



# TOWARD ENSURING A HEALTHY AND ROBUST WORKFORCE

*Insights into the New York State*

*Office of Mental Retardation and*

*Developmental Disabilities'*

*Health Care Enhancement Program*

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## EXECUTIVE SUMMARY

This report presents the findings of the New York State Association of Community and Residential Agencies' (NYSACRA) review of the New York State Office of Mental Retardation and Developmental Disabilities' (NYS-OMRDD) Health Care Enhancement (HCE) program. The review, funded through a grant from The City University of New York, John F. Kennedy, Jr. Institute for Worker Education, included a survey of NYSACRA member agencies. Focus groups with direct support professionals and senior agency administrators were also conducted. *(See report pages 5-7.)*

The HCE program was initiated by NYS-OMRDD as a means of enhancing health care related benefits for staff of not-for-profit agencies, particularly direct support professionals. In the face of escalating health care costs, the program was intended to lessen employee out-of-pocket health care expenditures and/or to enhance the quality of health services available to them. By doing so, it was also intended to assist in staff retention and recruitment matters. As a budget initiative of State Fiscal Year 2005-06, the program was continued in different phases in subsequent fiscal years. *(See report pages 8-12.)*

NYSACRA's review affirmed the value of the HCE program as a means of defraying staff's out-of-pocket health care costs, thus allowing them to retain more take-home pay; enhancing the range and quality of health services available to them; and promoting staff morale and, related, staff retention – objectives articulated by NYS-OMRDD when the program started. *(See report pages 13-19.)*

Over time, however, health care costs continued to rise; certain employees continued not to have health insurance coverage; and the evolving HCE initiative became more complex for agencies to administer, as each phase had its own unique rules with which agencies had to comply and account for. Some of these complexities dissuaded some agencies from participating. *(See report pages 19-22.)*

Agencies participating in NYSACRA's review offered suggestions on how the HCE initiative could be made simpler and more flexible, including combining the different phases into one program with fewer restrictions on use, and synchronizing application timeframes with agencies' planning and budget cycles. NYS-OMRDD, which should be lauded as the only New

York State agency to have launched such an initiative, should consider these suggestions, particularly as health care costs continue to rise and not all employees have health insurance. *(See report pages 22-23.)*

More importantly, New York State should consider ways of replicating NYS-OMRDD's HCE initiative to assist other human service agencies in their efforts to maintain a stable, healthy workforce. All human service agencies struggle to recruit and retain caring and competent workers, particularly direct support professionals. Yet, the ever increasing cost of providing employee health benefits is jeopardizing their ability to do so, or to do so in a way that does not erode employees' take home pay or their basic benefits. Some agencies supporting individuals with developmental disabilities opted not to partake in the NYS-OMRDD's HCE program because they could not offer its benefits to all their human service workers. Many more agencies, outside of the NYS-OMRDD service system, have no similar program to assist them in maintaining a vital workforce. *(See report pages 24-25.)*

Continuing and replicating NYS-OMRDD's Health Care Enhancement program, particularly in an era of dramatically increasing health care costs, would be a step toward ensuring that all New Yorkers receive the supports they need, by virtue of age or disability, to live successfully in the community.

## OVERVIEW

### INTRODUCTION

Supporting individuals with disabilities to enable them to live life to its fullest is contingent upon recruiting and retaining a competent and caring frontline workforce. The literature, however, is replete with discussions of factors that undermine efforts to maintain such a workforce today (*see Appendix A, Selected Bibliography*).

Changing demographics that are shifting the supply/demand ratio of support providers and those needing supports as baby-boomers age; inadequate salaries that fail to provide a living wage, particularly for direct support professionals; and spiraling employee health insurance costs that directly or indirectly erode workers' compensation, are converging to create a perfect storm that threatens systems of supports and services upon which so many depend. No system of human services is immune from that threat.

In New York, the New York State Office of Mental Retardation and Developmental Disabilities (NYS-OMRDD) supports over 140,000 individuals with developmental disabilities living in the community. Much of that support is provided by approximately 700 not-for-profit agencies certified or funded by NYS-OMRDD. These agencies employ over 65,000 direct support professionals<sup>1</sup> who, on an average hourly basis, earn approximately 46% less than their 22,000 counterparts in NYS-OMRDD operated programs.<sup>2</sup> As part of its ongoing efforts to address workforce issues, in 2005, NYS-OMRDD launched a Health Care Enhancement program.<sup>3</sup>

Across the nation, escalating health care costs have eaten away at workers' salaries and Americans are delaying medical care. In the Introduction to *Too Great a Burden: Americans Face Rising Health Care Costs*, Families USA reports that nearly 25% of individuals under the age of 65 will spend more than 10%

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<sup>1</sup> New York State Office of Mental Health, New York State Office of Mental Retardation and Developmental Disabilities, and New York State Office of Alcoholism and Substance Abuse Services. 2009, January. *Review of Work Hours and Schedules of Direct Care Staff in New York State*. Albany, NY. Page 8.

<sup>2</sup> American Network of Community Options and Resources. *2008 Direct Support Professional Wage Study*. Page 4. Retrieved July 13, 2009, from: [http://www.ancor.org/issues/shortage/ancor\\_wage\\_data\\_summary\\_2008.pdf](http://www.ancor.org/issues/shortage/ancor_wage_data_summary_2008.pdf).

<sup>3</sup> NYS-OMRDD has long recognized that the success of its efforts to support individuals with developmental disabilities hinges on its workforce. Historically, it has endeavored to bolster the workforce by, among other things, enhancing compensation through periodic reimbursement rate or cost of living adjustments, creating recognition programs such as *Everyday Heroes*, improving and making training more accessible and cost-effective, and creating an online Job Bank system. Most recently, NYS-OMRDD released \$2.5 million in demonstration grant funds to explore various approaches to training, mentoring and recruiting direct support professionals, and improving service agency cultures. It also created a Deputy Commissioner-level Division of Workforce and Talent Management.

of their family income on health care in 2009.<sup>4</sup> The Kaiser Family Foundation reports that a majority (59%) of Americans say that they or someone in their household have put off health care for cost reasons in the past year.<sup>5</sup>

NYS-OMRDD's Health Care Enhancement program was intended to promote the health of workers supporting individuals with developmental disabilities by providing funding to defray their costs for health care services and/or to augment the array of employee health care benefits offered by not-for-profit agencies.

In December 2008, the New York State Association of Community and Residential Agencies (NYSACRA) received a grant from The City University of New York, John F. Kennedy, Jr. Institute for Worker Education to examine the impact of NYS-OMRDD's Health Care Enhancement (HCE) program.

