

Financial Well-being of Frontline Healthcare Workers: The Importance of Employer Benefits

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Executive summary

Frontline healthcare workers – especially direct care workers (DCWs), such as home health aides, struggle due to low pay, lack of benefits, and difficult working conditions. The need for these workers is growing. Unless frontline healthcare jobs improve, positions may be difficult to fill, and care for vulnerable members of society may be compromised.

In this study, we surveyed 2,321 frontline healthcare workers and conducted in-depth interviews with 30 of these workers concerning pay, benefits, work conditions, and financial well-being. Key survey findings included:

- Only 39% of workers were eligible for at least four out of five major benefits (e.g., health, retirement).
- Compared to all U.S. workers, workers had less access to health, retirement, paid leave, dental, and tuition benefits.
- On average, the proportion of workers who said various benefits were important to them was 41 percentage points higher than the proportion of workers who had access to these benefits.
- Probabilities that workers had access to most major benefits were:
 - 138% higher among workers with college degrees compared to workers without degrees
 - 206% higher among workers in facility-based settings such as hospitals compared to workers in home health or private duty settings and
 - 24% lower among Black compared to white workers.
- Black workers, workers without college degrees, and workers in home health or private duty settings had significantly higher rates of 9 out of 10 financial difficulties such as problems paying bills.
- The greater the number of major benefits to which workers had access, the lower their probabilities for experiencing all 10 financial difficulties – after controlling for income and other factors.
 - For example, the probability of experiencing food insufficiency drops by 28% from having three benefits compared to one.

- 59% of workers changed jobs at least once in the past year.
- 34% of workers are somewhat or very likely to leave their current job in the next year.
- Workers with a greater number of major benefits to which they had access and those with higher levels of job satisfaction were less likely to consider leaving.

In-depth interviews revealed that workers struggle with challenging work conditions, such as severe staffing shortages. Work is physically and emotionally demanding, and burnout is high. Despite this, they want to remain in healthcare. Pay is the primary factor when considering a job change, yet workers yearned for more tuition assistance to support career development, more help with childcare, and less expensive health insurance. Many workers rely on public benefits and find it stressful to navigate benefits cliffs - the possibility of losing public benefits when income rises above income limits.

Based on these key findings, we outline a set of recommendations for employers, policymakers, and other stakeholders to improve pay, benefits, and work conditions for frontline health workers, especially DCWs, such as:

- Offering a core package of major benefits: health insurance, paid leave, retirement, dental, and childcare assistance and ensuring workers can afford health insurance premiums.
- Increasing spending on home and community-based services (HCBS) via Medicaid to raise pay for frontline healthcare workers.
- Increasing federal funding for childcare subsidies and fixing benefits cliffs.

Background

During the COVID-19 pandemic, healthcare workers have faced health risks and difficult working conditions, including repeated exposure to COVID-19 in the workplace (Belingeri et al., 2020) and shortages in personal protective equipment (PPE) (Cohen & van der Meulen Rogers, 2020). Burnout (Levine, 2021) and mental health problems (Marvaldi et al., 2021) among healthcare workers are widespread, which is contributing to a mass exodus, as almost a fifth of healthcare workers have quit during the pandemic (Galvin, 2021).

Numerous media stories concerning the COVID-19 pandemic have emerged concerning stressed and overworked frontline healthcare workers such as nurses, yet less public attention during the pandemic has been devoted to direct care workers (DCWs) – home care workers, residential care aides, and nursing assistants in nursing homes (PHI, 2021a).

The U.S. is facing a crisis among its frontline healthcare workforce, especially DCWs, who are quitting during the COVID-19 pandemic because of illness, concern about the coronavirus, family obligations, and financial challenges (McCall, 2021). Healthcare providers are struggling to fill positions and achieve adequate

staffing, which jeopardizes the quality of care for patients. While the COVID-19 pandemic has been a chief culprit, challenges faced by frontline healthcare workers existed before the pandemic, particularly among DCWs – who have the lowest pay and the worst job quality (Scales, 2022).

It costs \$2,500 to replace a DCW and turnover among DCWs impacts efforts to move patients out of expensive inpatient care to home- and community-based care. DCW shortages are expected to worsen as the proportion of the population that is 65 years or older rises and the under-65 working age proportion falls (Meyer, 2020).

Data profile

There are 4.6 million DCWs, including personal care aides, home health aides, and nursing assistants who help with activities of daily living (ADLs) such as bathing and feeding and/or instrumental ADLs like paying bills, shopping, taking medications, and cleaning. DCWs work in home, community-based, and facility-based settings and may work for an employer such as a home health agency or can be hired by individuals or family members to provide care in the home. DCWs care for vulnerable people such as people who need care after a hospitalization, frail elderly persons, and persons living with physical, intellectual, or developmental disabilities (Scales, 2022).

The following facts and statistics help describe the DCW workforce:

Labor force

- The number of DCWs has grown 48% from 3.1 million in 2010 to 4.6 million in 2020

Wages and income

- Wages grew by 8% from 2010 to 2020, yet wage growth among Registered Nurses (RNs) from 2011 to 2020 was 16% - twice as high
- Median family income is higher among male compared to female DCWs while Black DCWs have the lowest family income of all race/ethnicity groups
- 13% have incomes at or below the federal poverty level
- Almost half earn less than a living wage

Benefits

- 84% have some form of health insurance, yet less than half are enrolled in health insurance through their employer or a union
- 84% are not enrolled in employer-sponsored retirement benefits
- 57% receive at least one type of public benefit
- 60% were offered employer health insurance, including 91% and 23% of full- and part-time workers
- 55% were offered retirement benefits, including 71% and 36% of full- and part-time workers
- 58% were offered paid sick leave, including 84% and 28% of full- and part-time workers

Demographic characteristics

- 87% are female
- 51% are Black or Hispanic
- 27% are foreign-born
- Nearly half are parents

Sources: Government Accountability Office (2016); McCall & Scales (2022), PHI Workforce Data Center, Weller et al. (2020).

Data presented below compares DCWs with adjacent occupations – Licensed Practical Nurses (LPNs) and Registered Nurses (RNs) – to offer additional perspective concerning the DCW workforce.

| Indicator | DCW | LPN | RN | p |
|-----------------------------------|------------|------------|-----------|----------|
| Wages (annual median) | \$28,955 | \$48,070 | \$77,600 | *** |
| Benefits | | | | |
| <i>Health insurance</i> | | | | |
| Public coverage | 32% | 19% | 8% | *** |
| Employer coverage via self | 33% | 53% | 64% | *** |
| Employer coverage via HHM | 13% | 17% | 20% | *** |
| Employer coverage via outside HHM | 3% | 1% | 1% | *** |
| Direct purchase coverage | 10% | 4% | 5% | *** |
| <i>Retirement plan – employer</i> | 29% | 42% | 58% | *** |
| Public benefits | | | | |
| Earned Income Tax Credit | \$1,019 | \$660 | \$123 | *** |
| <i>Education</i> | | | | |
| Less than high school | 11% | 2% | 0% | *** |
| High school diploma | 38% | 25% | 1% | *** |
| Some college, no degree | 25% | 30% | 1% | *** |
| Associates degree | 12% | 37% | 29% | *** |
| College degree or higher | 13% | 6% | 69% | *** |

Note: DCW = Direct Care Worker. LPN = Licensed Practical Nurse. RN = Registered Nurse. HHM = household member. Data sources: Bureau of Labor Statistics, 2021 Annual Social and Economic Supplement, Current Population Survey.

As seen in the table above, pay for LPNs and RNs 56% and 152% higher than for DCWs. Compared to LPNs and RNs, DCWs are less likely to have health insurance through their employer, more likely to have a public form of coverage (e.g., Medicaid), and less likely to have a retirement plan through their employer. DCWs receive more in Earned Income Tax Credits, yet this makes up very little for the wage differences with LPNs and RNs. Greater pay and employer benefits is related to higher levels of education among LPNs and RNs.

Study purpose

Little is known about employer benefits among frontline healthcare workers, nor the relationship between access to benefits and household financial security. Benefit access is an important issue because benefits comprise 31% of total employee compensation among workers in the U.S. (Bureau of Labor Statistics, 2021b) and can affect household financial security in important ways. For example, paid leave can help workers avoid losing income when they are unable to work, while childcare assistance can make it easier for them to get to work and earn income.

The stability of frontline healthcare workers impacts the care of vulnerable members of our society – especially older adults and individuals living with physical and cognitive disabilities. In this report, we examine access to and use of benefits, work conditions, and household financial security among frontline healthcare workers from a sample of 2,321 workers who completed a detailed online survey. We focus on differences among workers with respect to educational attainment, race/ethnicity, and employment setting – comparing workers in institutional, home health, and private duty settings. Findings can help employers and policymakers consider ways in which benefits and work conditions among frontline healthcare workers could be improved to retain and strengthen this incredibly valuable part of the healthcare workforce.

Focusing on frontline healthcare workers is also important for broader reasons. The disproportionate number of women of color in the DCW workforce is viewed as a form of occupational segregation and structural racism in which work that is gendered and racialized is devalued (Dill & Duffy, 2022; Price-Glynn & Rakovski, 2012; Sullivan et al., 2019; Yearby & Mohapatra, 2020). Thus, improving the stability and well-being of the frontline healthcare workforce – especially DCWs – is a way to help confront structural racism and economic inequality.

This report is organized as follows. First, we summarize important findings from prior research concerning benefits and working conditions among frontline healthcare workers, with a focus on DCWs. Next, we describe the study purpose, methods, and results, followed by a discussion focusing on implications for employers and policymakers.

Prior research

Frontline healthcare workers have struggled during the COVID-19 pandemic, particularly DCWs. A qualitative study of home health workers in New York City found that workers felt invisible during the COVID-19 pandemic, faced elevated risk for coronavirus transmission, and received uneven information, PPE and other supplies, and training to cope with the pandemic (Sterling et al., 2020). Yet challenges existed prior to the pandemic concerning aspects of job quality including benefits, work conditions, and financial well-being.

Access to and use of employer benefits

An important source of information about access to and use of employer benefits comes from the 2007 National Home Health Aide Survey (NHHAS), the first probability-based survey of DCWs. Concerning

employer benefits, 73% of home health aides had access to health insurance, 59% paid time off (PTO), 51% paid sick leave, 49% retirement benefits, and 56% dental, vision, and/or prescription drug benefits. Only 6% had access to paid childcare assistance. Access to benefits was somewhat higher in a study of CNAs: 90% had access to health insurance, and 71% were offered paid leave (Squillace et al., 2009).

