

# Expanding Health Benefit Eligibility: Impacts on the IHSS Workforce

*Prepared for the Personal Assistance Services Council of Los Angeles County (PASC)  
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## BACKGROUND

Across the nation, states and counties are striving to replace institutional care with consumer-directed, in-home services whenever possible. The State of California, through its In-Home Supportive Services (IHSS) program, has been providing consumer-directed services since the early 1970s. IHSS is now nationally recognized as a model for enabling consumers to remain in their homes and direct their own services.

In the early 1990s, the California legislature gave counties the option of creating public authorities – quasi-governmental, consumer-directed agencies designed to enhance IHSS. Public authorities help consumers find homecare workers by operating worker registries, make possible collective bargaining by functioning as IHSS providers' employer of record, arrange training and support services for workers and consumers, and offer workers and consumers a voice in program and policy development. In 1992, California amended its State Medicaid plan to make IHSS a Medicaid entitlement and make available federal financial participation in IHSS worker wages and benefits. The California Assembly Bill 1682, enacted in 1999, mandated that counties form employers of record for Independent Provider (IP) IHSS workers.

The 2000-01 California Budget Act created an additional incentive – State matching funds – for counties to develop public authorities, increase IHSS wages, and offer health care coverage to IHSS workers. These were improvements for IHSS workers, who have been plagued by low wages, no benefits, and little or no training or support. Health benefits were implemented in order to 1) reduce unnecessary worker hospitalization, promote preventive health care, and 2) enhance workforce stability as well as quality of IHSS services.

In 1997, Los Angeles County created a public authority, the Personal Assistance Services Council (PASC), which has significantly enhanced the county's IHSS program.

As of March 2005, PASC functions as the employer of record for collective bargaining for 115,387 IHSS workers in Los Angeles County. This number represents 36% of all California IHSS providers.

In April 2002, PASC, in conjunction with the county and Service Employees International Union Local 434B (SEIU), the union which represents homecare workers in Los Angeles, offered a medical benefits plan for the first time to qualified IHSS homecare workers. The resulting PASC-SEIU Homecare Workers Health Care Plan (“the PASC-SEIU Plan” or “the Plan”) implemented a comprehensive employer-funded Health Maintenance Organization medical benefits program for homecare workers, at a premium cost to homecare workers of only \$1.00 per month. Initially, homecare workers had to be authorized to work 112 hours per month for two consecutive months to become eligible for coverage under the Plan. In 2004, the eligibility requirement was reduced from 112 hours to 80 hours per month. This expansion, together with overall growth in the program, increased the number of eligible homecare workers from 30,302 in 2003 to 58,561 in 2004.

A study of homecare workers in Los Angeles conducted in 2000 found that 45%, or nearly half, were uninsured.<sup>1</sup> The same study found that many homecare workers delay care, have chronic medical conditions that go untreated, and lack access to preventive care. Data derived from the California Management Information and Payrolling System (CMIPS) and adjusted data from a May 2005 Los Angeles worker survey indicated that the total percentage of uninsured workers has decreased to 39% in 2005. Data from a May 2005 survey of Los Angeles homecare workers indicated that PASC’s health benefit program has been a driving force in the decrease of uninsured workers. Eighty percent of enrollees surveyed reported that they had no health insurance prior to enrolling in PASC’s program.<sup>2</sup>

## RATIONALE

The current study follows up on previous work evaluating the **impact of benefit programs on worker retention and stability**. Turnover among homecare workers is a significant problem, creating chronic worker shortages, low skill levels, State financial loss, and compromised quality of IHSS services. Studies commissioned by PASC in

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<sup>1</sup> Cousineau, M.R. (2000). *Providing Health Insurance to IHSS Providers (Home Care Workers) in Los Angeles County*. Prepared for the California HealthCare Foundation, Oakland.

<sup>2</sup> Zawadski, R. (2005). *Impacts of medical benefits on service use and satisfaction: A survey of IHSS homecare workers in Los Angeles County*. Prepared for the Personal Assistance Services Council of Los Angeles County (PASC).

2003<sup>3</sup> and 2004<sup>4</sup> showed that health benefits reduced worker turnover. Therefore, it was postulated that expanding the number of workers eligible for benefits by reducing the eligibility requirement from 112 authorized hours to 80 authorized hours, as referenced above, would 1) increase the number of insured workers, and 2) extend the positive effect of benefits on worker retention. The present study evaluates the impact of expanded eligibility on worker enrollment in the health benefit program, on worker retention, and on worker satisfaction with benefits. It also explores factors that may inhibit worker enrollment in the health benefits program.