As an association of 200 member agencies serving individuals with developmental disabilities statewide, and dedicated to advocating on behalf of those individuals and the men, women, and organizations that support them, NYSACRA is intimately familiar with workforce issues, having identified workforce matters as one of its strategic priorities in the mid 1990s. Among its other workforce related projects, NYSACRA had previously partnered with The City University of New York and NYS-OMRDD in 2004 on a study of health care coverage for workers in the field of developmental disabilities.<sup>6</sup>

## **METHODOLOGY**

In conducting its review, NYSACRA sought to determine: the number of agencies that had participated in the HCE initiative and how they augmented employee health care benefits with HCE funding; the perspectives of agency administrators on the utility of the program, as well as the perspectives of employees who had received additional benefits through the HCE program; why agencies

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<sup>4</sup> Families USA. 2009, April. *Too Great a Burden: Americans Face Rising Health Care Costs*. Washington, D.C. Retrieved June 1, 2009, from: <http://www.familiesusa.org/assets/pdfs/too-great-a-burden-2009.pdf>.

<sup>5</sup> The Henry J. Kaiser Family Foundation. 2009, April. Many Americans still delaying care, struggling to pay medical bills. *Kaiser Health Tracking Poll*. Retrieved June 1, 2009, from: <http://www.kff.org/kaiserpolls/upload/7891.pdf>

<sup>6</sup> Ebenstein, W. 2004, October. *Exploring opportunities to expand health coverage for low-wage workers in the developmental disabilities field in New York State*. New York: The City University of New York, John F. Kennedy, Jr. Institute for Worker Education. Retrieved April 27, 2009, from: [http://www.nysacra.org/downloads/Health\\_Insurance\\_Briefing.pdf](http://www.nysacra.org/downloads/Health_Insurance_Briefing.pdf)

chose not to participate in the HCE program; and how the HCE program might be improved in the future.

Toward these ends, NYSACRA:

- Created an advisory panel, consisting of representatives from CUNY, NYS-OMRDD, a major provider association, and service provider agencies, to guide it in its work from study protocol development through analysis of findings (*Appendix B, HCE Advisory Committee*);
- Secured data from NYS-OMRDD on the utilization of the HCE program;
- Conducted an electronic survey of NYSACRA member agencies concerning their participation in, experiences with, and suggestions on how to improve the HCE program (*Appendix C, HCE Program Survey Instrument*);
- Convened two focus groups of senior administrators – including executive directors, chief operating officers, human resources directors and other program directors – of 20 NYSACRA member agencies to obtain their perspectives on the HCE program;
- Conducted two focus groups involving 30 direct support professionals to discuss the HCE program from their vantage point; and
- Conducted telephone interviews with administrators from agencies that had not participated in the HCE program.

## **Health Care Enhancement Program: BACKGROUND**

In recognition of the tremendous increases in health care costs incurred by employers and their employees, NYS-OMRDD launched the HCE program as a budget initiative in State Fiscal Year 2005-06. With health care costs escalating at rates well above the rate of inflation and above increases in employee earnings, the program offered funding to not-for-profit agencies providing services on NYS-OMRDD's behalf so that those agencies could enhance health care related benefits for their NYS-OMRDD program employees, particularly their direct care and support employees. The program was intended to lessen employee out-of-pocket health care expenditures, thus allowing them to retain more take-home pay, and/or to enhance the quality of health care available to them. By doing so, it was also intended to assist agencies in staff retention and recruitment.

As described below, the initiative was continued in different phases in subsequent fiscal years, with HCE II commencing in SFY 2006-07, and HCE III beginning in SFY 2007-08. As of June 2009, NYS-OMRDD was developing implementation plans for phases IV and V of the Health Care Enhancement program.

### **THE INITIAL PHASE OF HCE**

In implementing the HCE program, in 2005, NYS-OMRDD surveyed its network of not-for-profit agencies to determine a benchmark of health care benefits the agencies offered their full-time and part-time employees – a benchmark which reportedly only a few agencies surpassed. In September 2005, those agencies below the benchmark were invited to apply for funding under the HCE program.<sup>7</sup>

This phase of the HCE initiative had two parts, each with different guidelines. Under Part I, effective January 1, 2006, providers could receive funding that would have been received for employee health related costs for the period April 1, 2004 through December 31, 2005 if the funding described below had been paid. Under Part II, funding was available to reimburse agencies for assistance with

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<sup>7</sup> The 12 provider agencies at or above the benchmark were entitled to three percent of their operating costs (for trended programs) in the rate in effect on December 31, 2005.

employee paid health care related costs and enhancing health benefits, beginning January 1, 2006. Agencies could apply for either or both Part I or Part II funding.<sup>8</sup>

Under Part I of the 2005 HCE initiative, agencies which had reported in the NYS-OMRDD survey that they provided health insurance to some or all of their employees would be eligible for an allocation of \$325 multiplied by the number of employees they intended to offer the enhancement to. The annual allocation of \$325 would be adjusted for the 21 month period, April, 2004 through December, 2005. If an agency opted not to offer this enhancement to certain employees reported in the NYS-OMRDD survey, the allocation would be adjusted accordingly.

These funds could only be used to directly reimburse employees for out-of-pocket health related expenses. It was also expected that direct care and support staff would be involved in deciding how this allocation would be spent.<sup>9</sup>

Part II of the 2005 initiative had two allocation methodologies:

- Agencies which had reported in the NYS-OMRDD survey that they did not offer employees health care benefits would be eligible for a total allocation of \$2,500 multiplied by the number of employees reported in the survey that they intended to offer the enhancement to. The funding was to be used to establish employee health care benefits or to reduce employee out-of-pocket health related expenses.
- Agencies which had reported offering health insurance coverage to some or all of their employees would be eligible for an allocation of \$325 multiplied by the number of employees reported in the NYS-OMRDD survey that they intended to offer the enhancement to.

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<sup>8</sup> In this and other phases of the HCE program, there were guidelines concerning the inclusion and exclusion of employees. HCE funding was intended to benefit employees working in NYS-OMRDD funded/certified programs. Some not-for-profit agencies operating NYS-OMRDD certified/funded programs also operate programs under the auspices of other state agencies, such as the Office of Mental Health or the State Education Department. HCE funding could not be used to benefit employees working in these non-NYS-OMRDD programs.

As funding was intended to benefit employees, particularly direct care and support staff, of all NYS-OMRDD programs, it was expected that an agency operating several different NYS-OMRDD programs (e.g., day programs, residential programs, etc.) would offer the benefits to employees of all such programs.

Agencies, however, could choose not to make HCE benefits available to all employees in NYS-OMRDD programs; but NYS-OMRDD's guidelines on this were weighted in favor of direct care and support staff. An agency, for example, could identify a salary level above which no employee would receive HCE benefits and below which all employees would, providing that direct care/support staff were included in the level receiving benefits. In such a case, the agency could redistribute HCE funding designated for staff above the identified salary level equally among staff below the level. An agency could also determine that only full-time, and no part-time, employees could receive HCE benefits. In that case, however, funding that would have been made available for part-time staff could not be redistributed among full-time workers.