Access to and use of benefits varies across employment settings. Public health nurses had higher rates of retirement plan access, participation, and employer plan contributions compared to school and home health nurses (Charlie, 2017). Benefits access was much greater among those working in hospice care compared to home health agencies. Employer size also mattered. Benefits access was much higher among those working in large compared to small and medium size home health agencies, and among those working in medium or large hospice care organizations compared to small ones (Bercovitz et al., 2011). Larger home health agencies offer more benefits to home health aides than smaller agencies (Franzosa, 2016) and large hospitals offer better pay, benefits, and career development and have lower turnover than smaller long-term care facilities (Meyer, 2020). Among CNAs, nonprofit hospitals offer more benefits than for-profit hospitals and larger hospitals offer more benefits than small ones (Temple et al., 2010). Union membership is associated with greater access to benefits among DCWs (Kim et al., 2020).

Race and ethnicity also plays a role concerning benefits access. From the NHHAS, fewer Black and other race/ethnicity workers had access to employer health insurance compared to white workers (Bercovitz et al., 2011). Similarly, Sullivan et al. (2019) found that among DCWs, Black and Latino workers had the lowest pay and fewest benefits. Black women CNAs have lower pay and fewer benefits compared to white women CNAs, a trend driven by Black women being more likely to work in for-profit companies which have worse pay and benefits than other settings (Price-Glynn & Rakovski, 2012).

Concerning use of benefits in the NHHAS, nearly half of home health aides were not enrolled in their employer's health insurance plan and 19% were uninsured. The health insurance take-up rate was roughly comparable by race/ethnicity and education level but was considerably lower among workers making less than \$20,000 – a group that was much more likely than workers earning more to enroll in a government-sponsored plan (Bercovitz et al., 2011). Similarly, among DCWs, 43% have Medicaid, Medicare, or other public coverage – more than coverage through their employer or union (37%) (PHI, 2021a). Using data from the National Nursing Assistant Survey, Squillace et al. (2009) found that 42% of CNAs who were uninsured said they turned down their employers' health insurance plan because it was too expensive. Enrollment in retirement plans is low among DCWs – just half of the participation rate among all workers, and especially low among DCWs who work in private households (Fremstad, 2011).

Satisfaction with benefits

In addition to considering whether frontline healthcare workers have access to and use benefits, it is important to consider whether these benefits help meet their needs. Among nurses in community-based settings, 42% and 51% were dissatisfied with their health insurance and retirement benefits, respectively. Dissatisfaction with retirement benefits predicted intention to leave (Charlie, 2017).

Job conditions, satisfaction, and turnover

It is well known that the work performed by DCWs – bathing, lifting, and performing household tasks – is physically demanding and difficult. Over half (56%) of CNAs had at least one injury on the job in the past year including cuts, back injuries, bruises, and human bites (Squillace et al., 2009).

Despite low pay and challenging work conditions, 88% of home health aides said they were very or somewhat satisfied with their job and 76% said they felt respected by their supervisor (Bercovitz et al., 2011). Higher quality work environments are associated with lower burnout, job dissatisfaction, and intent to leave among nurses in community-based settings (Charlie, 2017).

Turnover is high among DCWs (Gandhi et al., 2020). The turnover rate among CNAs in long-term care facilities is 55%. Working in a for-profit chain facility was associated with higher turnover while working in a nonprofit facility predicted lower turnover. CNAs who felt more empowered had lower turnover (Kennedy et al., 2020). Among home health aides working in hospice agencies, access to health insurance, retirement benefits, and bonuses were associated with lower turnover (Luo et al., 2012). Among CNAs, a lack of paid sick and vacation time was a reason for leaving CNA work, while having health insurance predicted retention (Rosen et al., 2011). Similarly, Stone et al. (2017) found that having health insurance was a stronger predictor of turnover than wages and that working for a nonprofit organization was associated with lower turnover. Wiener et al. (2009) found that paid leave and a pension plan predicted longer job tenure.

Financial well-being

Research shows that DCWs are financially vulnerable. Nearly half (44%) of DCWs who provide care in the home live in a low-income household and 45% receive some type of public assistance (PHI, 2021a). Similarly, Bercovitz et al. (2011) found that almost half of home health aides had household incomes under \$30,000 and that 52% were receiving public benefits. During the COVID-19 pandemic, DCWs felt they had to endure the risk of becoming infected with the coronavirus because they could not afford to miss work and lose income (Sterling et al., 2020). Food insecurity is generally low among healthcare workers; only 7% had experienced it in the past month. However, the odds of experiencing food insecurity were more than five times higher among DCWs (Srinivasan et al., 2021).

Current study

As an extension of its research on workplace benefits and conditions of work among frontline workers, the Workforce Financial Stability Initiative (WFSI) of the Social Policy Institute (SPI) at Washington University in St. Louis examined employee benefits, work conditions, and financial security among DCWs, such as home health aides and CNAs. We chose this segment of the healthcare workforce because they are often overlooked in research, have low pay, and are disproportionately women of color, a population group that experiences greater levels of financial insecurity in the U.S.

Prior research shows that the value and importance of benefits and working conditions differs among employees based on their pay and occupational status. We add to this knowledge base by focusing on

frontline healthcare workers and by examining how benefits and working conditions relate to workers' financial security. Accordingly, our research questions are as follows:

- What types of benefits are available to frontline healthcare workers? To what extent does the composition of benefits differ by workers' employment setting (home health, private duty, facility), race/ethnicity, and educational attainment?
- What types of benefits are used and valued by frontline healthcare workers? Is the use and perceived value of benefits related to worker demographic characteristics?
- Why do workers value or not value certain benefits?
- How could benefits be improved to better meet workers' needs?
- To what degree do frontline healthcare workers experience financial insecurity? Is financial insecurity related to workers' employment setting, work conditions, demographic characteristics, and/or access to and use of benefits?
- What public benefits do frontline healthcare workers use? What factors help explain why some workers may be more likely to use public benefits?

The goal of this study is to produce insights that encourage employers to offer benefits of greater interest and value to frontline healthcare workers and that achieve greater internal equity with respect to employee financial stability. Yet employers' ability to offer good benefits is affected by the levels of reimbursement they receive from third parties, which is especially true in the home health and private duty industry. Thus, we also hope findings from this study can inform public policy discourse concerning increasing Home and Community-Based Services reimbursements under Medicaid.

Methodology

To answer our research questions, we used an exploratory sequential mixed-methods research design (Creswell & Clark, 2017). First, we designed a survey for frontline healthcare workers to complete concerning their access to, and use and perceptions of various workplace benefits, employment settings and experiences, and financial security. The initial drafting of the survey was based on a review of prior research concerning pay, benefits, and working conditions among frontline workers and measures used in previous research of the SPI concerning household financial security.

The survey draft was reviewed by several SPI researchers, external experts, and by colleagues of PHI, a national organization focused on promoting the quality of direct care jobs, which agreed to partner with SPI to complete this study. A final version of the survey was reviewed by an advisory committee comprised of direct care workers, which PHI helped SPI recruit to help guide the study. The final version included 100 questions and took about 15 minutes to complete. Major categories of survey items included:

- Employment arrangements and decisions
- Access to, use of, and perception of benefits
- Work experiences and job satisfaction
- Financial security

- Use of public benefits
- Demographic and household characteristics

Participants were offered a \$25 Amazon gift card for completing the survey and informed they may be contacted for an opportunity to complete an interview at a later date. The survey was administered online via the Qualtrics platform which collected participants’ informed consent and survey responses. PHI helped advertise the survey among its national network of affiliate organizations in the direct care industry. Survey responses were collected over a three-week period in September and October of 2021. Survey data were analyzed using uni-, bi-, and multivariate statistics. For multivariate statistics, probit regression with robust standard errors were used to assess dichotomous (yes/no) dependent variables such as access to benefits and Poisson regression for the number of benefits received as a count variable. Multivariate statistics allowed us to examine differences among workers with respect to work setting, education level, and race/ethnicity while holding other factors like household size and income constant.

Initial survey findings were reviewed by the research team and advisory committee to consider ways to modify the initial draft of a semi-structured interview guide, which was adapted accordingly. Workers who completed the survey were randomly selected to participate in an interview. Selected participants were contacted by phone and email and asked if they were interested in completing an interview. Subsequent snowball sampling was used to attain saturation. Two researchers conducted the first portion of interviews to establish a common interviewing approach. Afterwards, interviews were divided between the two researchers. Interviews were transcribed verbatim and loaded in NVivo for analysis. A directed content analysis approach was employed because of the existing theory on the topic and findings from the prior survey. The research team developed an initial codebook based on theory and survey findings. Three coders analyzed the data, conducting three rounds of coding and codebook revisions. Between each round, the three researchers met to assess inter-rater reliability. Next, the researchers conducted axial coding and matrix analyses. The study protocol was approved by the Institutional Review Board of Washington University in St. Louis.

Quantitative findings

Sample description

Table 1 displays the characteristics of the frontline healthcare workers who completed the survey. Most survey respondents were women, white, married, had one or more children, did not have a college degree, and had household income of \$50,000 and above. The average and median age of respondents was 35 years old with a range of 20 to 69 years old.

Table 1. Sample description (N = 2,321)

| | All | | Home health or Private Duty |
|-----------------|--------------|--------------|-----------------------------|
| Age | 35.07 (5.53) | 35.09 (5.05) | 34.99 (7.05) |
| Gender Identity | | | |

| | | | |
|-------------------------------------|-------------|-------------|-------------|
| Female | 57 | 42 | 46 |
| Male | 42 | 58 | 53 |
| Other/non-binary | <1 | <1 | 1 |
| <i>Race/Ethnicity</i> | | | |
| Non-Hispanic white | 74 | 75 | 72 |
| Non-Hispanic Black | 15 | 15 | 16 |
| Hispanic | 8 | 8 | 5 |
| Other | 3 | 2 | 6 |
| <i>Marital status</i> | | | |
| Married | 91 | 92 | 88 |
| Not married | 8 | 8 | 12 |
| <i>Adults living in the home</i> | 2.55 (1.08) | 2.52 (1.04) | 2.66 (1.19) |
| <i>Children under age 18</i> | | | |
| None | 11 | 10 | 16 |
| 1 child | 71 | 74 | 65 |
| 2 or more children | 17 | 16 | 20 |
| <i>Educational Attainment</i> | | | |
| Less than a college degree | 53 | 49 | 68 |
| College degree or above | 47 | 51 | 32 |
| <i>Income</i> | | | |
| Under \$25,000 | 12 | 9 | 21 |
| \$25,001-\$35,000 | 9 | 8 | 15 |
| \$35,001-\$50,000 | 17 | 17 | 19 |
| \$50,001-\$75,000 | 40 | 44 | 26 |
| \$75,001 or higher | 21 | 22 | 19 |
| <i>Geographic area of residence</i> | | | |
| Northeast | 10 | 10 | 10 |
| Midwest | 29 | 29 | 30 |
| West | 26 | 25 | 30 |
| South | 35 | 36 | 30 |

Some demographic characteristics differed based on employment setting. Workers in facilities such as hospitals were more likely than workers in home health or private duty settings to have a college degree and household income of \$50,000 or more.