## 2003 PRELIMINARY ANALYSIS

The 2003 preliminary analysis, focusing on worker retention and stability, revealed two suggestive trends:

- 1) Workers who enrolled in PASC's health benefits program were more likely to remain in the workforce in month 12 than workers who did not enroll.
- 2) Health plan enrollees who leave the workforce during the 12-month period were more likely to return to the workforce within those 12 months than were non-enrollees.

## 2004 ANALYSIS

The 2004 analysis further developed the 2003 study in three important ways: 1) It extended the study period from 12 to 24 months, thereby assessing the impacts of health benefits on worker retention over a longer period of time. 2) It expanded the scope of the study by examining health benefits impacts on six cohorts as compared to four cohorts. 3) It isolated the impact of specific provider characteristics such as age, ethnicity, gender, and family or non-family provider status on both the worker's benefits enrollment status and the length of a worker's tenure in the field. **The 2004 study yielded three major findings:**

- 1) Workers who enrolled in PASC's health benefits program were far more likely to remain in the workforce in month 24 than workers who did not enroll.

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<sup>3</sup> Zawadski, R. & Radosevich, J. (2003). *The impact of health benefits on retention of homecare workers: Preliminary analysis of the IHSS health benefits program in Los Angeles County*. Prepared for the Personal Assistance Services Council of Los Angeles County (PASC).

<sup>4</sup> Zawadski, R. (2004). *The impact of health benefits on retention of homecare workers: A two-year study of the IHSS health benefits program in Los Angeles County*. Prepared for the Personal Assistance Services Council of Los Angeles County (PASC).

- 2) Health plan enrollees were far more likely to work continuously for the 24-month period of the study than non-enrollees.
- 3) Retention rates across all subgroups of race, gender, provider relationship to consumer, and age were significantly higher for enrollees than non-enrollees.

## PROJECT RATIONALE

This study builds upon previous studies and evaluates the impact of expanded medical benefit eligibility on retention. Additionally, the study charts the long-term impacts of benefits on recruitment and retention. Specifically, the 2005 study addresses questions raised in the 2003 and 2004 studies in three important ways: 1) It evaluates the impact of reducing the eligibility threshold from 112 to 80 hours by comparing the demographics, enrollment rate, and retention of workers enrolled under the 80-hour requirement rate to workers enrolled under the original 112-hour requirement. 2) It revisits and extends, from two to three years, the longitudinal analysis of retention rates for the original cohorts from the 2003 and 2004 study. 3) It supplements quantitative data on retention with responses from a survey of Los Angeles homecare workers conducted in May 2005, which provided vital information on worker enrollment, medical service use, and satisfaction.

The 2005 study sought to answer four major questions:

- 1) Are the workers who enrolled under the new 80-hour requirement similar (in terms of age, gender, race, and relationship to consumer) to workers enrolled under the 112-hour requirement?
- 2) Is the enrollment rate for *newly eligible* workers *invited* under the new 80-hour requirement as high as the enrollment rate for workers under the 112-hour requirement?
- 3) Are workers who enroll in health benefits under the new 80-hour requirement more likely than their non-enrolled counterparts to remain in the workforce and to work continuously over the 16-month study period?
- 4) Does the positive impact of health benefits on retention, identified in the 2003 and 2004 studies, continue over a three-year study period?

## Study Population

PASC initiated its new 80-hour criterion for benefit eligibility in April 2004. In February 2004, benefit enrollment packets were mailed to workers who were newly eligible for benefits because they were authorized to work 80 hours per month for two consecutive months (referred to as “newly eligible”). Packets were also mailed to individuals who

had been eligible for benefits under the 112-hour requirement but who had not yet enrolled in the program (referred to as “re-invitees”). The initiation of this new policy created a natural experiment whereby PASC could track the enrollment and work patterns of these workers from April 2004 to July 2005.

This study also included a three-year retention analysis of six provider cohorts, or new workers for each of the six months from February 2002 through July 2002. Worker retention rates and employment patterns were tracked longitudinally over the three-year study period. These cohorts constitute the original study group identified in PASC’s 2003 health benefit impact analysis and followed-up on in 2004. Using the same study group makes possible an expanded longitudinal analysis of health benefits on retention.