<sup>9</sup> In its review, NYSACRA did not explore agencies' experiences with Part I of the initial HCE phase.

It was expected that agencies applying for Part II funding would consult with staff in determining how the funds would be used. NYS-OMRDD indicated that funding could be used for, but not limited to, one or more of the following:

1. new benefits for uninsured workers;
2. enhancements to existing benefits, e.g., adding dental or vision care;
3. reimbursing health benefit premiums and deductibles paid by employees;
4. reimbursing employee co-payments for covered services;
5. reimbursing employee payments for non-covered health related expenses;
6. reimbursing employee payments related to the use of a non-network provider; or
7. establishing Flexible Savings Accounts (FSA) to offset employee out-of-pocket health care related expenses. FSAs are one of several options that exist under Internal Revenue Code allowing employers to provide accounts that employees can use to pay for health care expenses not otherwise covered by a health plan. Other options include Health/Medical Savings Accounts (HSA) and Health Reimbursement Arrangements (HRA). Each option varies to some degree as to tax treatment, interest accruals, contribution limits, etc., but all share a common purpose: funding employee health care expenses.

Applications for inclusion in either or both parts of the HCE I initiative, along with instructions, were mailed to agencies on September 13, 2005. The due date for completed applications was on or before September 30, 2005. As part of the application process, agencies had to identify the number of employees by program type that would be covered by the initiative, include a narrative statement describing in detail how the HCE funds would be used, and provide an attestation that direct care and support staff were involved in deciding how the funds would be used. Upon approval of the application by NYS-OMRDD, agencies also had to submit a Board Resolution specifying the governing body's approval and determination to carry out the specific health care initiative that was proposed and approved.

## **HCE II**

With SFY 2006-07, NYS-OMRDD launched its second phase of the HCE initiative. HCE II differed from the initial, SFY 2005-06, program in several major respects:

- NYS-OMRDD did not conduct a health care benefit survey to establish benchmarks;
- All agencies were eligible to apply for funding even if they did not complete the 2005 survey or participate in HCE I; and
- There was more flexibility as to how HCE II funds could be spent. Whereas under HCE I an agency had to detail the manner in which all employees covered by the plan would receive

a benefit of exactly \$325 (\$2,500 if the agency did not offer health insurance benefits), under HCE II agencies were given more flexibility in formulating plans to distribute funds tailored to the needs of their workforce, providing that all eligible employees could access HCE benefits.

Participation in HCE II had no impact on funding an agency received under HCE I: an agency which had participated in HCE I would continue to receive HCE I funds as long as it distributed the funds in accordance with its approved HCE I plan.

Under HCE II, agencies were eligible for either:

- An annual allocation of \$425 per individual employee if the agency offered health insurance benefits to employees; or
- An annual allocation of \$2,500 per individual employee if the agency did not offer employee health insurance benefits and was not funded at a sufficient level to do so. However, agencies that had received funding at the \$2,500 per employee level under HCE I were not eligible for that level of payment under HCE II.

Like HCE I, HCE II funds were intended to establish or enhance employee health care benefits or to reduce employee out-of-pocket health care related expenses. It was also expected that agencies would secure staff input on the distribution of HCE II funds.

In its application instructions for HCE II, NYS-OMRDD listed possible uses of the funds. These essentially mirrored the seven suggestions offered in its instructions for HCE I with the addition of two other possible uses: Health Savings Accounts and Health Reimbursement Arrangements.

Agencies received notice of the availability of HCE II funding and instructions for applying in an NYS-OMRDD letter dated June 29, 2006. The due date for completed applications was on or before July 31, 2006. In applying for funding, agencies were expected to provide statistical data on eligible employees and their program types as well as narrative information detailing how the funds would be used, including information on the input offered by staff on the distribution of funds. If an application was approved by NYS-OMRDD, a Board Resolution affirming the governing body's determination to carry out the proposal was also required.

### **HCE III**

A third phase of the HCE initiative, HCE III, was launched in SFY 2007-08. HCE III differed from the first two HCE phases in two significant ways.

First, funding allocations were not tied to the number of eligible employees. Rather, agencies would be funded at a level of one percent of their operating funding (for rate-based programs) or at one percent of their contract funding (for contract programs).

Secondly, agencies were permitted to use HCE III funds to offset increases to employer health insurance premiums in excess of trend factors or cost of living adjustments (COLAs). Such was not permitted during the first two phases of the HCE. In those phases, funding was to be used to provide benefits for uninsured workers, enhance existing benefits, defray employee out-of-pocket health related expenses, establish employee FSAs, HRAs, etc. With HCE III, agencies could use the funding to defray their increasing costs of providing employee health insurance.

Participation in HCE III had no impact on funding agencies received under HCE I and/or HCE II: agencies receiving funds under either or both of those phases would continue to receive the approved amount.

Notice of the availability of HCE funding and application guidelines were sent to agencies on August 31, 2007 with a deadline for applications on or before October 1, 2007. The application process for HCE III was simplified to some degree. Agencies could use a check list, rather than a narrative explanation, to indicate how funding would be used; documentation concerning employee input on decision making was not required (although it was expected that such input would be secured); and although a Board Resolution was required, it did not have to be submitted to NYS-OMRDD.

According to NYS-OMRDD staff, 373 not-for-profit agencies participated in at least one phase of the HCE initiative, most in all three phases. While these agencies constitute 53% of the approximately 700 non-profit agencies providing NYS-OMRDD services, they represent the lion's share of the NYS-OMRDD service delivery system and account for 98% of the total NYS-OMRDD service dollars expended annually in the private sector. According to NYS-OMRDD, the annual State cost of the HCE program (Phases I through III) is \$52 million.

## **Health Care Enhancement Program: INSIGHTS**

NYSACRA member agencies constituted nearly half of the 373 agencies that participated in the HCE program. In conducting its review of the program, NYSACRA surveyed its member agencies, receiving responses from 75. This constituted a 43% response rate from member agencies and represented 20% of the total agencies that had participated in the HCE program.

Through focus groups with administrators and direct support professionals, NYSACRA was able to expand upon data gathered during its survey to offer the following insights into the HCE initiative.

### **AGENCIES' USE OF HCE FUNDING**

As indicated in Table 1 (*see page 14*), agencies responding to NYSACRA's survey used HCE funding in a variety of ways.<sup>10</sup> In addition to the possible uses outlined by NYS-OMRDD and summarized in Table 1, several agencies used some of the funds for other purposes, such as wellness or smoking cessation programs and biometric testing.

In each of the three phases, however, funding Health Reimbursement Arrangements (HRA) was the most frequent option chosen by agencies. Over 60% of the agencies funded HRAs in HCE I, as did almost 60% in HCE II, and over 45% in HCE III. Using HCE funds to reimburse or reduce health benefit premiums and deductibles paid by employees was the second most frequently chosen option in all three phases. Over a third of the agencies used HCE funding for this purpose in each phase. Reimbursing or reducing employee co-payments for covered services was the next most frequently used option chosen by agencies in at least phases I and II.

