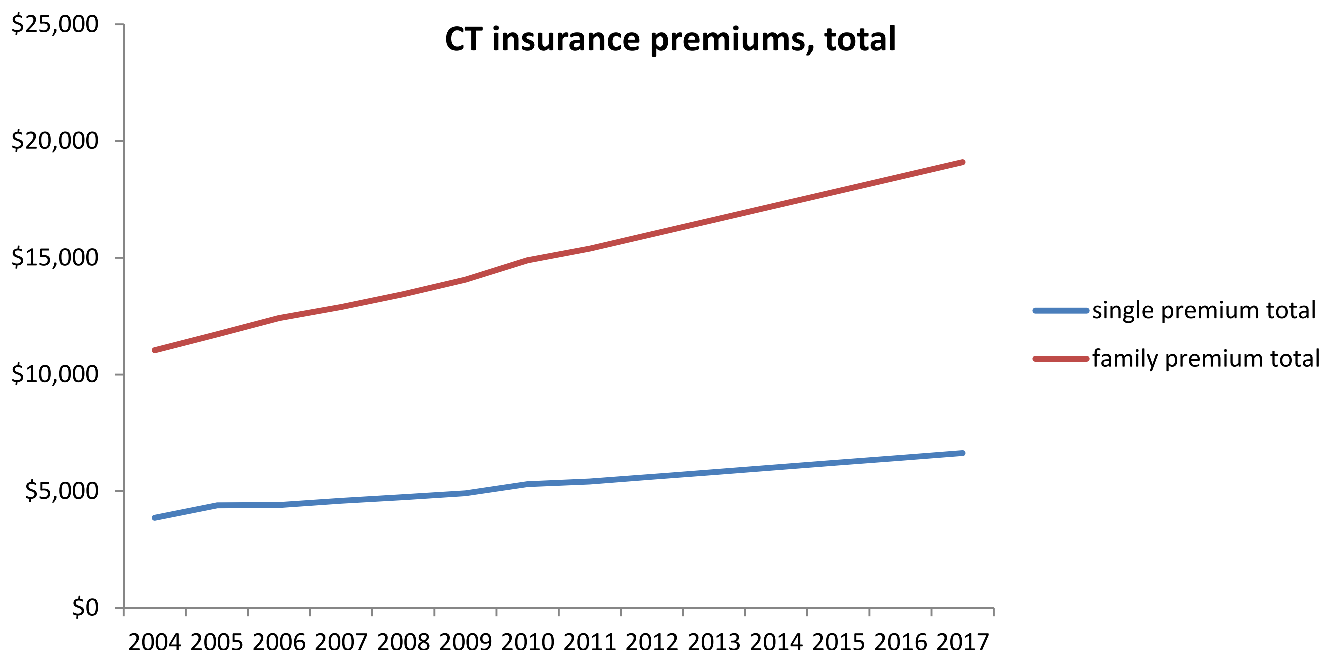
Introduction

Most clients of Connecticut's Department of Developmental Services (DDS) are cared for by hard working direct care staff providing high quality care in private group homes operated by non-profit provider agencies. However, state resources to support that care have not kept pace with the need. Among other problems, this chronic under-funding has eroded the ability of private agencies to provide adequate wages and health benefits for workers. With inadequate wages and unaffordable benefits, those workers may be forced into Connecticut's Medicaid program, providing less access to care for DDS client caregivers and adding to swelling Medicaid caseloads for the state budget.

The same pressures and trends apply to all not-for-profit agencies providing care for, and funded by, the Departments of Mental Health and Addictions Services (DMHAS) and Children and Families (DCF) in addition to those serving DDS clients. All have received 0 to 1% increases over the last two decades. At the same time, their costs, including health benefits, have skyrocketed. However, DDS group homes are at special risk from flat state funding as they are almost completely dependent on state funding.