### **Data Source**

Demographic information, authorized hours, and benefit eligibility were culled from data in California’s Case Management Information and Payrolling System (CMIPS), the information system used by the State’s Department of Human Services to record IHSS recipient assessment and authorization data as well as IHSS provider work authorizations. State employment data for Los Angeles County for the period of April 2004 through July 2005 was obtained and analyzed to identify workers entering the PASC workforce in each month. A 12-month history of work activity and health plan enrollment was compiled for both newly eligible and re-invited workers. Providers who had current CMIPS work authorizations in a given month were considered active, and those who did not were considered inactive.

To supplement this data, and as part of its ongoing quality assurance and worker retention efforts, PASC engaged RTZ Associates, Inc. to conduct a worker survey. In May 2005, a survey was mailed to 4,120 randomly selected IHSS workers (2,060 PASC-SEIU benefit plan enrollees and 2,060 eligible non-enrollees), with an overall response rate of 15.4%. The survey was designed to 1) compare demographic characteristics between enrolled workers and eligible non-enrollees, 2) identify reasons for non-enrollment on the part of eligible providers, 3) compare satisfaction with medical services between enrolled workers and eligible non-enrollees, and 4) compare the use of medical services between enrolled and eligible non-enrolled homecare workers.

### **Calculating Rate of Worker Retention**

For purposes of this study, the retention rate is defined as the percentage of new workers who remain active members of the workforce in each month. For example, if

4,000 workers enter the workforce in January and 2,000 of those workers remain active in February, there was a 50% retention rate after one month. A retention rate is calculated for newly eligible (80-hour criterion) providers, both enrolled and non-enrolled, and for re-invited (112-hour criterion) providers, both enrolled and non-enrolled, for each month following entry into the workforce. Aggregated retention rates for health plan enrollees were then compared with those of non-enrollees. A  $\chi^2$  test was used to verify the statistical significance of that comparison.

### **Differentiating Between Continuous Workers And Returning Workers**

Worker retention rates alone can be slightly misleading, because some Independent Providers of homecare may enter and exit the field frequently. As IHSS consumers go into or out of hospitals or nursing homes, some IPs may not work for a few days or even weeks while the person they care for is institutionalized. Thus, the number of hours per month worked by an IP may vary from month to month. For example, after six months, 80% of new workers may be active, but if 90% were active only in the first and sixth months, the retained workers would not constitute a very stable workforce. Therefore, the percentages of workers who remained in the workforce, who exited the workforce but returned, and who exited the workforce without returning during the study period were calculated for enrollees and eligible non-enrollees. These percentages were then compared across enrollees and eligible non-enrollees to produce an indicator of workforce stability.

### **Measuring Statistical Significance**

A  $\chi^2$  test was used to test the statistical significance of the difference between groups in terms of demographics, retention rates, and work pattern comparisons across newly invited and re-invited workers and across enrolled and non-enrolled workers. Generally, a  $\chi^2$  value that achieves a significance level of 0.01 or more is considered to indicate a significant difference between groups. Unless otherwise noted in the current study, all reported differences were found to be statistically significant at the 0.01 level, meaning that there is less than a 1 in 100 chance that the difference in responses occurred by chance.