Concerning differences by race and ethnicity, white workers were more likely to have a college degree and to have higher incomes compared to Black and Hispanic – differences that were statistically significant ($p < .001$).

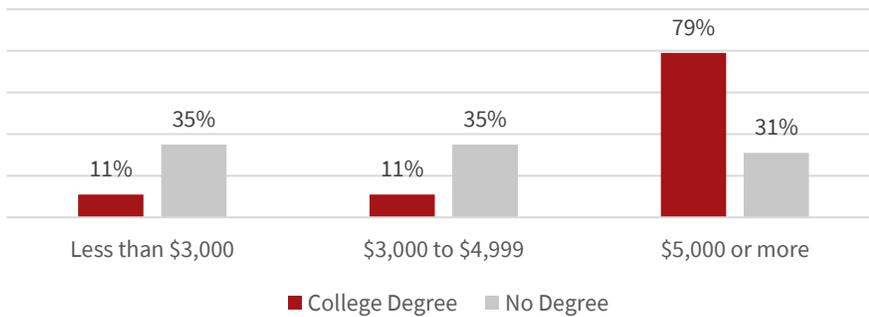
Employment characteristics

Most workers had just one job (95%) and less than half belonged to a union. Concerning work setting, most worked in a facility-based setting (79%) such as a hospital, followed by 12% in home health and 9% in

private duty. Most (72%) worked 31 to 40 hours per week; 17% worked more than 40 hours and 10% worked 30 hours or less per week. Nearly all workers (97%) said they receive bonuses, extra pay for being on call and/or for working in the evening or on weekends, and hazard pay related to COVID-19.

Concerning monthly pay, 24% make less than \$3,000, 50% make between \$3,000 and \$4,999, and 27% make \$5,000 or more. However, pay is much higher among workers with college degrees:

Figure 1. Monthly pay and educational attainment



Work setting also matters; 35% and 42% of workers in home health and private duty settings earn less than \$3,000 a month compared to 20% of workers in facility-based settings ($p < .001$).

Other employment circumstances included:

- 40% of workers did side or “gig” work in the past six months (pet sitting, Uber)
- 59% of workers changed jobs at least once in the past year
- Among those who changed jobs, 56% left their jobs due to concerns about COVID-19
- 34% of workers are somewhat or very likely to leave their current job in the next year
- Nearly two-thirds came to work sick at least once in the past year

Access to and use of employer benefits

In the survey, we asked workers whether their employer offered certain benefits and if so, whether they were eligible to receive the benefit and if they used the benefit. We also asked how important they felt each of these benefits was to them. In Table 2 below, “Access” means the employer offers the benefit and workers are eligible to receive it. Benefits are listed in rank order based on access.

Table 2. Employer benefits: Access, use, and importance

| Benefit | Access | Use | Unsure | Importance of benefits | | |
|------------------|--------|------|--------|------------------------|----------|------------|
| | % | % | % | Very | Somewhat | Not at all |
| Health insurance | 70.3 | 94.3 | 6.5 | 54.0 | 35.4 | 10.5 |

| | | | | | | |
|-------------------------|------|------|------|------|------|------|
| Paid time off | 60.4 | 95.0 | 12.5 | 44.3 | 40.5 | 15.3 |
| Retirement benefits | 53.1 | 84.0 | 9.6 | 49.0 | 37.5 | 13.4 |
| Childcare assistance | 40.7 | 85.4 | 15.7 | 30.7 | 40.4 | 28.9 |
| Dental benefits | 30.2 | 87.3 | 24.3 | 39.9 | 43.3 | 16.8 |
| Expenses reimbursement | 29.2 | 90.3 | 21.2 | 37.1 | 37.4 | 25.6 |
| Tuition assistance | 21.0 | 77.2 | 22.4 | 30.1 | 39.0 | 30.9 |
| Financial counseling | 20.5 | 82.4 | 22.5 | 29.4 | 39.5 | 31.1 |
| Pay advances or loans | 16.8 | 80.3 | 24.3 | 31.1 | 38.6 | 30.3 |
| Student loan assistance | 12.8 | 77.4 | 25.1 | 28.5 | 36.8 | 34.7 |

Most workers had access to health insurance (70%), paid time off (PTO) (60%), and retirement benefits (53%), while well under half had access to other benefits such as dental benefits and childcare assistance. Considering five commonly offered workplace benefits – health insurance, retirement, dental, PTO, and childcare, only 7% of workers were eligible for all five of these benefits and only 39% were eligible for four out of five of these benefits. For several benefits such as dental insurance and financial counseling, over a fifth of workers were not sure whether their employer offered the benefit.

In Table 2, health insurance and PTO stand out in terms of very high rates of usage and of workers who said these benefits were somewhat or very important. For several other benefits, both access and perceived importance were lower. These findings may reflect that most workers need certain benefits like health insurance, PTO, and retirement, while demand for other benefits such as tuition assistance and pay advances likely vary based on workers’ needs and circumstances.

Use of benefits did not vary greatly by educational attainment, work setting, and other factors, with some exceptions. Workers with incomes under \$25,000 were less likely to use most benefits compared to those with higher incomes, while workers with less than a college education were less likely to use retirement benefits, childcare assistance, and tuition or job training assistance.

To help put benefits access in a broader perspective, we compared frontline healthcare workers’ access rates to those of all U.S. workers. The *access gap* in Table 3 below represents the difference between frontline health care workers in this study and all U.S. workers concerning benefits they are offered. Workers had lower levels of access for five out of eight benefits compared to all U.S. workers.

Table 3. Employer benefits: Access and importance gaps

| Benefit | Access (%) | Access –U.S. workers (%)* | Access gap (%) | Important (%) | Importance gap (%) |
|-------------------------|-------------------|----------------------------------|-----------------------|----------------------|---------------------------|
| Health insurance | 70 | 73 | 3 | 89 | 19 |
| Paid time off | 60 | 77 | 17 | 85 | 25 |
| Retirement benefits | 53 | 72 | 19 | 87 | 34 |
| Childcare assistance | 41 | -- | -- | 71 | 30 |
| Dental benefits | 30 | 40 | 10 | 83 | 53 |
| Expenses reimbursement | 31 | -- | -- | 74 | 43 |
| Tuition assistance | 29 | 47 | 18 | 69 | 40 |
| Financial counseling | 22 | 17 | +5 | 69 | 47 |
| Pay advances or loans | 18 | 14 | +4 | 70 | 52 |
| Student loan assistance | 14 | 8 | +6 | 65 | 51 |

Note. Access is the percentage of workers whose employer offers the benefit and who are eligible to receive the benefit. Important is the percentage of workers who said the benefit was very or somewhat important. *Figures for all U.S. workers from the U.S. Bureau of Labor Statistics (2021c) and Society for Human Resource Management (2021).

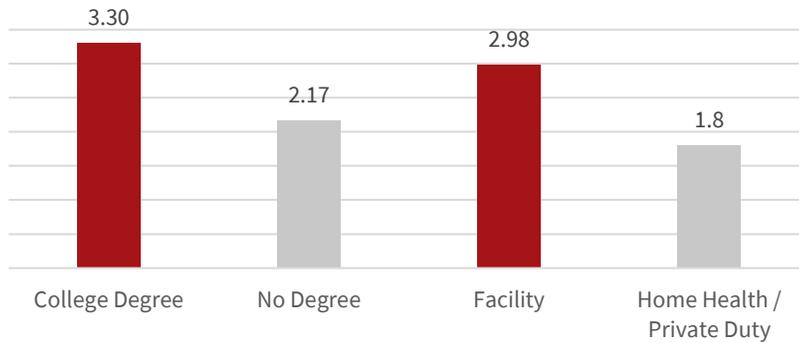
The *importance gap* represents the difference between the percentage of frontline health care workers who were offered the benefit and the percentage of these workers who said the benefit was important. As seen in Table 2, there was an importance gap for all 10 benefits with an average of 41 percentage points. That is, there were far more workers who said benefits were important than workers who received these benefits, suggesting unmet need.

Differences in access to benefits

Some workers enjoyed greater access to benefits than others. Out of all ten benefits, workers with college degrees had an average of 4.91 benefits compared to 3.67 benefits among workers without degrees. Workers in facilities had an average of 4.80 benefits compared to 2.58 benefits among workers in home health or private duty.

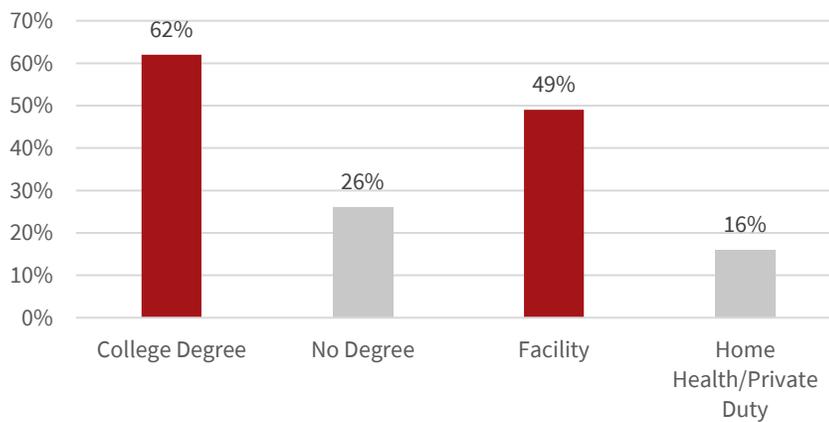
Considering five major benefits (health, dental, retirement, paid leave, childcare), workers in facility-based settings and those with college degrees had greater benefits.