Health costs are rising across Connecticut

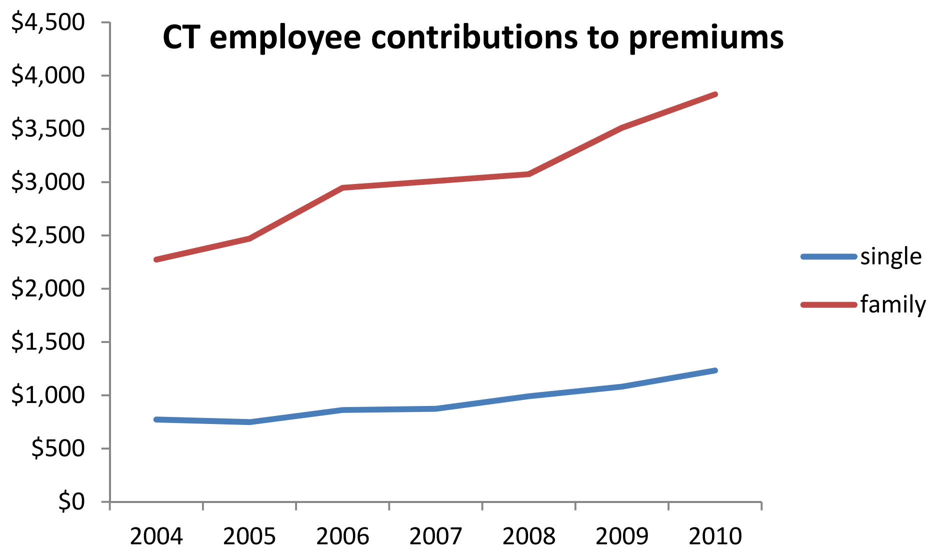
As across the rest of the United States, health care costs have increased for all Connecticut employers, and that trend is expected to continue in the near future.



Source: MEPS, AHRQ, US Dept. Health and Human Services, to 2010 actual, projected 2011 and beyond

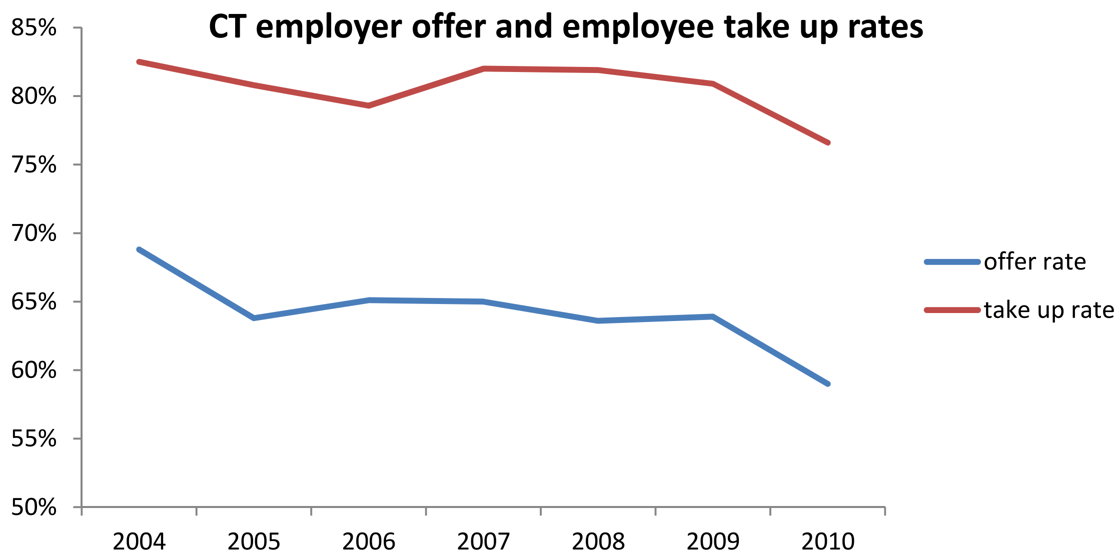
As costs rose between 2004 and 2010, the percent of Connecticut employers offering health benefits to workers dropped by 10% while the percent of employees who qualify for insurance benefits also dropped sharply

Responding to increasing premiums, Connecticut employers have shifted more costs onto workers. Employee health premium contributions rose 60% on average for single coverage and 68% for family coverage from 2004 to 2010. Over those years, copayments for office visits increased 32% and deductibles for both single and family coverage more than doubled.[i]



Source: MEPS, AHRQ, US Dept. Health and Human Services

As costs rise, the percent of Connecticut employers offering health benefits to workers has dropped by 10% from 2004 to 2010. And as costs rise, the percent of employees lucky enough to qualify for health insurance benefits who elect coverage is also dropping sharply.[ii]