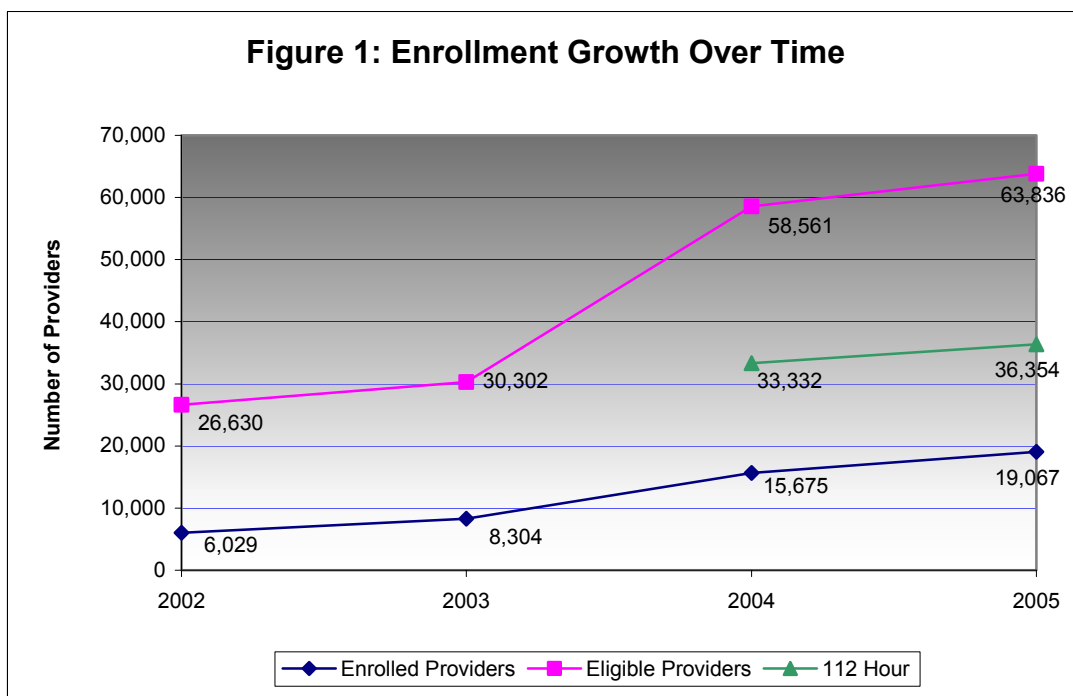
## **OVERVIEW OF FINDINGS**

### **Enrollment Growth**

An important indicator of the extent of health coverage under a medical plan is the enrollment rate. Enrollment rates represent the percentage of workers eligible for

medical benefits who have chosen to enroll in the program. IHSS benefit enrollment rates typically grow over time through increased worker exposure to the program and word of mouth information. PASC-SEIU Plan enrollment rates typify this steady growth, with a 23% enrollment rate in June 2002 rising to a 30% enrollment rate in June 2005. It is important to note that the number of homecare workers eligible for the plan has also grown significantly. The number of homecare workers eligible for the PASC-SEIU Plan is currently 2.4 times higher than the number of homecare workers eligible in 2002, and the Plan now insures over three times the number of homecare workers it insured in June 2002. The increase in both eligible and enrolled providers is also shown in Appendix A, which compares the numbers of active, eligible, and enrolled providers over time in each Los Angeles County Supervisorial District.

The graph below shows eligibility and enrollment growth for the PASC-SEIU Plan over time from 2002 to 2005. The bottom line shows the numbers of enrolled providers over time, the top line shows the total number of eligible providers over time, and the middle line shows the number of providers eligible under the 112-hour eligibility criterion. The numerical difference between the top and the middle line results in the number of providers who became eligible due to the shift to the 80-hour eligibility requirement. For example, in June 2004, 33,332 providers were eligible for the PASC-SEIU Plan under the 112-hour eligibility criterion. The difference between that number and the total number of eligible providers (58,561) is 25,229, which is the number of additional providers who became eligible under the 80-hour criterion.





## DEMOGRAPHICS

Provider demographics such as age, gender, race, and family or non-family relation to consumer employer were compared between 1) workers newly eligible under the 80-hour eligibility criterion and 2) re-invited workers who were eligible under the 112-hour eligibility criterion. Statistical comparison between the two groups found them to be similar across all demographic categories.

Next, provider demographics were compared across enrollee and eligible nonenrollee groups. For this comparison, the enrollee group was comprised of providers enrolled under both the 80-hour and the 112-hour eligibility criteria. In general, these findings confirm demographic findings from the 2005 worker survey and the 2004 study of Los Angeles workers. The table below shows the total group of workers divided by race, gender, worker relationship, and age. There were no significant differences found between enrollees and eligible non-enrollees in terms of gender or worker-consumer relationship. Racial and age differences between the two groups are discussed below.

**Table 1: Demographics of Enrollees and Eligible Non-enrollees**

<b>Race</b>	<b>Enrolled</b>		<b>Unenrolled</b>	
	<b>n=5,868</b>		<b>n=28,127</b>	
American Indian or Alaskan Native	9	0%	49	0%
Asian	856	15%	2,777	10%
Black	1,113	19%	6,169	22%
Hispanic	1,765	30%	7,715	27%
Native Hawaiian or Other Pacific Islander	52	1%	294	1%
White	2,073	35%	11,123	40%
<b>Gender</b>	<b>Enrolled</b>		<b>Unenrolled</b>	
	<b>n=7,909</b>		<b>n=37,174</b>	
Female	6081	77%	29,205	79%
Male	1,828	23%	7,969	21%
<b>Worker-Consumer Relationship</b>	<b>Enrolled</b>		<b>Unenrolled</b>	
	<b>n=7,909</b>		<b>n=37,482</b>	
Close	2,803	35%	12,490	33%
Other	5,106	65%	24,992	67%
<b>Age</b>	<b>Enrolled</b>		<b>Unenrolled</b>	
	<b>n=7,909</b>		<b>n=37,482</b>	
Under 40	2,076	26%	10,774	29%
40-49	2,329	29%	10,381	28%
50-59	2,503	32%	8,949	24%
60+	1,001	13%	7,378	20%