In HCE III, there was a shift in how agencies used HCE funding. In this phase, for the first time, agencies were permitted to use HCE funding to offset inflationary increases to employer health insurance premiums in excess of trend factors or cost of living adjustments. Twenty-two (31%) of the responding agencies that participated in HCE III reported using the funds for this purpose.<sup>11</sup> Whereas 21 of these agencies had participated in earlier HCE phases — offering new or enhanced benefits,

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<sup>10</sup> It should be noted that not all 75 responding agencies participated in all three phases of the HCE initiative. This will be discussed later.

<sup>11</sup> NYS-OMRDD staff reported that 61% of agencies participating in HCE III used some funding to offset inflationary increases to employer health insurance premiums in excess of trend factors or cost of living adjustments.

reimbursement for deductibles or co-pays, HRAs, etc. – only eight continued to use HCE III funds for these purposes **and** to offset their premium increases. Most of the 22 agencies used HCE III funds exclusively to offset their premium increases.

**TABLE 1**  
**RESPONDING AGENCIES’ USE OF HCE FUNDS IN EACH PHASE\***

USE	AGENCIES		
	HCEI (n=69)	HCEII (n=68)	HCEIII (n=71)
New benefits for uninsured employees	7.2%	7.4%	5.6%
Enhancements to existing benefits, e.g., adding dental or vision care	10.1%	8.8%	7.0%
Reimbursed or reduced health benefit premiums and deductibles paid by employees	40.6%	36.8%	38.0%
Reimbursed or reduced employee co-payments for covered services	18.8%	20.6%	16.9%
Reimbursed or reduced employee payments for non-covered health related expenses	10.1%	11.8%	9.9%
Reimbursed or reduced employee payments related to the use of a non-network provider	8.7%	10.3%	7.0%
Funded Flexible Spending Accounts (FSA)	8.7%	14.7%	11.3%
Funded Health Reimbursement Arrangements (HRA)	62.3%	58.8%	45.1%
Funded Health Savings Account (HSA)	2.9%	1.5%	1.4%
Offsets to inflationary increases to employer health insurance premiums	n/a	n/a	31.0%
Other	1.4%	2.9%	5.6%

\*Percentages do not total 100%. Agencies could use HCE funds for more than one purpose.

**EFFECTIVENESS OF THE HCE PROGRAM**

Agencies were asked to rate the effectiveness of the HCE program in enabling them to achieve certain desired aims, such as recruiting and retaining employees, providing health insurance for employees, defraying employees’ direct costs for health care, etc. A five-point rating scale was offered with “1” indicating “to a negligible degree;” “3” indicating “to a moderate degree;” and “5” indicating “to a great degree.”

As illustrated in Table 2 (*see below*), the responding agencies gave the HCE program high grades in terms of its ability to defray employee direct health related costs, which scored an average rating of 4.29 out of a possible 5; promote employee satisfaction/morale, which scored an average rating of 4.04; and help retain employees, which scored an average rating of 3.49.

**TABLE 2**  
**RESPONDING AGENCIES' RATINGS OF HCE'S EFFECTIVENESS**

Domains	Ratings					Rating Average
	1. To a Negligible Degree	2.	3. To a Moderate Degree	4.	5. To a Great Degree	
Recruit employees (n=73)	19.2% (14)	17.8% (13)	<b>41.1%</b> <b>(30)</b>	8.2% (6)	13.7% (10)	2.79
Retain employees (n=75)	2.7% (2)	10.7% (8)	<b>38.7%</b> <b>(29)</b>	30.7% (23)	17.3% (13)	3.49
Promote employee satisfaction/morale (n=75)	0.0% (0)	1.3% (1)	29.3% (22)	33.3% (25)	<b>36.0%</b> <b>(27)</b>	4.04
Promote healthy life styles for employees (n=74)	12.2% (9)	14.9% (11)	<b>37.8%</b> <b>(28)</b>	20.3% (15)	14.9% (11)	3.11
Provide health insurance for employees (n=73)	<b>26.0%</b> <b>(19)</b>	17.8% (13)	21.9% (16)	16.4% (12)	17.8% (13)	2.82
Improve employee health insurance (n=73)	21.9% (16)	16.4% (12)	<b>26.0%</b> <b>(19)</b>	15.1% (11)	20.5% (15)	2.96
Defray employee direct costs for healthcare (n=75)	2.7% (2)	0.0% (0)	20.0% (15)	20.0% (15)	<b>57.3%</b> <b>(43)</b>	4.29
Ease financial strain on agency (n=74)	18.9% (14)	20.3% (15)	<b>27.0%</b> <b>(20)</b>	14.9% (11)	18.9% (14)	2.95

Comments offered by agency administrators in the survey, and by direct support professionals during open forums, put flesh and blood on these bare bone statistics.

Repeatedly, administrators praised the value of the HCE program as a means of defraying employee out-of-pocket expenses, a boon for morale as employees could access health services without reducing their take home pay, and a way for employees to secure otherwise cost prohibitive medical goods and services (*see below*).

<b>AGENCY COMMENTS ON HOW HCE BENEFITED EMPLOYEES</b>
It increased the morale of underpaid employees, providing them the possibility of affordable health care for their families.
The HCE helped employees keep insurance and added dental and vision benefits.
The HRA has been a plan favored and appreciated by employees as it helps to defray out of pocket and OTC medicine expenses.
Employees now have funds allocated to them to pay for health care expenses.
Employees have been able to make purchases of quality of life related devices... such as hearing aids, braces and orthodontia for their kids, Lasik surgery to correct their vision...that they would otherwise have to forego.
Decreased premiums assisted employees to afford the best insurance offered and HRAs enabled staff to have access to medications and treatments they would have previously foregone.
To save expense, co pays were raised last year, and the HRA is a great way for employees to defray the additional expense.
There are many employees with dependent children. The HRA is very beneficial to parents who can use the HRA to plan for health care expenses not covered by their insurance plan.
We were able to maintain good coverage without increasing out-of-pocket expenses for the employee.
It allowed employees to obtain health services they might otherwise not been able to afford, fill prescriptions in a timely manner, receive financial assistance with insurance premiums, and purchase over the counter health related/first aid supplies.
Employees were able to purchase glasses and prescriptions.
Most of our population is aging – the co-pays for medications and office visits add up. HCE funds helped greatly with that.
The HRA has allowed employees, both with and without insurance, to access medical care and prescriptions when needed versus choosing between health care and other basic needs.
Establishing HRAs promoted morale and is a great recruiting tool.

Comments by direct support professionals echoed those of administrators, but from very personal perspectives. Phrases like, “worry free,” “stress free,” and “peace of mind” peppered their conversations and accounts of how the HCE helped them afford care in cash-strapped times, be more proactive in health matters, and provide for their families’ health needs (*see below*).