Figure 2. Number of major benefits



The differences in benefits access noted above remain true after controlling for factors such as age, gender identity, and income using multivariate analysis. The predicted probability that a worker with a college degree had access to four out of five major benefits was 62% compared to only 26% among workers without a degree.

Figure 3. Probability of having most major benefits



This pattern of results held true for most specific types of benefits, as reflected in Table 4. For 7 out of 10 benefits, workers in facility-based settings had greater access than those in home health and private duty that was statistically significant.

For 9 out of 10 benefits, workers with a college degree had greater access than those with no degree, differences that were statistically significant. The degree/no degree distinction is important as it reflects differences in access to benefits for workers in different occupational categories such as DCW (mostly no degree) and RN (degree required).

Table 4. Factors Predicting Access to Benefits

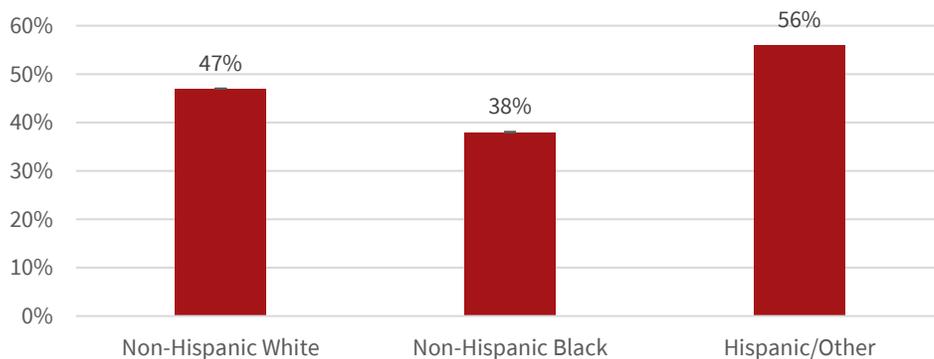
| Benefit | All | Work setting | | | Education level | | |
|-------------------------|-----|--------------|-------|-----|-----------------|-------------|-----|
| | | Facility | HH/PD | | Degree | No degree % | |
| Health insurance | 75 | 78 | 61 | *** | 76 | 74 | -- |
| Paid time off | 66 | 71 | 44 | *** | 72 | 60 | *** |
| Retirement benefits | 58 | 62 | 40 | *** | 68 | 49 | *** |
| Childcare assistance | 40 | 47 | 19 | *** | 58 | 26 | *** |
| Dental benefits | 28 | 28 | 32 | -- | 22 | 35 | *** |
| Expenses reimbursement | 30 | 30 | 29 | -- | 33 | 26 | ** |
| Tuition assistance | 28 | 29 | 23 | * | 31 | 23 | *** |
| Financial counseling | 20 | 21 | 19 | -- | 22 | 18 | * |
| Pay advances or loans | 17 | 18 | 14 | * | 19 | 13 | ** |
| Student loan assistance | 12 | 14 | 8 | *** | 15 | 9 | *** |

Note: HH/PD = home health or private duty settings. * $p < .05$, ** $p < .01$, *** $p < .001$.¹

Differences by race/ethnicity

Black workers were less likely than white and Hispanic workers to have four out of five major benefits – a difference that was statistically significant ($p < .01$):

Figure 4. Probability of having most major benefits



Health insurance type

Among workers using health insurance, 34% are enrolled in high deductible health plans (HDHPs) in which workers must pay at least \$1,400 for an individual or \$2,800 for a family out-of-pocket (OOP) before plan coverage begins. Workers without a college degree are more likely to have an HDHP (43%) and to pay \$400 or more per month on health insurance (33%) than those with a college degree or higher (25% and 20%) ($p < .01$).

¹ These “p values” mean that the difference in results were due to chance were less than 5, 1, and 0.1 percent, respectively. This means that the result was statistically significant.

.001). Also, workers in home health (38%) and private duty (51%) are more likely to have HDHPs than workers in facilities such as hospitals (30%) ($p < .001$).

Financial difficulties

Workers were asked about multiple aspects of financial well-being, including food insufficiency, material hardship, and having emergency and retirement savings. Notable findings included:

- A third of all workers experienced food insufficiency at least on occasion
- A quarter had problems paying for housing in the prior six months
- More than a third had emergency savings equivalent to less than one month of living expenses
- A third had recent problems making credit card and loan payments

Differences among workers emerged based on their race or ethnicity. As reflected in Table 5 below, Black workers had higher rates for 7 out of 10 financial difficulties that were statistically significant:

Table 5. Financial difficulties and race/ethnicity

| Financial difficulty | white | Black | Hispanic | |
|---------------------------------|-------|-------|----------|-----|
| Food insufficiency | 37 | 38 | 28 | * |
| Housing hardship | 28 | 31 | 27 | -- |
| Problems paying bills | 24 | 29 | 20 | * |
| Medical care hardship | 23 | 27 | 18 | * |
| Prescription drug hardship | 23 | 28 | 18 | * |
| <1 month in emer. savings | 36 | 46 | 36 | ** |
| No retirement savings | 23 | 44 | 34 | *** |
| Very hard to pay for childcare | 12 | 7 | 8 | * |
| Credit card/loan problems | 37 | 52 | 34 | *** |
| Problems getting by financially | 24 | 34 | 40 | *** |

Note: Results are from Chi Square tests. * $p < .05$, ** $p < .01$, *** $p < .001$.

Results of multivariate analyses showed that for most issues, workers without a college degree and who worked in home health or private duty settings had greater financial difficulties than workers with college degrees and who worked in facility-based settings.

Table 6. Factors Predicting Financial Difficulties

| Financial difficulty | Work setting | | | Education level | | | |
|-----------------------|--------------|----------|-------|-----------------|-------------|----|-----|
| | All | Facility | HH/PD | Degree | No degree % | | |
| Food insufficiency | 34 | 32 | 41 | *** | 25 | 42 | *** |
| Housing hardship | 25 | 24 | 29 | * | 16 | 35 | *** |
| Problems paying bills | 22 | 21 | 25 | * | 15 | 29 | *** |
| Medical care hardship | 20 | 18 | 28 | *** | 14 | 27 | *** |

| | | | | | | | |
|---------------------------------|----|----|----|-----|----|----|-----|
| Prescription drug hardship | 20 | 18 | 27 | *** | 12 | 28 | *** |
| <1 month in emer. savings | 34 | 31 | 45 | *** | 25 | 43 | *** |
| No retirement savings | 22 | 21 | 30 | *** | 13 | 34 | *** |
| Very hard to pay for childcare | 9 | 7 | 14 | *** | 8 | 9 | -- |
| Credit card/loan problems | 34 | 32 | 41 | ** | 23 | 45 | *** |
| Problems getting by financially | 26 | 25 | 27 | -- | 26 | 25 | -- |

Note: Results are from probit regression models using covariance control. HH/PD = home health or private duty. * $p < .05$, ** $p < .01$, *** $p < .001$.

Breaking down food insufficiency into its two components, differences among workers based on educational attainment and work setting are further illustrated:

Figure 5. Probability of worrying about running out of food

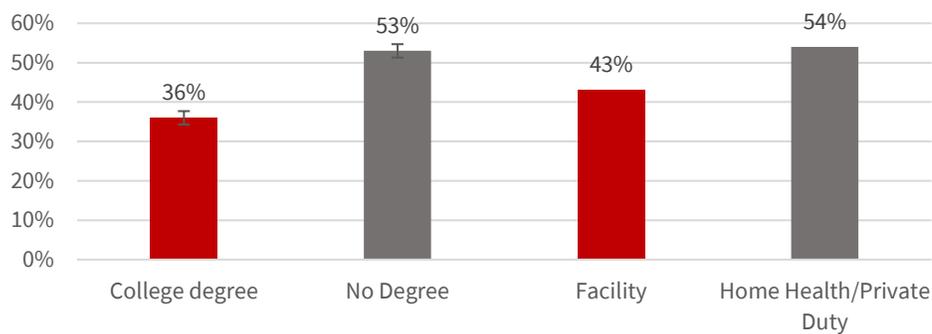
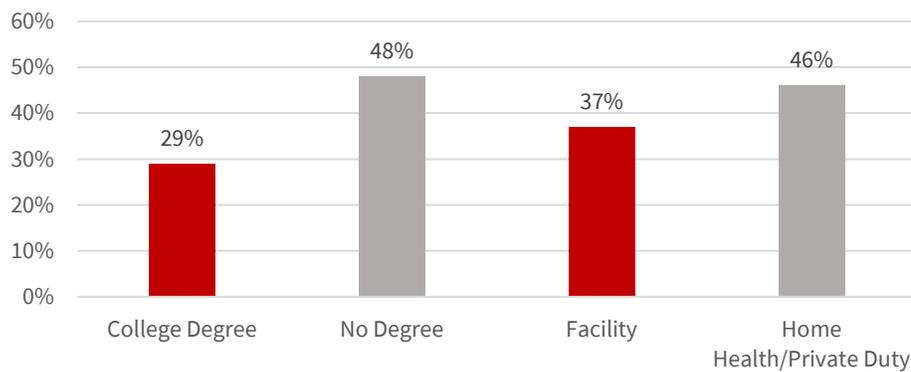


Figure 6. Probability of food not lasting



Access to benefits and financial well-being

Workers who have greater access to benefits such as health insurance may have greater financial well-being because these benefits help them cover important expenses, which frees up resources to meet other household needs such as food and housing. To assess this possibility, we examined how having access to a

greater number of benefits affected workers' risks for different bad financial outcomes, such as having trouble paying bills.

As seen in Table 7, the chances that workers experienced any of the 10 financial difficulties decreased with each additional benefit.