### **Race**

There was a disproportionately larger percentage of Asians and Hispanics, and a disproportionately smaller percentage of Blacks and Caucasians who enrolled in benefits. As found in previous studies, Asian workers comprise a larger percentage of enrolled (15%) than eligible non-enrolled (10%) workers, and Blacks comprise a slightly larger percentage of eligible non-enrolled (22%) than enrolled (19%) workers. Whites and Hispanics constitute 35% and 30%, respectively, of the total population of PASC-SEIU enrolled workers. These racial groups also constitute the largest proportion of eligible non-enrollees.

### **Age**

As in previous studies, enrollment percentages grow as age increases, and peak in the 50-59 age group. A considerably smaller percentage of the total enrolled population is aged 60 or over, due both to smaller numbers of seniors working and to seniors over 65 becoming eligible for Medicare benefits.

## **Previous Demographic Findings**

The most significant previous demographic finding emerged from the 2004 study and showed that benefits enrollees from *all* demographic subgroups of age, gender, race, and family or non-family relation to consumer employer were more likely to remain in the workforce after 24 months than eligible non-enrollees.

### *Gender*

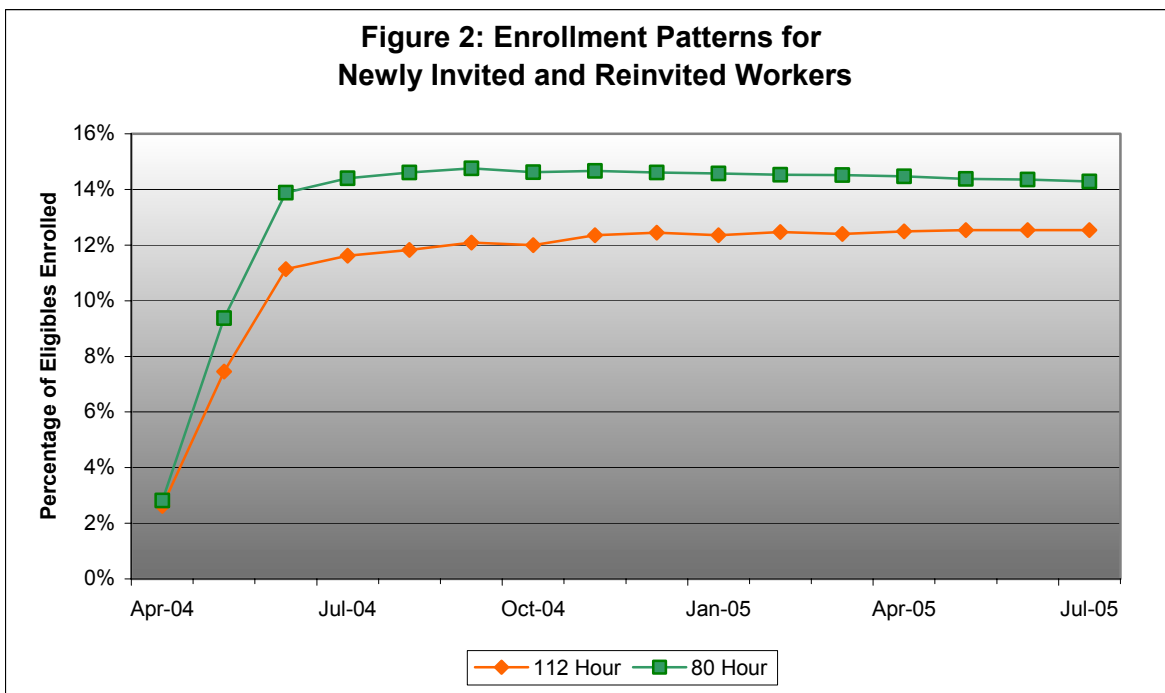
Previous studies found that female homecare workers tend to work more hours than male homecare workers, thus forming a larger proportion of workers eligible for PASC-SEIU benefits.

### *Age*

The 2004 study found that the highest proportion of enrollees *and* the highest proportion of workers who remained in the workforce after 24 months were found in the 46-55 age group. A smaller proportion of workers over 55 were either enrolled in PASC-SEIU benefits or remained in the workforce after 24 months.