<b>DIRECT SUPPORT PROFESSIONALS’ COMMENTS ON THE BENEFITS OF HCE</b>
I have a son with special needs. The HRA helps when we need to go “off network” for services or to purchase items, such as Vitamin B-12 shots or nutritional supplements, not covered by his HMO.
I recently suffered an eye injury. I needed to go to the ER and then buy medications. By the end of the day, my co-pays totaled over \$100 which I would have had to pay out-of-pocket had it not been for my HRA debit card.
Before the HCE, if certain household expenses went up, I would put off going to the doctor because I couldn’t afford both the doctor’s visit and the increased household expenses.
With the HCE, I was able to afford the cost of an ultrasound which I had been putting off because of the out-of-pocket costs. The HCE has eased the stress. I’m able to handle the co-pays and I’m now more proactive in seeking health care services.
Before the HCE, I’d hesitate going to the doctor if I felt sick. It would mean a co-pay and possibly a prescription, which would mean another co-pay. So, I’d go to work, in order to make money, only to spread my illness.
Doctors want cash or checks on the spot. Now when we have a doctor’s appointment, I don’t have to balance my checkbook first to be sure I have the co-pay or worry about a maxed-out credit card.
Without the Health Care Enhancement, I couldn’t afford to buy groceries. It would be a trade off...seek medical care or put food on the table.
I am a diabetic and require numerous treatments including the insulin pump. The medical treatment and medications are very expensive. Before HCE, I would struggle to budget for the medications. Knowing that I now have a health reimbursement account to help with costs has brought me tremendous financial relief and peace of mind.
My son broke his leg, just when rent was due. Thank God I had an HRA to cover the out-of-pocket expenses for my son’s medical care. I would have been worried sick over the rent and what the landlord would do.
My daughter has severe asthma which at times means ER visits and \$100 co-pays. With HCE, I now have the peace of mind of knowing that I can afford to pay.
Knowing that I have the extra benefits means that I can attend my required doctor's appointments and not "pick and choose" what prescriptions I will fill each month.

In an effort to quantify the number of staff who were assisted by the HCE program, the survey asked agencies to identify the number of employees who benefited from the agency’s involvement in each of HCE’s three phases during the first year of that phase. Not all agencies provided data; some did not participate in all three phases; and some responded in an unquantifiable manner (e.g., “All our employees benefited.” or “All our NYS-OMRDD staff.”).

However, as indicated in Table 3 (*see below*), quantifiable data was received from 56 to 61 agencies for the three year period. Approximately 20,000 employees from these agencies benefited from the program during the first year of the HCE’s three phases. Some agencies were very small, while others were large. One agency, for example, which operates only one program serving fewer than 15 individuals, reported that six to seven staff received HCE benefits. At the other end of the spectrum, another agency, operating over 100 residential sites and serving thousands of individuals in non-residential settings, reported that approximately 2,000 employees benefited in the first year of each of the HCE’s phases. Despite their organizational differences, both agencies gave the program similar high marks for assisting in defraying employees’ direct health care costs, improving morale, helping to retain staff, and easing the financial strain on the agency.

**TABLE 3**  
**NUMBER OF EMPLOYEES BENEFITING FROM HCE PROGRAM**

	HCE I	HCE II	HCE III
Number of Agencies Reporting Data	61	58	56
Number of Employees Reported	20,401	19,584	20,170

In focus groups, both administrators and direct support professionals commented that the HCE initiative helped to educate staff on health insurance matters and to promote consumer driven health care decision making. Securing employee input, as required by NYS-OMRDD, in the design of how agencies would use HCE funds helped shape that knowledge base. The degree to which employees had discretionary funds at their disposal for health related needs helped them focus on options and make informed decisions (e.g., Should I use my funds for a smoking cessation program? Braces for my child? etc.)

However, in rating the HCE initiative, agency administrators scored it as being less than moderately helpful in providing health insurance for employees (average rating of 2.82); improving employee health insurance (average rating of 2.96); and easing the financial strain on the agency (average rating of 2.95).

Relatedly, when asked to complete the following sentence: “*Even with the availability of HCE funding...*”

- 52.4% of the responding agencies said: *certain employees do not have access to health insurance;*
- 31.7% reported that: *the range of benefits for covered employees has been reduced;*
- 81.0% said: *employee premium payments have increased;* and
- 19.0% indicated that: *the agency had to seek other funding to cover insurance cost increases.*

## **THE HCE PROGRAM: THE LARGER CONTEXT**

In discussing the above findings, administrators participating in NYSACRA’s focus groups commented that while the HCE program was an excellent vehicle for defraying employee out-of-pocket expenses, thereby improving morale and perhaps retention, and enabling staff to avail themselves of certain medical goods and services without worry or stress, continuing double digit increases in health insurance costs have presented a conundrum. While staff may be reimbursed or have an HRA account to pay for certain health related expenses (e.g., aspirin for pain relief), they may not have adequate insurance (e.g., dental or vision) to cover the cost of an examination or treatment for the underlying medical problem (i.e., the cause of the pain) as their benefits may have been reduced or they opted out of the insurance plan due to its cost.

As part of the survey, agencies were asked to provide data on increases or decreases in their employee health insurance premiums in each of the last three years. Most experienced increases and the average yearly increase ranged from 10.61% to 12.42% (*see Table 4, page 20*).

Focus group administrators indicated that, in the face of these increases, critical decisions negatively impacting employee health insurance programs had to be made: at times certain benefits, e.g., dental and vision coverage, were dropped; or the range of choices of health insurance plans available to employees was reduced; or employees had to pay increased premiums or higher deductibles. The administrators also indicated that the increases in the health insurance costs reported in the survey would have been even higher had not these decisions been made.

Ironically, some administrators pointed out that while agencies struggled with these decisions, which would impact basic insurance coverage for all their employees, certain employees, particularly young and healthy ones, had and still have thousands of untouched HCE dollars accrued in HRA accounts.

**TABLE 4**  
**CHANGES IN REPORTING AGENCIES' HEALTH INSURANCE PREMIUMS**

	YEAR		
	2006	2007	2008
Agencies providing data:	66	68	70
Agencies with no percentage change:	4	4	1
Agencies with decreased premiums:	1	5	2
Average percentage decrease in premiums:	-2.01%	-7.35%	-11.0%
Agencies with increased premiums:	61	59	67
Average percentage increase in premiums:	+11.20%	+12.42%	+10.61%
Range of overall percentage change in premiums:	-2.01% to +22.0%	-13.0% to +40.0%	-15.0% to +41.0%
Overall percentage change in premiums:	+10.48%	+10.24%	+9.84%

Focus group administrators explained that when HCE III allowed agencies to use funds to offset inflationary increases to their employee health insurance premiums, they availed themselves of this option in an attempt to preserve the integrity of their insurance plans and to make ever increasingly expensive insurance more affordable to their employees.<sup>12</sup> But still, as the survey results indicated, there are staff that do not have access to health insurance.