Source: MEPS, AHRQ, US Dept. Health and Human Services

As costs rise, coverage drops

Not surprisingly these trends have increased the number of uninsured in Connecticut significantly. One in ten Connecticut residents lacks health coverage; that is more than the combined populations of Hartford, New Britain and Stamford. Also not surprisingly, being uninsured can be harmful to health. Connecticut's uninsured are ten times less likely to get care for an injury and seven times less likely to get care for a medical emergency. In a national study, uninsured car accident victims were 37% more likely to die of their injuries than victims with insurance, receiving 20% less care including fewer X-rays, medications and shorter hospital stays. Twelve percent of uninsured hospital stays in Connecticut could have been avoided with early treatment. Uninsured patients are less likely to get on-going care to manage chronic diseases. It is estimated that every week three Connecticut residents die because they lack health insurance.[iii]

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Lack of insurance impacts Connecticut's economy

Lack of insurance also impacts Connecticut's economy – both the financial health of people without coverage and our entire state economy. Nationally, 62% of bankruptcies are due to medical bills.[iv] In 2010 uncompensated care delivered at Connecticut hospitals totaled over $637 million and there were 8,295 uninsured patient discharges.[v] There is good evidence that lack of health coverage impacts worker productivity. Workers with limited access to health care are more likely to miss work and have difficulty concentrating at their job. Employers that offer health benefits report that it fosters a more satisfied and more

productive work force. Employers report that workers without coverage are more likely to be distracted on the job and unable to pay full attention to their duties due to health problems.[vi]

Health care pressures on DDS private providers and workers

Private DDS group home employers in Connecticut and their workers have encountered the same skyrocketing health costs as the rest of the state's economy. They are also squeezed by stagnant wages and flat state funding levels since 2007. As one group home manager stated, "We are just treading water financially."[vii]

Connecticut's 800 private DDS group homes provide care to over 3,000 DDS clients, or about three out of every four clients. Private group homes care for the majority of DDS clients at every level of need, including those with the greatest needs. Clients with the highest level of need are five times more likely to be living in a unionized private group home. Privately run group homes provide high quality care to clients, getting significantly fewer deficiencies cited in licensure site visits over the last fifteen years. Unionized group homes had even fewer deficiencies than other private group homes. [viii]

Because of flat state funding over the last twenty years, many private group homes are operating at a loss.[ix] Recent proposals to change private group home rate setting methodology and stricter federal reimbursement requirements will place further pressures on private group home budgets.[x]

The large majority of direct care workers in DDS group homes work part time and, as for other Connecticut workers, are generally not eligible for health benefits. Many workers must work multiple part time jobs, in addition to their employment at the group home, to make ends meet.[xi] Part time workers in private group homes are less likely to be eligible for health benefits than state-run group home workers. In addition, benefits offered to state-run home workers are more generous than those available to workers in private group homes. Benefits make up 30 percent of total compensation for workers in state-run homes compared to only 14 percent for private group home workers.[xii] Over 60 percent of nonprofit community-based providers report that they have reduced employee benefits and/or their employer contribution this year to save money.[xiii]