## ENROLLMENT IN NEWLY ELIGIBLE AND RE-INVITED WORKERS

Figure 2, below, shows the rate of enrollment in the Plan for newly eligible workers and re-invitees during the first 16 months of the expanded eligibility policy. Initial enrollment rates were relatively low. For newly eligible workers (those invited in April 2004), just over 14% of those invited enrolled for benefits. Although they were invited at least once before, the enrollment rate for re-invitees was almost as high, at just over 12%. While these initial enrollment rates may seem surprisingly low to some observers, they were consistent with initial enrollment rates after the inception of the benefits program in 2002. In addition, previous research has shown that enrollment continues to increase over time as workers become more aware of the benefit program.



To evaluate the impact of benefits on enrollment over time, an additional analysis was conducted to compare current enrollment rates for 1) individuals invited to enroll under the 112-hour eligibility criterion, and 2) those invited to enroll under the new 80-hour eligibility criterion. As of July 2005, 22% of individuals who were mailed enrollment packets *during or after April 2004* had enrolled. Of all workers invited *prior to April 2004*, 36% had enrolled. **In other words, longer length of service as an IHSS worker is associated with a higher benefits enrollment rate.** One possible explanation is that, as worker awareness of the benefits program increases over time, workers enter the IHSS workforce or remain in it in order to obtain medical coverage.

A correlation between longer length of service and benefits enrollment was also found in PASC's Homecare Worker Survey. Survey results showed that workers who enroll in benefits have been working longer than eligible non-enrollees. Thirty-six percent of the enrolled respondents have more than 5 years in the workforce, as compared to 27% of non-enrollees. In comparison, IHSS homecare workers with less than one year in the workforce account for only 11% of enrolled workers. A quarter of enrolled workers (25%) have been in the workforce for one to two years, and homecare workers with three to five years in the workforce account for 28% of enrollees.

Current data, in addition to previous trends, suggests that worker enrollment in the program will continue to increase. First, 12% of re-invitees enrolled during the current study period, showing that more than one invitation may be necessary in order to engage workers. Second, 35% of eligible non-enrollees who responded to the May 2005 worker survey said they would enroll if they received another packet.

### *Reasons for Worker Non-Enrollment*

The May 2005 Homecare Worker Survey sheds some light on workers' reasons for not enrolling in PASC's benefit program. A majority of eligible non-enrollees (53%) reported that they had other medical coverage, such as spousal benefits, Medi-Cal, Medicare, or coverage from another job. In comparison, a much lower percentage (20%) of enrollees report having other coverage prior to enrollment in the PASC-SEIU plan. This difference reaffirms the fact that PASC is succeeding in its objective of focusing resources on the uninsured sector of homecare workers.

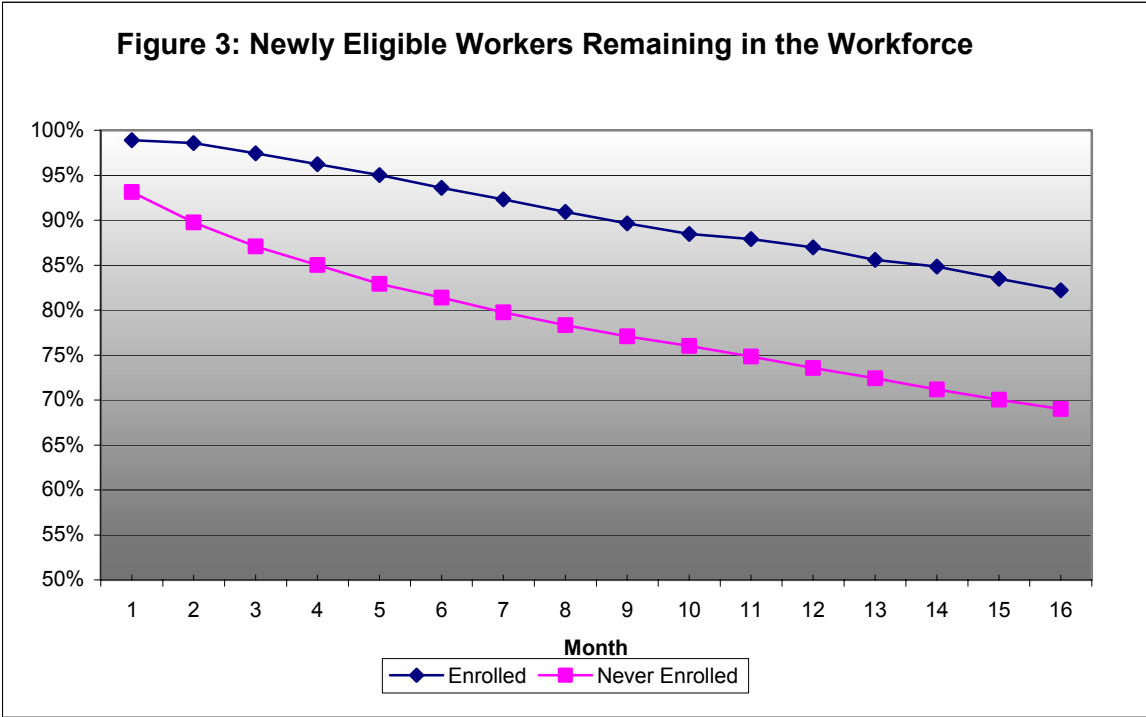
In a separate survey question utilized in the May 2005 survey, a large proportion (47%) reported that they were unaware of their eligibility. Yet, each worker was mailed at least one enrollment packet, in some cases three or more, informing them of their eligibility. Packets were mailed to the same addresses successfully used to deliver paychecks. Therefore, the survey response data presents a significant question: are workers receiving enrollment packets and not recognizing them as such? Homecare workers may be mistaking the enrollment packet for an insurance company solicitation or general "junk mail." If this is the case, it is very likely that the receipt of the packet would be quickly forgotten.