A number of agency administrators in the focus groups indicated that they do not offer health insurance to part-time workers. The cost is too prohibitive, yet at the same time the demand for part-time workers is growing as the nature of service delivery changes.<sup>13</sup> These administrators, however, indicated

<sup>12</sup> Even with this financial assistance to offset insurance increases, however, the administrators indicated they are behind the eight ball in trying to make ends meet as they face inflationary increases in other aspects of agency operations without a trend factor and with downstate agencies facing the additional burden of a payroll tax imposed as a result of recently enacted Metropolitan Transportation Authority legislation.

<sup>13</sup> This trend, which is reportedly continuing, was discussed at page 7 and pages 28-29 in Dr. Niev Duffy's October 2004 report: *Keeping Workers Covered: Employer Provided Health Insurance Benefits in the Developmental Disabilities Field*. New York: The

that part-time staff are eligible for funds available through HCE to pay for out-of-pocket health related expenses. The administrators also indicated that sometimes full-time employees opt not to participate in agency offered insurance plans because of their costs. One reported:

*“Premiums have been increasing so much that employees would rather go uninsured than risk their ability to pay rent, get to work (gas), or feed their families. Even co-payments have become unaffordable, and our two person and family rates are exorbitant. On our basic plan, an employee who grosses \$779.00 per pay period, would have to pay \$282.00 PER PAY to pay for a family plan. After taxes, nearly half of a person's take home pay would go to pay that premium. On our richest plan, the PER PAY family premium would be \$490.00, eating up nearly all of their take home pay.”*

While going “uninsured” is an option for full-time employees at some agencies, it is not at others. Some participants in the administrator focus groups indicated that their agencies require full-time employees to provide proof of insurance if they opt not to partake of the agency’s offerings. Other participants did not require such proof.

## **THE HCE PROGRAM: WHY AGENCIES DID NOT PARTICIPATE**

Thirteen NYSACRA member agencies did not participate in the HCE program, and 10 of the 75 member agencies that completed the survey did not participate in all three phases of the program.

The agencies that did not participate in any of the HCE phases tended to be multi-service providers, operating more than just NYS-OMRDD certified/funded programs, or national organizations, providing services beyond New York State. In telephone conversations, administrators of a sample of these agencies reported that they did not participate in the HCE program because they could not offer the HCE benefits to all of their employees as the program was limited to employees of programs certified or funded by NYS-OMRDD.

The reasons why 10 agencies participated in some, but not all three phases of the HCE program varied. Most (six of the ten) reported that they either did not receive an application or just simply missed a deadline for applying. As the administrator of one agency – which had participated in HCE I and II, offering HRAs and other benefits to staff – reported:

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City University of New York, John F. Kennedy, Jr. Institute for Worker Education. “From 2000 to 2003, rates of full-time employment in NYS-OMRDD funded agencies declined from 72.8% to 68%. Thus, about one-third of the workforce was part-time. About 62% of NYS-OMRDD funded employers offered health coverage to part-time staff.”

*“We missed HCE III. It still kills me. We had a changeover in CFOs, and it sat on their desk in the interim. I missed it, our HR missed it, and the new CFO missed it. That error cost us around \$50,000 per year.”*

The remaining four agencies cited the onerous process or limitations of some phases as reasons for not participating in all three.<sup>14</sup>

## **THE HCE PROGRAM: SUGGESTIONS FOR IMPROVEMENT**

In the survey, agencies were invited to offer suggestions on improving the HCE program. Nearly 60 agencies took advantage of this opportunity and their responses are appended (*see Appendix D, Agency Suggestions on Improvement*). Suggestions ranged from: opening the program to non-NYS-OMRDD program employees; to allowing agencies that had missed out on earlier HCE phases to reapply; to creating a state sponsored health insurance plan for non-profit agencies.

Two key themes, though, were reiterated in most of the suggestions: simplify the HCE program and make it more flexible. Administrators in the focus groups expanded on these themes.

Acknowledging that with each HCE phase NYS-OMRDD had endeavored to simplify the HCE application process and make the program more flexible, the administrators indicated that more could be done in three general areas:

- **Application Timeframes:** Timeframes for applying for HCE should be brought into sync with agencies’ planning cycles and be more predictable. Agencies go through insurance open enrollment periods and benefit planning processes without knowing what will be available through HCE and when. For example, agencies have been awaiting the announcement of the availability of funds and guidelines for HCE IV and V for months, during which time many have already had to make decisions on employee health insurance matters.
- **Administrative and Accountability Issues:** Each HCE phase had its own unique methodologies and guidelines concerning the distribution and possible uses of funds – methodologies and guidelines that continue to this day. As such, in administering the program, agencies participating in more than one phase, as most do, face compounded administrative and accounting burdens in ensuring compliance with the different rules of each phase.

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<sup>14</sup> It should be noted that NYS-OMRDD made every effort to ensure that each agency received an HCE application, using return receipts for each mailing and contacting by phone any agencies for which a return receipt was not received. NYS-OMRDD also indicated that provider associations agreed to both the imposition of deadlines and the decision not to accept late applications.

- Use of Funds: There should be greater flexibility in the use of HCE funds, perhaps even collapsing all the various phases into one pool of funds. It is an unwise use of funds, given the objectives of the HCE program, to allow money to continue to accrue and sit idle in HRA accounts while people who need insurance go without it due to high premiums.

## CONCLUSION

Several conclusions can be drawn from NYSACRA's review of NYS-OMRDD's Health Care Enhancement program:

- First, the program met its intended outcomes;
- Second, agencies participating in the program, while giving it high ratings for effectiveness in critical domains, have suggestions on how it can be improved; and
- Third, the initiative should be viewed as a model for government, other human service agencies, and other states to assist them in their efforts to maintain a healthy and robust workforce.

Data collected from NYSACRA member agencies and reports by administrators and direct support professionals consulted during the review affirmed the value of NYS-OMRDD's Health Care Enhancement program as a means of defraying staff's out-of-pocket health care expenditures, thus allowing them to retain more take-home pay; enhancing the range and quality of health services available to them; and promoting staff morale and, related, staff retention – objectives articulated by NYS-OMRDD in budget documents and memoranda when the program commenced in 2005. As the only New York State agency to have launched such an initiative, NYS-OMRDD should be lauded for its efforts, and its success.

Can the program be improved? Of course. As the program evolved over three phases, in certain ways it became more flexible and responsive to employee and agency needs. For example, whereas initial HCE phases provided funds directly for employee's out-of-pocket medical expenses, in its most recent phase (Phase III), the program allowed agencies to use funds to offset their increasing employee health insurance premiums which, if left unchecked, would ultimately and negatively impact on employee health care options, take-home pay, or out-of-pocket expenses. At the same time, however, the evolving HCE initiative became more complex for agencies administratively, as each phase had its own unique rules which agencies had to comply with and account for over time. Some of these complexities dissuaded some agencies from participating. During NYSACRA's survey, however, participating agencies offered suggestions on how the HCE program could be made even simpler and more flexible – suggestions which NYS-OMRDD should consider.