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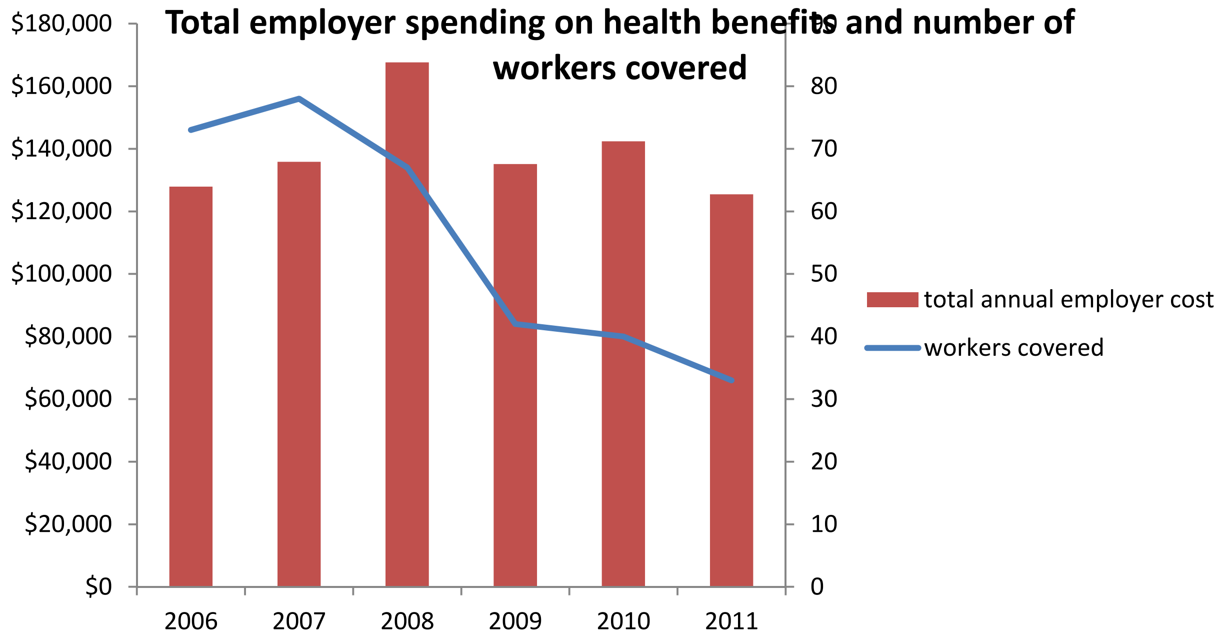
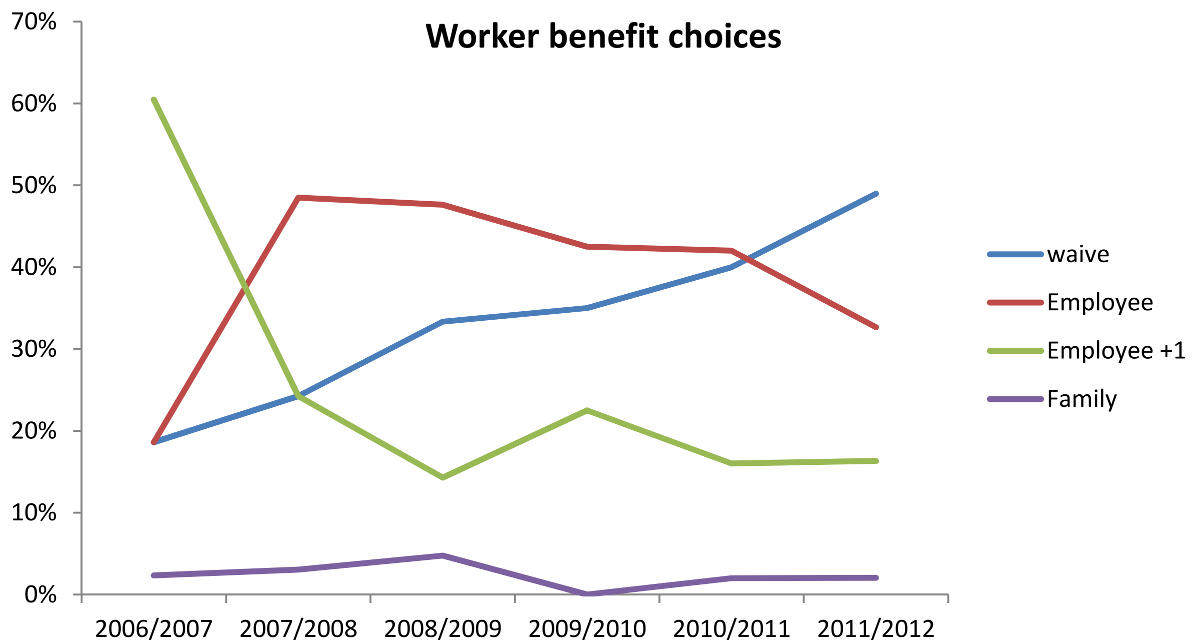
Premium costs and the number of workers at one private group home demonstrate the squeeze placed on private group homes. The graph on the next page compares total employer health benefit costs and the number of workers covered in one private group home. Over five years, employer costs are essentially unchanged, but that spending is covering about half as many workers' benefits.



Source: Employer survey, SEIU District 1199, 2012

As health costs have risen and employers have shifted more of those costs onto workers, benefit decision choices by workers in one private group home demonstrate the impact below. Family coverage, the most expensive, has always been low. Employee plus one person, the next most costly, dropped significantly as costs rose. Workers in these families may have shifted children onto Medicaid to reduce their costs. Employee only coverage varied, but the percentage of workers waiving coverage altogether rose significantly.



Source: Employer survey, SEIU District 1199, 2012

Financial pressures on group homes affect quality

Evidence shows that, despite flat funding, DDS private group homes provide quality care, with few deficiencies found at licensure site visits and maintaining staff to client ratios. But further reductions in funding are likely to have a powerful negative impact. Wages at unionized group homes are higher than non-union homes, and quality is higher including fewer deficiencies found at licensure site visits than for non-union homes. Unionized group homes also care for clients with disproportionately higher needs.[xiv]

The transition of DDS group homes from the non-union Care Focus agency to unionized employers provides an example of the impact of lowered funding. Several years ago, to save money, DDS put the operation of several group homes out to bid. The homes cared for clients with relatively high needs. Care Focus, a West Virginia company, had the lowest bid and was awarded the contract. Just a short time after, in response to concerns raised by DDS case managers, the state transferred control of the homes to an accounting firm. A few months later, the homes were transferred to unionized groups in Connecticut operating other DDS group homes.