Table 7. Access to benefits and predicted probabilities of financial difficulties

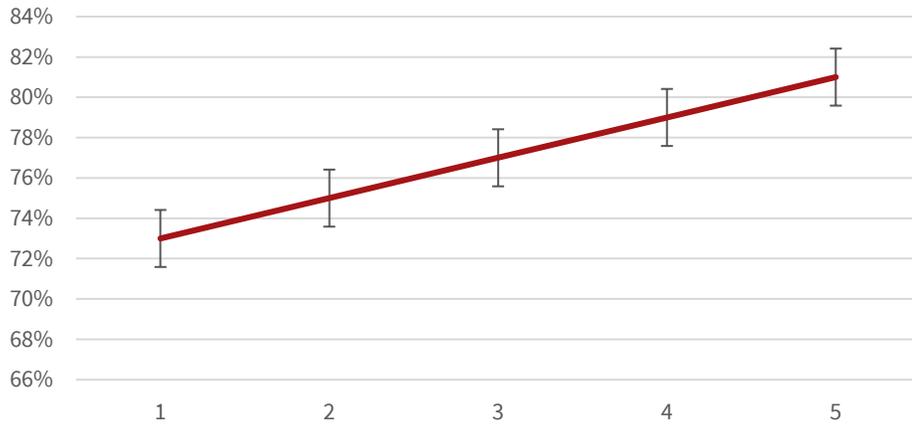
| Financial difficulty | Number of benefits | | | | | p |
|---------------------------------|---------------------------|------------|--------------|-------------|-------------|----------|
| | <i>One</i> | <i>Two</i> | <i>Three</i> | <i>Four</i> | <i>Five</i> | |
| Food insufficiency | 36 | 30 | 25 | 20 | 16 | *** |
| Housing hardship | 40 | 29 | 20 | 13 | 8 | *** |
| Problems paying bills | 31 | 25 | 19 | 15 | 11 | *** |
| Medical care hardship | 30 | 21 | 15 | 10 | 6 | *** |
| Prescription drug hardship | 29 | 21 | 15 | 10 | 6 | *** |
| <1 month in emer. savings | 45 | 38 | 31 | 25 | 19 | *** |
| No retirement savings | 37 | 31 | 26 | 21 | 17 | *** |
| Very hard to pay for childcare | 8 | 7 | 5 | 4 | 3 | ** |
| Credit card/loan problems | 67 | 49 | 32 | 18 | 9 | *** |
| Problems getting by financially | 37 | 34 | 32 | 29 | 27 | *** |

Note: Results are from probit regression models using covariance control. Benefits counted included health insurance, retirement, dental, paid time off, and childcare. * $p < .05$, ** $p < .01$, *** $p < .001$.

The results in Table 7 show that the more benefits to which workers have access, the better off they are financially. The risk for financial difficulty falls considerably with each additional benefit. For example, the risk for food insufficiency drops by 28% from one to three benefits, and by 34% from three to five benefits.

Whether workers say they are living comfortably is good way to gauge their overall financial situations. As seen below, the chances workers say they are comfortable rise steadily with the number of benefits to which they have access:

Figure 7. Predicted probabilities of living comfortably as a function of number of benefits



While having more benefits is better than less, do certain types of benefits matter more than others in this respect? We examine the unique contributions of health insurance, retirement, and paid time off regarding risks of financial difficulties in Table 8 below:

Table 8. Predicted probabilities of financial difficulties based on access to certain benefits

| | Health Insurance | | Retirement | | PTO | |
|--------------------------------|------------------|-----|------------|-----|-----|-----|
| | No | Yes | No | Yes | No | Yes |
| Food insufficiency | 48 | 27 | 47 | 22 | 42 | 26 |
| Housing hardship | 45 | 17 | 43 | 11 | 36 | 17 |
| Problems paying bills | 31 | 17 | 31 | 13 | 26 | 16 |
| Medical care hardship | 35 | 14 | 31 | 10 | 29 | 14 |
| Prescription drug hardship | 32 | 14 | 34 | 9 | 28 | 13 |
| <1 month in emer. savings | 49 | 28 | 49 | 21 | 39 | 29 |
| No retirement savings | 24 | 21 | 36 | 13 | 29 | 18 |
| Very hard to pay for childcare | 8 | 6 | 9 | 3 | 9 | 4 |

| | | | | | | |
|---------------------------------|----|----|----|----|----|----|
| Credit card/loan problems | 59 | 24 | 56 | 16 | 57 | 18 |
| Problems getting by financially | 31 | 23 | 35 | 19 | 27 | 23 |

Note: Results are from probit regression models using covariance control.

The pattern seen in Table 8 shows that each of these benefits is independently associated with decreased chances of experiencing all 10 financial difficulties. On average, having access to health insurance, a retirement plan, and paid time off reduces the chances of having a financial difficulty by 43%, 63%, and 44%, respectively.

Worker characteristics related to financial well-being

In addition to the roles of education, work setting, and benefits access, various worker characteristics were associated with greater probabilities of experiencing financial difficulties:

Race/ethnicity: Black and Hispanic workers had higher probabilities of *lacking retirement savings* and *just getting by financially or struggling to make ends meet* yet lower probabilities of *food insufficiency* compared to white workers, differences that were statistically significant. In addition, Black workers had a higher probability of *difficulties making credit card and loan payments*. No differences by race/ethnicity were found for 7 other financial difficulties.

Household income: Households with annual income of \$50,000 or more had lower probabilities for 9 of 10 financial difficulties while households with incomes of \$25,000 to \$35,000 had higher probabilities for 5 of 10 difficulties compared to the lowest income group (<\$25,000), differences that were statistically significant.

Children in the home: Having two or more children in the home was associated with a higher probability of *food insufficiency* and *having less than 1 month of emergency savings* compared to households with no children.

Emergency savings benefit experiment

Over a third of workers had emergency savings that would cover less than one month of usual expenses. In the survey, we randomly assigned workers to one of four questions concerning emergency savings. Workers were told “Imagine if your employer offered a benefit where a certain portion of your paycheck went into a savings account so you can have money for emergencies. Under this program,

- 3% of your paycheck would automatically go into a savings account and you could use the money whenever and however you wished.
- \$75 from your monthly pay would automatically go into a savings account and you could use the money whenever and however you wished.
- 3% of your paycheck would automatically go into a savings account and you could use the money whenever and however you wished. Also, your employer would contribute an extra \$500 if you completed a financial education program.

- 3% of your paycheck would automatically go into a savings account and you could use the money whenever and however you wished. Also, your employer would contribute an extra \$500 after your account reached \$500.”

Each worker saw one of these four statements and were asked to indicate on a scale of 0 to 10 how likely they would participate in the described savings program. These program scenarios were meant to test whether certain types of anchors (a percentage of one’s paycheck or a fixed amount) and/or incentives (employer matches under two scenarios) might make workers more or less likely to participate. Workers gave an average score of 6.87 (SD = 2.14) suggesting moderate interest in participating, yet there were no differences among the four groups. That is, no hypothetical program structure was better than the others.

Certain workers were more likely to say they would participate in a savings program. Workers with college degrees had an average participation scale of 7.31 compared to 6.21 among workers without degrees $p < .001$, yet there was no difference among workers based on work setting. Income was a factor; workers in the highest income group (\$75,000 or higher) were more likely than workers with lower incomes to participate $p < .001$. Workers who already had emergency savings were also more likely to participate than workers with no savings $p < .001$.

Conditions of work

Workers were asked a set of questions concerning work scheduling, as reflected in Table 9 below. In general, there were few differences between workers based on their work setting. Some variation in work schedules and hours was common, while nearly half of workers felt they did not have the right number of hours and did not have enough control over their schedules.

Table 9. Work scheduling experiences

| | Overall (%) | Facility (%) | HH/PD (%) |
|---------------------------------------|-------------|--------------|-----------|
| <i>Schedule variation</i> | | | |
| Same hours each week | 38 | 40 | 30 |
| Schedule varies at worker request | 37 | 38 | 34 |
| Schedule varies at employer request | 25 | 22 | 36 |
| <i>Number of work hours each week</i> | | | |
| Same number of hours | 43 | 43 | 40 |
| Hours vary somewhat | 41 | 41 | 41 |
| Hours vary a lot | 17 | 16 | 19 |

Satisfaction with number of hours

| | | | |
|---|------|------|-----|
| Right number of hours | 52 | 49 | 62 |
| Work too many hours | 31 | 32 | 27 |
| Work too little hours | 17 | 19 | 11 |
| Hours provide enough income to meet needs | 81 | 83 | 75 |
| Control over my work schedule | 54 | 54 | 50 |
| N | 2321 | 1833 | 487 |

Note: HH/PD = home health or private duty.

Workers were asked a set of questions about whether they had experienced various adverse events in the prior six months, as reflected in Table 10 below. Most workers did not experience each of these events, though more than a third felt they were underpaid at least once.

Table 10. Adverse Work Experiences in Prior Six Months

| Condition | Overall (%) | Facility (%) | HH/PD (%) |
|--|--------------------|---------------------|------------------|
| Patients need more care than I can provide | 18 | 19 | 14 |
| I was treated unkindly by a patient | 24 | 25 | 19 |
| My paycheck should have been higher | 37 | 36 | 38 |
| I did not get paid on time | 13 | 11 | 20 |
| I felt unsafe in a patient's home | 39 | -- | 39 |
| Patients live too far away from where I live | 40 | -- | 40 |
| N | 2321 | 1833 | 487 |

Note: HH/PD = home health or private duty.

Workers were also asked to indicate their agreement or disagreement with a set of statements reflecting various aspects of job satisfaction. Responses were recorded on a six-point likert scale where 1 = “disagree very much” 2 = disagree moderately” 3 = disagree slightly” 4 = agree slightly 5 = “agree moderately” and 6 = “agree very much”, with higher average scores indicating greater job satisfaction, as reflected in Table 11 below:

Table 11. Job Satisfaction

| Job aspect | Overall M(SD) | Facility M(SD) | HH/PD M(SD) | p |
|---|------------------|-------------------|----------------|-----|
| When I do a good job, I get the recognition I deserve | 4.13 (1.29) | 4.13 (1.29) | 4.12 (1.29) | -- |
| Communication seems good at my job | 3.87 (1.41) | 3.85 (1.43) | 3.93 (1.34) | -- |
| Most of our rules and procedures make it easy to do a good job | 4.10 (1.36) | 4.14 (1.34) | 3.97 (1.41) | * |
| I usually feel like my job is meaningful | 4.08 (1.33) | 4.08 (1.32) | 4.08 (1.38) | -- |
| I like doing the things I do at work | 4.04 (1.39) | 4.05 (1.40) | 4.03 (1.33) | -- |
| People who do well on the job here have a good chance of being promoted | 4.00 (1.37) | 4.05 (1.37) | 3.82 (1.39) | *** |
| I feel I'm being paid a fair amount for the work I do | 4.06 (1.36) | 4.10 (1.35) | 3.91 (1.40) | ** |
| The benefits I get are as good as what most other places offer | 4.13 (1.31) | 4.19 (1.27) | 3.92 (1.41) | *** |
| N | 2321 | 1833 | 487 | |

Note: Results are from t tests. HH/PD = home health or private duty. * $p < .05$, ** $p < .01$, *** $p < .001$.