More importantly, however, New York State should consider ways of replicating NYS-OMRDD's HCE initiative, together with participating agency suggestions, to assist other human service agencies in their efforts to maintain a stable, healthy workforce – as such is vital to their missions.

All human service agencies struggle to recruit and retain caring and competent workers, particularly direct support professionals. While salaries in the human service sector tend to be low, the provision of employee benefits – particularly health care related benefits – often distinguishes the human

services sector from other service sectors in the labor market and serves as an incentive, drawing prospective employees to the field and enticing them to stay.

Yet, the ever increasing cost of providing employee health benefits is jeopardizing the ability of human services agencies to do so, or to do so in a way that does not erode employees' take home pay or their basic benefits.

NYS-OMRDD's Health Care Enhancement program served as a buoy, helping agencies to tread water in the rising tide of insurance costs...helping them to keep their heads above the surface in their efforts to provide employee health benefits and/or reduce employees' costs for health related expenses. Yet, some agencies supporting individuals with developmental disabilities opted not to partake in the NYS-OMRDD program because they cannot offer its benefits to all their human service workers. Many more agencies, outside of the NYS-OMRDD service system, have no similar life line available to them in their efforts to keep their workforce afloat.

Continuing and replicating NYS-OMRDD's Health Care Enhancement program, particularly in an era of dramatically increasing health care costs, would be a step toward ensuring that all New Yorkers receive the supports they need, by virtue of age or disability, to live successfully in the community.



## **APPENDIX A: SELECTED BIBLIOGRAPHY**

Excellent references on workforce issues include:

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## **APPENDIX C: HCE PROGRAM SURVEY INSTRUMENT**

Agency Name:

Corporate ID:

Person Completing Survey:

Contact Information: (Telephone, E-mail)

- 1) Identify the nature of your agency's insurance plan for employee health coverage: Check one:  
 Self-insured    Experience Rated    Community Rated    Other
  
- 2) Identify the percentage of the agency's health insurance premium increase (+) or decrease (-) for each of your last three fiscal years.   2006 \_\_%   2007 \_\_%   2008 \_\_%
  
- 3) Did your agency participate in the Health Care Enhancement (HCE) program?  
 Yes    No (If no, please skip the following Questions and answer Question 14)
  
- 4) Which phase(s) of HCE did your agency participate in? Check all that apply:  
 Part 2 of HCE I    HCE II    HCE III
  
- 5) If your agency participated in Part 2 of HCE I, please indicate how your agency used the HCE funding. Check all that apply:  
 New benefits for uninsured employees  
 Enhancements to existing benefits, e.g., adding dental or vision care  
 Reimbursed or reduced health benefit premiums and deductibles paid by employees  
 Reimbursed or reduced employee co-payments for covered services  
 Reimbursed or reduced employee payments for non-covered health related expenses  
 Reimbursed or reduced employee payments related to the use of a non-network provider  
 Funded Flexible Spending Accounts (FSA)  
 Funded Health Reimbursement Arrangements (HRA)  
 Funded Health Savings Account (HSA)  
Other, describe:  
  
5a) If your agency currently uses Part 2 HCE I funds differently from what was initially proposed by your agency, please explain the nature of the change:  
  
5b) In the first year of the initiative, how many employees benefited from your agency's involvement in Part 2 of HCE I? \_\_ # of employees.
  
- 6) If your agency participated in HCE II, please indicate how your agency used the HCE funding. Check all that apply:  
 New benefits for uninsured employees  
 Enhancements to existing benefits, e.g., adding dental or vision care  
 Reimbursed or reduced health benefit premiums and deductibles paid by employees  
 Reimbursed or reduced employee co-payments for covered services  
 Reimbursed or reduced employee payments for non-covered health related expenses  
 Reimbursed or reduced employee payments related to the use of a non-network provider  
 Funded Flexible Spending Accounts (FSA)

- Funded Health Reimbursement Arrangements (HRA)
- Funded Health Savings Account (HSA)
- Other, describe:

6a) If your agency currently uses HCE II funds differently from what was initially proposed by your agency, please explain the nature of the change:

6b) In the first year of the initiative, how many employees benefited from your agency's involvement in HCE II? \_\_ # of employees.

7) If your agency participated in HCE III, please indicate how your agency used the HCE funding.

Check all that apply:

- New benefits for uninsured employees
- Enhancements to existing benefits, e.g., adding dental or vision care
- Reimbursed or reduced health benefit premiums and deductibles paid by employees
- Reimbursed or reduced employee co-payments for covered services
- Reimbursed or reduced employee payments for non-covered health related expenses
- Reimbursed or reduced employee payments related to the use of a non-network provider
- Funded Flexible Spending Accounts (FSA)
- Funded Health Reimbursement Arrangements (HRA)
- Funded Health Savings Account (HSA)
- Offsets to inflationary increases to employer health insurance premiums in excess of trend factors and/or COLAs
- Other, describe:

7a) If your agency currently uses HCE III funds differently from what was initially proposed by your agency, please explain the nature of the change:

7b) In the first year of the initiative, how many employees benefited from your agency's involvement in HCE III? \_\_ # of employees

8) Overall, if HCE funding were not available, check all that apply:

- Certain employees would not have had access to health insurance
- Range of benefits for covered employees would have been reduced
- Employees would have had to pay increased premiums
- The agency would have had to seek other funding to cover insurance cost increases
- Other items of note, describe:

9) Overall, even with the availability of HCE funding, check all that apply:

- Certain employees do not have access to health insurance
- Range of benefits for covered employees has been reduced
- Employee premiums payments have increased
- The agency had to seek other funding to cover insurance cost increases
- Other items of note, describe:

10) On the below scale, please indicate the degree to which HCE has enabled your agency to:

	<b>To a Negligible Degree</b>		<b>To a Moderate Degree</b>		<b>To a Great Degree</b>
	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
Recruit employees	1	2	3	4	5
Retain employees	1	2	3	4	5
Promote employee satisfaction/morale	1	2	3	4	5
Promote healthy life styles for employees	1	2	3	4	5
Provide health insurance for employees	1	2	3	4	5
Improve employee health insurance	1	2	3	4	5
Defray employee direct costs for healthcare	1	2	3	4	5
Ease financial strain on agency	1	2	3	4	5

11) Below, please describe the **one** HCE-funded initiative of your agency which you believe **most** benefited your employees. Describe what the initiative entailed.

11a) Describe how the initiative benefited employees.

11b) Indicate the number of employees who benefited from this initiative.

12) Below, please describe what could be done to improve the HCE program.

13) If your agency participated in at least one phase of the HCE program but not others, please explain why.

14) If your agency did not participate in the HCE program, please explain why.