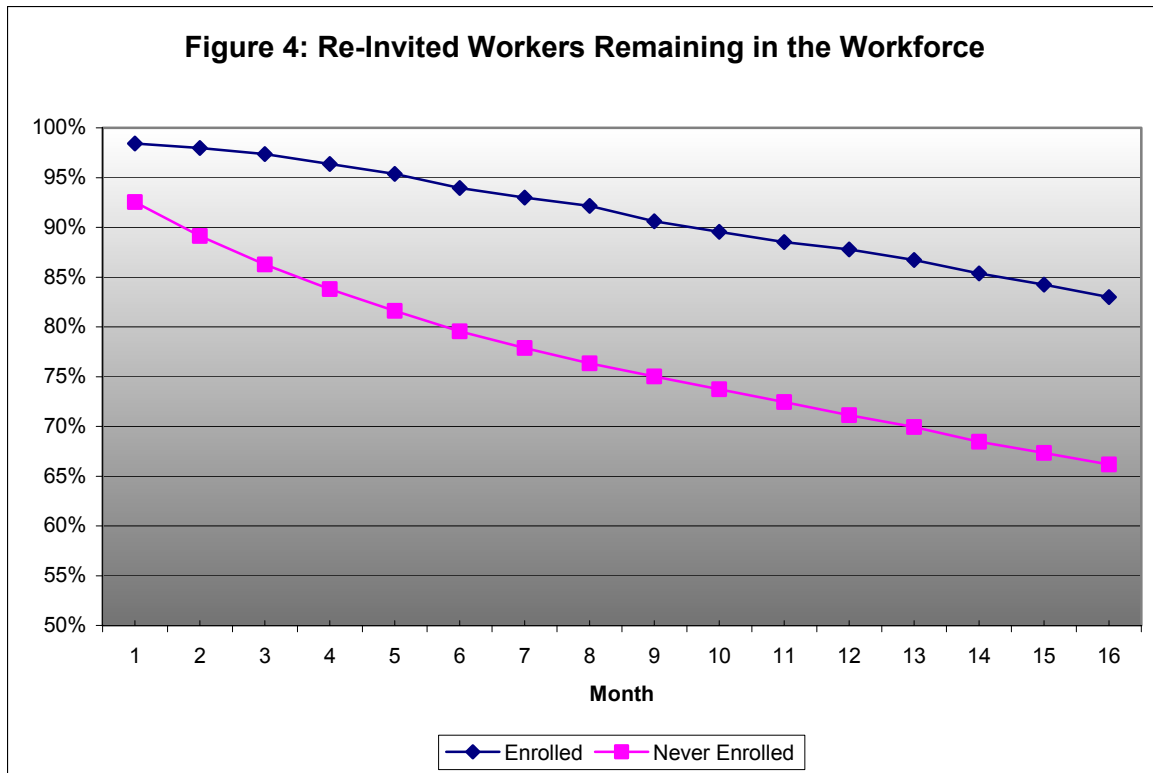
Workers may also choose to delay enrollment for a variety of reasons that were not captured in the above-referenced worker survey, including skepticism about the program and reluctance to become further involved in "the system." Again, data supports the view that worker awareness and trust in the program increase slowly but significantly over time.