On average, workers *slightly agreed* with all 8 job satisfaction items, though *communication* was rated lowest and *recognition* and *benefits* rated highest. For half of the items – *rules*, *promotion*, *fair pay*, and *benefits* – workers in home health and private duty settings had lower ratings than workers in facilities such as hospitals, differences that were statistically significant.

Frontline healthcare workers' intent to leave their jobs

Workers were asked how likely they would leave their current job within the next year, with 1 = very unlikely 2 = somewhat unlikely 3 = somewhat likely and 4 = very likely. On average, workers said they were *somewhat unlikely* to leave. Many factors might explain why a worker would consider leaving their job. Workers with kids and older workers might be more reluctant to change jobs. Access to benefits, pay, and job satisfaction

are other factors to consider. We conducted multivariate analysis to examine predicted probabilities of leaving controlling for demographic factors like age and having children.

Overall, 34% of workers said they were somewhat or very likely to leave their jobs within the next year. Workers without a college degree were more likely to consider leaving (38%) compared to those with degrees (23%) $p < .001$, yet there was no statistically significant difference by work setting. Workers with a greater number of major benefits to which they had access and those with higher levels of job satisfaction were less likely to consider leaving $p < .001$. Workers more likely to leave had an average of 1.82 major benefits compared to 2.92 among those less likely to leave. Similarly, workers more likely to leave had total job satisfaction scores that were 11% lower than workers not intending to leave.

Qualitative findings

Demographics of the sample

Thirty individuals were interviewed over the course of five months. The sample was predominantly female with only three male participants. There was a roughly even split between Black and white respondents with a small portion of interviewees of other races. Interviewees ranged in age from young adults to seniors. About half of the interviewees were in nursing assistant roles such as certified nurses' assistants (CNA's), registered nurses' assistants (RNA's), and licensed practical nurses (LPN's). The other interviewees had roles as aides or technicians, with job titles such as direct support professionals (DSP's), home health aides (HHA's), and resident technicians (RT's). The majority of interviewees worked in facilities such as hospitals or group homes

Pay and staffing

Low pay and staffing fuel burnout and job changes

Most interviewees were seriously concerned about staffing shortages in their workplace. High rates of staff turnover and persistent lack of adequate staffing resources were commonly reported issues. Some of these interviewees said that staffing shortages increased their own workload, causing extra stress and potential patient safety issues. As one interviewee described,

We're short three aides, and I have a couple of aides who have let me know that they are looking for other jobs. And so they're burnt out. And so like, I lose sleep over, 'Am I going to have enough people to cover? Am I going to be able to take care of these people like they need to be taken care of?'

Interviewees described a number of approaches that their employers had taken to address staffing concerns. Around a quarter reported that their employer offered overtime pay or shift coverage bonuses to incentivize current workers to pick up gaps in the staff schedule. Others said that their employer relied on outside staffing sources, including travel nurses and staffing agencies, to cover shortages. Many

interviewees expressed frustration at the large pay differences between in-house and contract staff. One CNA recounted an interaction she recently had with a colleague brought on from a staffing agency:

I personally make \$18.65. Now, that's also after 18 years of experience. I met an aide [from a staffing agency] that had two years' experience and she was making \$20-something an hour. I was like, 'Oh.' It was kind of a slap in the face.

Some interviewees acknowledged the necessity of contracting outside staff, but thought this strategy would make staffing issues worse in the long-term, since in-house staff would be motivated to seek employment elsewhere:

These places need coverage. They have to find people, and if they have to pay \$40 an hour for a CNA, then that's what they have to do. But it doesn't make the job any easier for the people who are doing it at regular pay. It makes them want to go travel. If somebody can come in and do the same job... Yeah.

Travelers have made money. They made a lot of money. But when you're in-house staff, you're not making that money. And then you ask them, 'You know, instead of paying travelers more money, why don't you just pay the nurses that you have more money so people can stay and not leave?' So that's been really a challenge. And that's why people are leaving and getting new jobs.

A considerable number of interviewees drew clear connections between staffing issues, pay, and burnout. Over half of interviewees brought up burnout as a major issue in their workplace or in the health care field in general. Many found their work environment to be physically and emotionally demanding, with some saying that staffing shortages have led them to feel overworked or taken for granted. A few participants said that this stress wasn't worth the low pay and lack of respect, suggesting a reinforcing feedback loop of feeling overworked, under-appreciated, and underpaid. As one interviewee said,

It just feels like sometimes it's... I don't want to say it's not worth it, because it is to me, but to a lot of other people, it doesn't feel worth it...even people who haven't been in it as long are like, 'You know, I'm making \$15 an hour. This isn't worth it.'

Another explained,

Well, I'll just talk about the pay. It \$14/hour... McDonald's, they pay \$15. And I'm taking care of people. I'm showering them. I'm giving them medicine. I'm keeping them alive.

Transitions and turnover

Few workers considered leaving the healthcare field

As illustrated, many interviewees found staffing and turnover challenges to be pervasive. However, very few of them were personally considering leaving the field. Most said they gained personal fulfillment from

working with their patients or clients, and some went as far as saying that patient care was the primary reason they remained in the field.

I'm doing it because I really love what I do. I love the patients. I love health... But if I didn't, I wouldn't do nothing like that, because it's not worth it to me, for what you're getting.

One source of turnover may stem from care workers “shopping around” in the field for better pay. Many interviewees were relatively new to their current role, even if they had been in the health care field for many years. Around two-thirds of had been in their current role for less than 5 years (and for many, less than 1 year). However, around half of these individuals specifically indicated they had transitioned to their current job from another health care position. According to one interviewee, the search for better pay was a major driver of these lateral job moves:

Right now, what's going on with the nurses...they're looking for jobs that are paying better now, because there are a lot of places that are paying good. There are places that are not paying well. So we're always trying around.

Benefits did not prompt job changes

Unlike pay, employee benefits did not seem to play as big a role in participants' decisions to stay in their current role or search for a new position. In fact, only one interviewee said that they considered benefits when in their job-seeking decision process:

That's one reason why I went back into the field, really, is to have health insurance and benefits... I think it's more of the benefits, more so than actually the job. What they have to offer you as an employee.

Another factor contributing to turnover in frontline care positions could be entry-level workers' aspirations to advance into roles with more responsibility and higher pay. Many interviewees were actively working to move up in the health care field; about a third of were enrolled in educational programs to earn more advanced nursing credentials.

I did realize that I definitely have to go back to school so I can be more marketable to maybe get in a different position that makes more money. I'm still probably going to fight the same battles, but at least if I go back to school, I can become a travel nurse. Now, they make money.

Tuition and student loan benefits

Some interviewees expressed a strong desire for their employer to offer tuition reimbursement and/or student loan benefits. As previously discussed, many workers were interested in or actively pursuing additional education in order to advance their careers. This benefit came up in connection to that educational advancement due to the high costs of tuition associated with it.

I'm in school now to get my BSN and it's pretty expensive. So if they would actually help us with the reimbursement or repayment of the student loans, I think that would be beneficial.

While many interviewees saw them increasing or desiring to increase their education as an important step in their career, they also expressed that their investment in their education in a benefit for the company. They believed that this benefit would have a return on investment for both parties.

Paying tuition...I think that would be great, too, 'cause I'm in school currently and just to have something to help out, because I'm essentially going to school for myself, but also to further the company. So that would be a benefit for the company as well.

Most interviewees who discussed tuition and student loan benefits did not have access to the benefit. However, there were a few who did. Among those interviewees, many of them mentioned restrictions around tuition reimbursement, such as limited degree and/or school options, limited amount of funding for reimbursement, or requirements around the length of time spent working for the company. These restrictions around the benefit created barriers to making the benefits useful. While some did experience these strict boundaries, a couple interviewees were satisfied with the options and support that the tuition reimbursement benefits at their company offered.

Childcare benefits

Although many interviewees did not have young children at the time of their interview, another commonly desired benefit was childcare assistance. This benefit was frequently mentioned as interviewees highlighted difficulties in childcare related to the high costs.

I do think that the childcare would be extremely helpful. Childcare is so ridiculously expensive right now, and that is a huge downfall for many parents.

Relatedly, a few interviewees discussed the disruptions to childcare that COVID-19 had created due to school closures or their children being exposed to the virus. These disruptions created conflicts with work schedules and/or finding replacement childcare.

Health insurance

Health insurance was highly valued but deeply critiqued due to affordability

A majority of interviewees received health insurance benefits through their employer. Some did not use or did not qualify for their employers' health insurance, so they opted to acquire health insurance on the marketplace, through a spouse, or through Medicaid. Of the participants who did use their employers' health insurance, most said that it is the most important benefit that they receive. Interviewees said this because it allows them to afford primary care, emergency care, medications, and other important health care.

Interviewer: And out of those [benefits], which ones do you find the most helpful?

Respondent: I mean, of course the health insurance.

As another interviewee said,

The most helpful would be insurance...vision, dental, and regular insurance. It's pretty important.

Despite the importance of it, interviewees were substantially dissatisfied with the health insurance they had. Many felt that their health insurance did not provide adequate coverage for care, had high deductibles, or other issues that led to it not being sufficiently beneficial. Further, many workers were frustrated and disappointed in the cost of the health insurance. One interviewee said,

A lot of us are afraid to go to the doctor, because it doesn't pay anything. So, and that's not good. They don't pay anything.

As another commented,

What I hear a lot is, people really, really, struggle to pay for this insurance, because their insurance is very expensive and high deductibles.

In another exchange, an interviewee communicated that health insurance would have been their most useful benefit if it was less expensive.

Interviewer: What ones are the most useful to you?

Respondent: Health insurance...well, no, paid time off. (laugh)

I: Why is that?

R: The health insurance is not that good. We got health insurance, but it's not nothing to brag about. You still pay a lot of money.

Adding family members was prohibitively expensive

One specific issue around health insurance costs that many interviewees discussed was the large jump in cost to add a spouse or child to their health insurance plan. Due to the high cost of adding a family member, many opted only to cover themselves alone and find other, more affordable options for their family members. One interviewee explained why she did not add her child to her plan.

I only carry health insurance on myself. We do have eye benefits, vision benefits. I do carry my daughter on my dental and vision benefits. I do not carry her on my health benefits, because if I put her on my

health benefits, it will increase my monthly premium by almost seven times more than I pay now. That is a huge downfall, being a single parent.