## **APPENDIX D: AGENCY SUGGESTIONS ON IMPROVEMENT**

The following suggestions and comments were offered by agencies completing the survey. NYSACRA did not verify their feasibility or accuracy.

- Allow the funds to go directly to the agency and let the agency use the dollars to apply the funds directly to offset the increase in premium. This would allow for either a reduction of the cost sharing that employees pay or mitigate some amount of the increase in premium up front.
- A state sponsored health insurance plan for non-profits.
- Give us more money.
- It would be great to have more flexibility to use toward premium costs.
- The program is being reviewed.
- Allocate more money to the initiative.
- HCE IV and V would be great.
- It would help if we could exempt the money from FICA and Medicare taxes, both employer and employee. It would help if we could exempt the money from Worker's Comp calculations of employer's salary base.
- Similar to HCE III, allow flexibility in the use of the funds.
- As the agency continues to grow with more services, more employees will be needed. Therefore, more money will be needed to continue to provide the same or better benefits to the employees overall.
- Ability to offset health care premiums directly.
- Increase the reimbursement rates.
- Don't include in rates- send separate checks.
- Be able to know how to change it over time. Be able to add people to existing HCE funding as the agency grows (we do this but receive no more funds to cover the expenses).
- Provide more funding.
- Allow for flexibility of use to fit the various needs of employees. From an administration perspective, introduction of the incentive prior to the effective date would be easier to administer. Research for eligibles after the fact is time consuming and can be complicated.
- Make it less cumbersome to apply for and figure out. Too much admin time spent...rates complicated, etc... results in employees having to wait for distribution.
- More flexibility in the use of funds.
- Allow employers the ability to off-set Agency expenses so that we are not forced to dramatically redesign our benefit plans to keep them affordable. This would be a win win for the Agency and for our employees.
- Flexibility is important so that needs are appropriately reimbursed. Also, funds received by check instead of our rate would ease the manpower need to calculate, distribute and audit the account.
- With the proposed Part IV and V - giving the Agency the opportunity to use the HCE monies to offset the Agency contribution - this will help the Agency use the savings to fund salary increases, etc. for the staff.
- Guidelines from OMR are very hard to interpret beginning with HCE III. The agency would have liked to use some of the funding to cover medical insurance premium increases (to the agency) that

took effect mid-year, but we are unsure if this is acceptable. Other agencies claim to use the money in ways that defray their costs and we would like clear answers on how to do the same. Until then, we are doing a direct pass to direct care personnel.

- Increase in funding to defray premium increases.
- 1) Provide a simplified mechanism for Agencies that provide Fiscal Employer Agent services under Consolidated Supports and Services contracts. 2) Allow the HCE funding to apply to compounded increases in health care premiums charged to the Agency.
- Instead of funding additional H.C.E. initiatives, funding is truly needed for trends.
- As in HCE III provide funding based on percentage of expenses rather than on per person reimbursement application. The per person method does not provide mechanism to adjust based on eligible participants after initial application. Lessen the paperwork, tracking, and monitoring associated with the funding. It is a nightmare to keep track of, to monitor balances at year's end, to apply COLA's if there is one after the fact, etc.
- I believe that the program is working very well.
- Simplify the use of the funds to allow the Agencies to use the total of all the Initiatives for the offset of the cost of the premiums not just the increases over the trend.
- It allowed us more flexibility in the use of HCE dollars to further offset premium increases and combine all HCE dollars allowing us the same flexibility with all dollars to make insurance more affordable for all employees.
- Easier application procedures
- Simplify the process. We have not tapped into HCE 3 because of the complexity of calculating what it means to us in \$.
- Restrictions have already been eased making it more flexible and easier to report.
- It is overly complex to maintain and report. Combining the initiatives together would be beneficial.
- More flexibility to pay for premium and family.
- Combine the funding streams of HCE I,II and III with HCE IV and V and allow the newer more flexible rules that we hear are coming with HCE IV and V to apply.
- The program is difficult and costly to administer with high turnover, employees changing eligibility as they move from full-time to part-time (or part-time to full-time) and transfer between OMR and non-OMR programs operated by our agency. Much of our staff is very young & don't have many out-of-pocket health care expenses. It would be nice to have the option to use the funds for wellness programs such as gym membership or purchasing exercise equipment.
- Have the HCE money roll over from year to year
- Allow money to be used to cover all employer paid premium for health insurance as this is our largest expense outside of salary
- The application process, especially for HCE I and II, was complicated. Also, the funding methodology is complicated and takes significant accounting oversight.
- Of course, increased funding that aligns with rising healthcare costs. Flexibility in using and distributing funds across employee groups. Simplicity of rules. Earlier notification in the year of HCE availability and application process.
- To continue the program and increase the payments would improve the benefit for the employees.
- Fund the HCE program at a higher level.
- Provide additional funding for health and wellness programs to promote mid to long range plans that can help reduce premiums.

- Let agencies use funds to cover annual health insurance premium increases.
- Let agencies who are missing HCE 1 or 2 or 3 reapply.
- The HCE program funds could be used to make plan simpler to administer.
- For agencies with multiple funding sources it would be helpful to receive reimbursement for all employees. It's not practical or fair to reimburse only NYS-OMRDD funded staff so our agency had to seek funding from other sources to reimburse non-NYS-OMRDD funded employees. It would be helpful to receive funding from all state agencies to increase health care access to all workers.
- The reimbursement thru price sheets means that we do not have a clear understanding of whether the HCE funds will cover benefits.
- Better communication and follow through, especially this year. Employees have been eagerly waiting for their HRA's to be funded this year and we have no information to pass along to them. Each month we receive mixed messages alluding to the fact that the program will continue as in the past, but to date there has been no funding.
- Take the amounts out of the rates and send in form of separate check; or pay out amount per employee as in the beginning as it is very difficult to reconcile for auditors.
- The less they restrict the funding, the more we can do with it to benefit our employees. We are all different in our operations, so there is no best fit for all when you restrict the funding. Why not have us apply for it with individual plans on how we would like to spend it?
- More flexibility in how agencies can use the funds. It seemed like the rules changed each year, which created confusion about what we could and could not do.
- Simplify eligibility and how funds can be used.
- Be more flexible with the usage of the funds.
- 2009 funding could be given by now. If this is a benefit that will be given annually, it should be given the same time each year.
- Simplify the HCE initiatives and allocation by allotting one total annual HCE dollar amount or percentage and announce the next year's allotted amount by September of the previous year to give ample time for benefit planning. Eliminate incorporating retro dollars. IRC Section 125 guidelines does not allow changes to benefit elections once a plan year begins. Rolling retro dollars into the next plan year distorts the total dollar amount available to employees which can have a negative impact in subsequent years if less is available. In addition, I would recommend that experts in the area of benefits participate in the HCE planning process.
- Provide more flexibility, as appears may be done with HCE IV & V.





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