Managers reported serious institutional neglect of clients and the homes at the time of the transition and that the quality of care delivered to the residents under Care Focus was "deplorable." Direct care staff hired by Care Focus received no training, were paid minimum wage, and received no benefits – health benefits or sick days. Most of the Care Focus staff had to be replaced. Residents were underfed -- frozen pizzas were a regular meal. Physically frail residents received no regular medical care; only receiving care in hospital emergency rooms during a crisis. Residents were engaged in no activities. The home and grounds were not maintained, leading to a flash flood at one home just days after the transition. A manager at one home stated that if Care Focus were in place another three months, three of the six residents would have died.[xv]

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Thankfully the transition from Care Focus back to unionized, quality care providers allowed all residents to return to health. Current plans by DDS to lower payments to private group homes will likely impact the quality of care delivered to clients.

Lower wages for private group home workers qualify many for state Medicaid coverage

Because flat state funding depresses direct care worker wages, there are reports that private DSS group home direct care workers qualify for public Medicaid coverage and have enrolled in response to rising costs of coverage from their employer.[xvi] Wages for direct care workers at private group homes average $15.53.[xvii] Below we have calculated average monthly and annual salaries for full-time workers at private group homes, in comparison to

average monthly premiums for health benefits and federal poverty levels (FPL) for varying family sizes. Families with incomes below 185% of FPL qualify for Connecticut's Medicaid program, HUSKY Part A. Above those income levels, children can qualify for subsidized premiums through the state's CHIP program, HUSKY Part B. We have used two standards for reasonable proportions of income devoted to health costs – the federal Patient Protection and Affordable Care Act exempts people from the 2014 individual mandate to purchase health care if the cost of care is more than 9.5% of income, and the federal CHIP program (HUSKY Part B in CT) limits premiums and cost sharing for health care to 5% of income. [xviii]

An important caveat in these calculations is that the examples assume full time employment at the group home. Very few direct care workers at private group homes work full time -- 35 or more hours per week. Part time workers are generally not eligible for health benefits at work[xix], even if they could afford them.

The annual income for the workers meets the 2008 CT self-sufficiency standard to live without government assistance ***only for a single adult living alone****; it is well below the standards for more than one adult or an adult with a child*

As shown below, full time workers at the average direct worker pay rate should be able to afford the employee's share of single plans to cover just the worker but not for a family at the 9.5% affordability level; they can afford neither the single or family plans according to the CHIP standard. Employees living with a child working full time at this rate would qualify for HUSKY Part B subsidized coverage. Workers in larger families would qualify for full Medicaid/HUSKY Part A coverage at no cost. It is important to note that the annual income for the workers described below meets the 2008 Connecticut self-sufficiency standard to live without government assistance only for a single adult living alone; it is well below the standards for more than one adult or an adult with a child.[xx] Part time workers, including most at DDS private group homes, would be below even these income levels.

Average hourly wage[xxi]	$15.53	CT average monthly premiums[xxii]		
Monthly if full time	$2,671.16	Total premium	Employee share	
5% of income[xxiii]	$133.56	$468	$111	Single coverage
9.5% of income[xxiv]	$253.76	$1,334	$298	Family coverage
Annual income if full time	$31,060.00			
Family of 1[xxv]	278% FPL	Not eligible for Medicaid coverage[xxvi]		
Family of 2	205% FPL	Children in these eligible for HUSKY Part B subsidies		
Family of 3	163% FPL	All family members eligible for Medicaid, at no cost		
Family of 4	135% FPL	All family members eligible for Medicaid, at no cost		

We also considered specific examples of direct service pay rates and health benefit costs at four private group homes. Due to high turnover rates, we used new hire hourly wages for these calculations and full medical and dental benefit costs, when available. Again, the calculations assume full time employment, which is required for health benefit eligibility, but most workers are not full time employees. Blue cells indicate premiums over federal affordability standards. Yellow cells indicate families eligible for Medicaid at no cost. A large number of the workers eligible for health benefits at these private group homes are faced with choosing between unaffordable premiums for private coverage and free coverage through the state's Medicaid program.