Another interviewee explained why she did not add her spouse.

Yes, they offer health insurance. I do use it. Since I'm married though, my husband is not on it, because it goes from \$100 a paycheck to \$700 a paycheck. And I was told that has to do with it being a nonprofit. So, he's not on my insurance, but I'm using the insurance right now, yes.

Even for interviewees who did include their family members on their health insurance, the choice was complex. As one individual noted, adding a family member prompted her to change her health plan.

I couldn't afford the PPO plan when I had my son on, so I had to do the high deductible. The high deductible makes me have to pay more money upfront before the insurance pays, so it's kind of a double-edged sword for me.

Many interviewees discussed the large difference between their gross pay and their net pay once health insurance and other taxes are taken out of their paycheck. To fill the gap, some interviewees mentioned they may work extra hours to make up for it. Between the high costs and the low-quality insurance, many interviewees were very disappointed with their insurance, but used it anyway as the alternative of having no insurance is too risky.

One of my coworkers, it was just her and her husband. And she was paying for his health insurance through our company and her paychecks for working 40 hours a week were only like \$500 for two weeks. So she works at least 20 hours of overtime a week to make what she would make if she didn't have health insurance through our agency.

Health insurance felt unjustly expensive for health workers

Some interviewees remarked that, as health care workers themselves, paying a substantial amount for their own insurance felt wrong.

We're considered human services. I feel like they should offer healthcare workers free health insurance.

Another interviewee felt other industries or companies provided better health care coverage than her own.

We have been complaining, because we pay a lot for health insurance, and we work for health care. If you work for you know, Foot Locker, you're paying cheaper in shoes, than somebody who is not working at Foot Locker. So you would think that the health insurance would be cheaper because of you working in health care. But it's not...we're paying very high I mean, if you work at Ford, they're covering their worker's health insurance. They don't pay for health insurance out of their pocket. That company pays for that. And we're paying a lot of money.

Plans have become more expensive

For workers who had been at their place of employment for a while, many commented on the declining value of the health care plans offered.

[The health insurance] used to be a lot better for us when this was a non-profit hospital. We got purchased by a for-profit company, and after that, it kind of went downhill a little bit. But it's still insurance.

We used to have pretty good health insurance, and it's not like, terrible now. But it would be better if the deductible... deductibles have gone up. It's not as good as it was. It doesn't cover as much.

We switched companies a couple of years ago, and it was just...the coverage was a little bit different. And so I feel like we took a little bit of a loss on that one...our job used to give us an amount, because we have a high deductible plan and we have a PPO and if you choose the high deductible plan, they would give you so much money toward your deductible. And I think when I started here it was \$1200 per person on the plan, and I think now it's down to like \$350.

Differences appeared in health insurance access and use by job role

Of the 30 interviewees, 16 were in nursing assistant or practical nursing roles (CNA's, RNA's, LPN's etc) while 14 were aides or technicians (HHA's, DSP's, hospital techs, etc). All 16 of the interviewees in nursing assistant roles reporting having access to health insurance through their employer. For aides and techs, 11 could access health insurance through their employer. The three people who did not have access to health benefits were all aides. However, in both roles, a portion of interviewees did not use their employer's health insurance despite having access to it. For nursing assistants, two used their spouse's health insurance while one used Marketplace insurance and another used Medicaid. The interviewee who used Medicaid said they became eligible after Medicaid expansion. The one who used Marketplace insurance had done so for the past two years due to travel nursing and wanting to avoid switching insurance with each new employer.

When the pandemic hit, I started travel nursing, so I would work with different agencies. So, to prevent me signing up with each agency, because most of them do offer it, I just got my own separate plan and I've been on that for the past two years.

Four of the eleven aides who had access to health insurance used other sources of insurance, but for different reasons. One used Marketplace insurance because they had used it prior to working for their current employer when they did not have access to employer coverage.

I don't use it. I just use the Affordable Care Act, the exchange stuff. That's the only thing that I've ever used since the last job I had 15 years ago that provided insurance. Yeah, I just use...I guess Obamacare is what it's called.

Another of the aides worked in direct service as their secondary job and had health insurance coverage from their primary job. The remaining two aides were under 26 and therefore were covered under their parents' health insurance plans.

Public benefits

The utilization of public benefits is an experience that many interviewees were familiar with. However, while there were a handful of interviewees currently enrolled in programs, most interviewees were not currently receiving public benefits. Some interviewees mentioned previously being enrolled in a public benefit program, but were no longer eligible due to increased income, changes in household composition, and/or overall growth in economic stability over the years.

It was more common for interviewees to mention that they knew of colleagues at their company who were using public benefits. One interviewee shared,

I have a coworker here who pretty much...we got a raise during COVID, and she had to...she declined the raise, just because she was going to lose coverage for her children through Medicaid. The raise wasn't going to cover the gap, so the best thing that she could do was just to decline the raise, so that she could keep the benefits for her children.

In conversations around public benefits, benefit cliffs came up multiple times as interviewees discussed their and/or others' experiences. These benefit cliffs create barriers for people who may want to work extra hours to increase pay, but cannot due to strict income eligibility rules related to public benefits. For the employees faced with this situation, the balance between upward mobility in the workplace and keeping public benefits needed to support one's household is a stressful one. As one interviewee said,

I had my daughter in 2016 and I was on public benefits. I had food stamps, she was on Medicaid, childcare assistance, I think that was it. And I was able to keep it through 2020. So about four years I got it, up until 2020. And the reason that I actually lost it in 2020 was due to getting the hazard pay that was being offered to work in a COVID-positive house.... It's a Catch-22. And I remember being in that place of, 'Oh, I just lost everything. How do I do this? I don't make that much, but they're telling me I make a ton.'...It's very, very stressful when you initially lose those benefits, especially when you've had them for so long.

Discussion

In this study, we examined access to benefits, conditions of work, and financial well-being of frontline health care workers. Eight key insights emerge from and ground our study:

Insight 1: Frontline health care workers have less access to workplace benefits compared to all U.S. workers.

Only 39% of workers were eligible for at least 4 out of 5 major benefits (e.g., health, retirement) and there was a large gap (41 percentage points) between the proportion of workers who said various benefits were important to them versus the proportion of workers who had access to these benefits.

Insight 2: Workers with college degrees *greater access to benefits* and *greater financial well-being* than workers without degrees.

Median wages for RNs (degree required) are 2.68 times higher than wages for DCWs. We find that this wage gap is exacerbated by a gap in benefits. As noted above, frontline healthcare workers without college degrees are more likely to be Black and Hispanic, which reflects racial disparities regarding access to higher education. Yet, even after controlling for income, workers without degrees are *still* at higher risk for financial difficulties.

Insight 3: Workers in facility-based settings like hospitals enjoy *greater access to benefits* and *greater financial well-being* than workers in home health or private duty settings.

Study results suggest that workers are better off financially if they work for a large employer such as a hospital rather than a home health agency. Like other large employers, hospitals and other large healthcare institutions typically have greater resources for offering benefits. Workers who are self-employed in private duty may enjoy scheduling flexibility, yet in general, self-employed workers are financially worse off than employer-attached workers (Auguste et al., 2022). For example, self-employed workers pay 15.3% of their net earnings for Social Security and Medicare taxes compared to 7.65% for employer-attached workers and lack access to important benefits like paid sick leave.

Insight 4: Black workers are more disadvantaged than white and Hispanic² workers; they have *lesser access to benefits* and *lesser financial well-being*.

Black workers had higher rates of financial difficulty, reflecting the larger social problem of racial economic inequality. This finding shows how being employed and earning income does not guarantee financial well-being. In general, Black households face an array of disadvantages that likely help explain our findings – lower levels of access to affordable housing, healthcare, affordable high-quality food, and educational opportunities, lower rates of home ownership, lower levels of wealth and inter-generational wealth transfers, and discrimination in housing and labor markets.

Insight 5: Workers who have *greater access to employer benefits* have *greater financial well-being*.

Our study illustrates how important benefits are as part of total compensation workers receive, especially in lieu of well-noted financial challenges confronting workers (Prudential, 2020). Financial difficulties are common – affecting a fifth to a third of frontline healthcare workers in our study. While there is growing interest in new types of benefits like earned wage access and workplace loans (Despard et al., 2020), “traditional” benefits like paid leave (Prudential, 2021) and health insurance are critical. An emerging marketplace of personal financial apps and digital platforms promise to help workers better

² We did not field the survey in languages other than English. This likely resulted in Hispanic respondents not being representative of all Hispanic frontline healthcare workers whereas Hispanic households in general are known to have lower levels of financial well-being compared to white households (Hernández Kent, 2020).

cope with their financial challenges, yet it is important that employers first look at how to improve existing benefits (Despard, 2021).

Insight 6: Conditions of work are affecting frontline healthcare workers downstream.

The introduction of this report describes the pressures all healthcare workers are enduring during the COVID-19 pandemic. Workers corroborated these points by talking about how staffing shortages are wearing them down. Almost a third of workers in our study said they are working *too many* hours and only half say they have control over their schedules. On average, workers said their satisfaction with different aspects of their job was a 4 out of 7. These findings act as an important reminder that conditions of work affect turnover. Improving pay and benefits may not be enough for frontline healthcare workers who are suffering from poor working conditions.

Insight 7: Job changes are common.

Over half of workers changed jobs in the prior year and over a third said they are likely to leave their current job within the next year. Factors that made workers less likely to consider leaving their jobs included having access to a higher number of major benefits. In interviews, workers explained that in considering a job change, they wish to stay in healthcare but want to be paid more; they did not say they looked at prospective employers' benefits packages to help them decide. Higher pay is easy to understand; \$2 more an hour means more food on the table. It may be less clear how an improved benefit package will translate into being better off financially, as employers typically only list the benefits they offer, not important details that could help workers assess the value of benefits.

Insight 8: Workers want to advance in their careers but lack support.

Healthcare is an industry in which career development ladders are readily apparent. Workers can clearly see a path from home health aide to LPN to RN, which would result in substantial wage gains. In interviews, workers talked about the importance of tuition assistance in supporting their career development, yet less than a third had access to this benefit. Workers also mentioned the issue of benefits "cliffs" – when higher earnings result in a loss of public benefits such as Medicaid, which is a major barrier to career development among frontline healthcare workers. For example, a CNA would be worse off financially in the short term if they advanced to become an LPN, despite long-term benefits of years of higher wages (Altig et al., 2021).

Insight 9: Workers are unhappy with their health insurance.

Workers we interviewed described how hard it was to afford healthcare despite having insurance through their employers. Premiums – especially for spousal or family coverage – take a huge bite out of workers' pay, while deductibles are high; over a third of workers had a high deductible health plan (HDHP). Workers without college degrees – who have greater financial difficulty – were more likely to have an HDHP and to pay \$400 or more per month on health insurance than more advantaged workers with college degrees. Having expensive premiums and high deductibles are a problem for workers because individuals delay or defer healthcare when their out-of-pocket costs rise (e.g., Al Rowas et al., 2017; Brot-Goldberg et al., 2017; Wharam et al., 2018).

Overall, given what prior research has found about frontline healthcare workers, our study findings come as no surprise. Yet what stands out about our study is that the more benefits workers have, the greater their financial well-being – even while controlling for income. In considering job changes, workers should understand the value of benefits a prospective employer offers, not just the change in pay. Workers told us loud and clear that improving health insurance and tuition assistance should be a key priority for employers. Also, certain types of workers are at a much greater disadvantage than others concerning benefits and financial well-being– those without college degrees, who work in home health or private duty settings, and who are Black. The good news is that workers told us they want to stay in healthcare and that they want to advance in their careers.

Implications

Our findings have important implications for healthcare employers and policymakers. Poor pay and benefits is not an inevitability for DCWs. Cooperative Home Care Associations (CHCA) is a worker-owned cooperative home health agency that offers a starting wage of \$15 an hour, health, dental, retirement, life insurance, and paid time off benefits as well as the opportunity to buy into the cooperative to receive dividends during profitable years. CHCA also partners with PHI and Independence Care System to offer a training program for home health aides to become care coordinators (Hostetter & Klein, 2021).

Loretto, a post-acute care provider, is offering new benefits to their employees including a car buying and financing program, free diapers, free healthcare and prenatal care, and emergency financial assistance. The company also provides tuition assistance for CNAs to return to school to earn credentials such as Licensed Practical Nurse (LPN) (Meyer, 2020).

Employer practices

Healthcare employers could consider additional strategies and practices related to study findings:

1. Offer a core package of benefits including health insurance, paid leave, retirement, dental, and childcare assistance. Access to these core benefits was strongly associated with greater financial well-being among workers. Childcare assistance is especially important because due to a lack of funding, less than a fifth of families eligible for public childcare subsidies receive them (Schulman, 2022).
2. Increase pay for DCWs. Pay for DCWs such as home health aides is dramatically lower than pay for other frontline health workers such as LPNs and RNs. While improving benefits is critical, raising wages is even more important as higher wages among DCWs boost recruitment and retention (Brannon et al., 2007; Howes, 2005) and improve care outcomes (Ruffini, 2021).
3. Establish and support career ladders for DCWs. Helping DCWs advance to positions such as LPN and RN offers a clear path to higher wages and economic mobility, reduces recruitment costs to and fills open positions for employers (Dill et al., 2012). Most home health aides aspire to achieve career mobility; 80% became aides because they eventually wish to become a nurse (Bercovitz et al., 2011).

Challenges of implementing career ladder partnerships include the bureaucracy and rigid work scheduling of healthcare organizations that make attending classes difficult and difficulties negotiating with educational institutions to identify alternative training opportunities (Dill et al., 2012). Also, DCWs can benefit from tuition assistance so they can afford a return to school.

4. Make health insurance more affordable. The simplest way to do this is to offer income-based premiums and deductibles so that frontline workers are not paying so much larger a share of their wages on insurance (Sammer, 2020). Another option is for employers to make contributions to lower-paid employees' Health Savings Accounts (HSAs) to help workers pay for needed healthcare until they meet their deductibles.
5. Promote emergency savings. Over a third of workers had no emergency savings or an amount of savings that would cover less than one month of usual expenses. The simplest way to do this is to offer employees the opportunity set up split direct deposit so that a certain percentage of pay is deposited in a savings account. Better yet, employers can offer matches and other types of incentives (Sammer, 2021). Emergency savings lowers the risk of workers experiencing many of the financial difficulties we assessed in this study (Despard et al., 2018). Workers in our study were moderately interested in building emergency savings through the workplace. Of the four savings program configurations we tested, none stood out as more appealing than the others, suggesting that *any* effort to make saving for emergencies easier will be welcome among many employees.
6. Improve work conditions. Many workers in our study lack control over their work schedules. Workers we interviewed are dealing with severe staffing shortages. Workers in home health and private duty settings had significantly lower levels of job satisfaction than those in facility-based settings. Many of these workers said they sometimes feel unsafe in patients' homes and live far away from their work assignments. When possible, employers can give workers more say in the creation of their work schedules, offer gas vouchers, mileage reimbursement, and other types of transportation assistance, and offer greater support for worker safety. PHI offers a comprehensive guide for improving work conditions for DCWs.³

Public policies

Employers need help from public policies to offer greater pay and improved benefits and work conditions. Public policies are also needed to help frontline healthcare workers beyond what employers can do. For example, healthcare providers and consumers who depend on Medicaid to finance care are less able to raise wages and improve benefits among DCWs (Campbell et al., 2021).

Employers and other stakeholders who are concerned about frontline healthcare workers – especially DCWs – can support the following policies and actions:

³ See <https://www.phinational.org/wp-content/uploads/2020/10/Would-You-Stay-2020-PHI.pdf>

1. Pass the Direct Creation, Advancement, and Retention of Employment (CARE) Opportunity Act (H.R. 2999), which would allocate \$300 million annually over five years toward recruitment, advancement, and retention strategies for the DCW workforce (PHI, 2021b).
2. Allow state wage pass-throughs. Several states allocate funds to long-term care facilities and home health agencies to increase compensation for DCWs via state Medicaid program waivers (Yearby et al., 2020).
3. Improve DCW pay and benefits via increased public spending on home and community-based services (HCBS). States are currently implementing home and community-based services (HCBS) spending plans under Medicaid (Section 1915c of the Social Security Act) using federal American Rescue Plan Act funding. The Build Back Better proposal⁴ includes additional HCBS enhancements to improve benefits and training for DCWs (Scales, 2022).
4. Change Affordable Care Act (ACA) regulations so that the determination of the affordability of employer-sponsored health insurance is made based on premiums for *family* not *individual* coverage (aka the “family glitch”).
5. Amend the Affordable Care Act (ACA) to allow lower-wage workers to opt into ACA Marketplace subsidies as a more affordable alternative to employer-sponsored coverage.
6. Increase federal funding for the Child Care and Development Block Grant program so that all families that are eligible for childcare subsidies can receive them.
7. Fix “benefits cliffs” by making public assistance benefits phase out more gradually as earnings rise for frontline healthcare workers to remove economic disincentives for career development (Altig et al., 2021).
8. Provide transitional income assistance benefits to DCWs enrolled in college or other training programs.

Conclusion

Frontline healthcare is perhaps the most demanding type of work in the U.S., made even more difficult by the COVID-19 pandemic and severe staffing shortages. Yet frontline healthcare workers fall behind other workers in the U.S. when it comes to workplace benefits, which we find are associated with having fewer financial difficulties and a lower chance of leaving one’s job. Frontline healthcare workers are dedicated,

⁴ As of August 2022, the Build Back Better proposal had not moved forward in Congress. A much smaller version of the proposal, the Inflation Reduction Act of 2022 is under consideration yet excludes provisions that would support DCWs.

but they need higher pay, better benefits, and improved work conditions. Employers can better support these workers by advocating for critical public policies and taking action to improve the benefits they offer and making work less emotionally and physical difficult.

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Technical Appendix and Study Limitations

Measures

To measure food insufficiency, workers were asked whether in the prior 6 months: “We worried whether our food would run out before we got money to buy more” and “The food that we bought just didn’t last, and we didn’t have money to get more.” Workers who responded “sometimes” or “often” to both questions were considered to have food insufficiency. These two questions were taken from the USDA household food insecurity survey module (USDA, 2012).

For material hardship, workers were asked whether in the prior 6 months they had difficulty paying for rent or mortgage, bills, medical care, and prescriptions. Workers were also asked whether they had any money in emergency savings and if so, for how long savings would last. Responses were coded as having less than one month of emergency savings or one month or more. Workers were also asked whether they had any retirement savings, which was coded as yes or no.

Concerning childcare, workers were asked, “In a typical month, how difficult is it for you to pay for child care?” with response choices of very, somewhat, not at all or not applicable. Responses were coded as 1 for very difficult and 0 for somewhat or not at all difficult.

For problems with credit card payments, workers were asked “Thinking about any credit cards and loans you have, which of the following best describes your ability to make monthly payments?”. Responses of “We are behind on our payments”, “We have stopped making some payments”, or “We have stopped making all payments” were coded as 1 to indicate having credit card problems and 0 if the response was “We are usually able to pay on time”.

For problems getting by financially, workers were asked “Overall, which one of the following best describes how well you are managing financially these days”. Responses of “Just getting by” and “Finding it difficult to get by” were coded as 1 indicating problems getting by and 0 for responses of “Living comfortably” and “Doing okay”.

Analysis

For multivariate analysis, we used Probit regression with robust standard errors and margins commands to estimate predicated probabilities. Covariates used in these models included age, income, gender identity, race/ethnicity, marital status, number of adults in the households, number of children under age 18 in the household, region, educational attainment, employment setting, and union membership.

Limitations

The key limitation of this study is that the survey sample was non-probabilistic; it was not possible to take a random sample of all frontline healthcare workers in the U.S. As a result, our findings may not generalize to all frontline healthcare workers. Characteristics of the sample reflected in Table 1 show that compared to

prior studies and data profiles of frontline healthcare workers, women, Black and Hispanic, and single workers were under-represented in the sample. Because we did not field the survey in languages other than English, workers born in countries other than the U.S. were likely under-represented. We did not ask a separate question about whether participants were living with a partner. It is possible that participants in partnered relationships answered that they were married.

We intended to focus our study on DCWs and recruited survey participants through a group of organizations that represent and/or advocate for DCWs. However, many frontline healthcare workers other than DCWs responded to the survey. Because we had expected only to hear from DCWs, we did not ask specifically about workers' title or credentials (e.g., CNA, RN). Instead, we used educational attainment (college degree or not) as a proxy for identifying DCWs which is a less accurate method than having asked survey participants to indicate their job titles.