	Home A	Home B	Home C	Home D
Hourly wage[xxvii]	$14.70	$13.42	$12.22	$12.78
Monthly total if full time	$2,528.24	$2,308.24	$2,101.84	$2,198.16
Health premium – single plan	$360.84	$119.85	$184.74	$164.43
% of income	14.27%	5.19%	8.79%	7.48%
Premium – family plan	NA	$527.26	$643.24	$313.67
% income		22.84%	30.60%	14.27%
Annual income if full time	$29,400	$26,840	$24,440	$25,560
Family of 1	263% FPL	240% FPL	219% FPL	229% FPL
Family of 2	194% FPL	177% FPL	162% FPL	169% FPL
Family of 3	154% FPL	141% FPL	128% FPL	134% FPL
Family of 4	128% FPL	116% FPL	106% FPL	111% FPL

CT's Medicaid program struggles to provide care and is overwhelmed by currently eligible members

Many private home workers and their families are likely turning to Medicaid as an affordable option for health coverage. However accessing care in Connecticut's Medicaid program is far more difficult than in employer-sponsored plans. Only about half of Connecticut physicians accept Medicaid, a lower rate than our surrounding states and well below the rate of states with lower provider payment rates. Delays in paying Medicaid claims are twice those for commercial insurance and physicians are often more willing to accept uninsured, self-pay patients than Medicaid members.[xxviii] It is also very difficult to get an appointment with participating providers. A 2006 secret shopper survey found they could only get appointments with one in four providers.[xxix]

Connecticut Medicaid patients are five times more likely to visit an Emergency Department (ED) than state residents with employer coverage and twelve times more likely to have an ED visit that did not result in hospitalization, and may have been for care that should have been provided in an office if an appointment was available.[xxx] As evidence that access to care is getting worse, Medicaid patients account for the overwhelming majority of the 3%

annual growth in ED use in CT in the last five years.[xxxi] Only 57% of children covered by Connecticut Medicaid received a well-child exam in 2008.[xxxii]

Even enrolling in Connecticut's Medicaid program can be a struggle; DSS is currently being sued on behalf of clients for significant enrollment delays. [xxxiii]Connecticut's Medicaid caseload has averaged annual increases of 5.9% over the last decade and is expecting 140,000 new members to become eligible in 2014 under the Patient Protection and Affordable Care Act.[xxxiv] Medicaid consumes 22% of the state budget and is growing.[xxxv] Important improvements are being planned and implemented to improve enrollment, access to care and provider participation, but there is a very large gap between the level of care for group home workers and their families in Medicaid and in their employer-sponsored plan.

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Summary

It is clear that because of flat funding from the state, DDS private group homes are struggling to provide livable wages and affordable health premiums to their workers. The resulting lower wages ensure that workers qualify for state Medicaid coverage. It is likely that many workers, both those eligible for benefits and those who are not, are forced to enroll in Medicaid for their medical care increasing stress on that program and increasing state costs. Medicaid coverage provides less access to care than private coverage, potentially compromising worker productivity and the quality of care provided to DDS clients. The unfortunate results of state flat funding of private group homes are low wages and increased Medicaid rolls.

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[ii] ibid
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[iv] D.Himmelstein, et. al., Medical Bankruptcy in the United States, 2007: Results of a National Study, American Journal of Medicine, August 2009
[v] Financial Status of CT'S Short Term Acute Care Hospitals for Fiscal Year 2010, OHCA, DPH, September 2011
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[vii] Provision of Selected Services for Clients with Intellectual Disabilities, CT Legislative Program Review and Investigations Committee, September 27 and December 20, 2011; Communication with group home administration
[viii] Ibid
[ix] Ibid
[x] Ibid, DDS Working Group document, January 2012
[xi] Communication, SEIU District 1199

[xii] PRI reports and MEPS, AHRQ, US HHS
[xiii] December 2011 survey, CT Community Providers Association, CT Association of Nonprofits
[xiv] PRI reports
[xv] Communication with DDS private group home administration
[xvi] PRI report December 20, 2011; reports from DDS group home administrators
[xvii] Ibid
[xviii] HUSKY/Medicaid eligibility guidelines, DSS
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[xx] The Self-Sufficiency Standard for CT: How Much Income do Families Require in Order to Live Without Assistance?, Wider Opportunities for Women and the CT Permanent Commission on the Status of Women, December 2008.
[xxi] ibid
[xxii] MEPS, AHRQ, HHS, trended to 2012
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