### RATE OF WORKER RETENTION

As seen in Figures 3 and 4, below, individuals who enrolled in the benefits program, whether under the 112-hour or the 80-hour work requirement, were more likely than eligible non-enrollees to remain in the IHSS workforce. In the final month of the study, 83% of newly invited enrollees were still working, whereas only 66% of eligible non-enrollees remained in the workforce (Figure 3). For re-invitees, 82% of those who enrolled during the study were still in the workforce in the final study month, whereas only 69% of eligible non-enrollees remained (Figure 4).

This data is consistent with the one-year study of retention rates of workers enrolling in health benefits under the 112-hour criterion conducted in 2003 and a two-year longitudinal study of work patterns for that group conducted in 2004. **There is now a consistent pattern of data showing that homecare workers receiving benefits have a lower rate of turnover and, therefore, a higher level of stability.**





### *The Impact of Health Benefits on Worker Retention over a Three-Year Period*

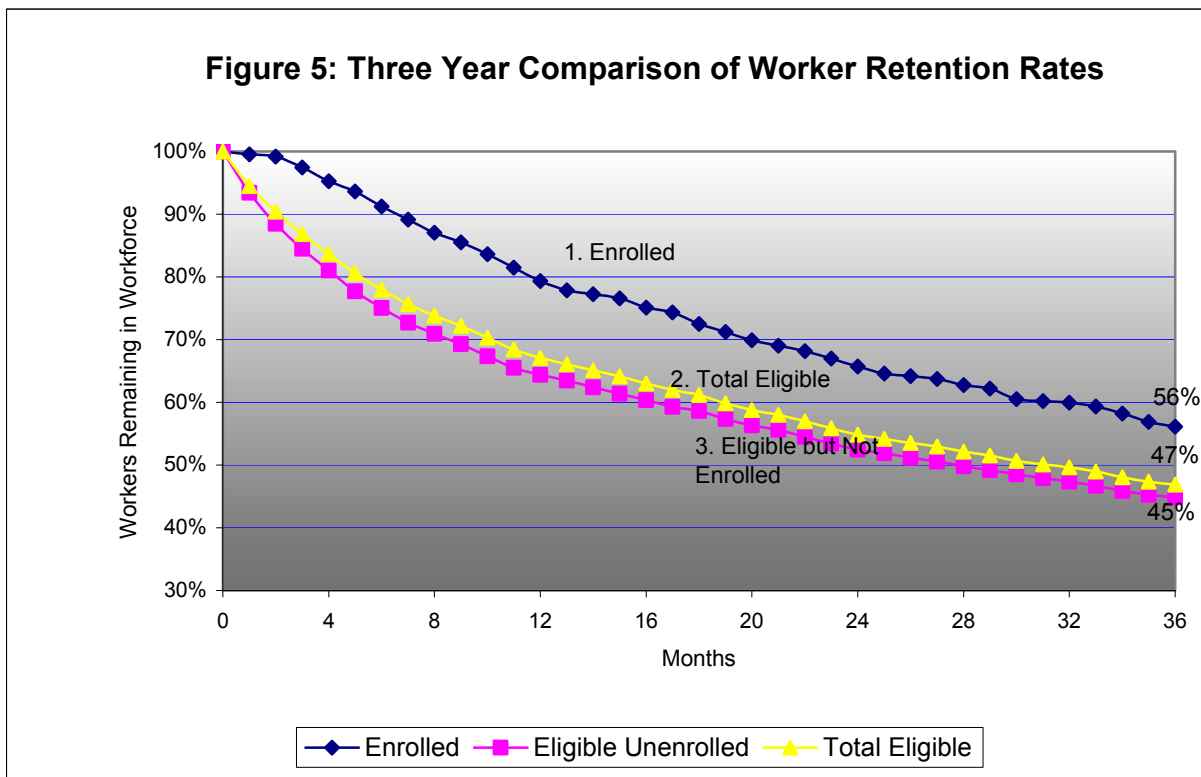
Figures 3 and 4, above, compare worker retention between enrolled and eligible unenrolled workers across 112-hour and 80-hour eligibility groups over the study period of April 2004-July 2005. These comparisons provide an accurate picture of worker retention during those months. In order to broaden that picture, PASC also commissioned a three-year longitudinal retention analysis of the original study group, used in PASC's 2004 health benefit impact analysis.

Data from the six original cohorts, or new workers for each month from February through July 2002, were compared, found to be similar, and combined for analysis. Figure 5, below, plots and compares, by month, the retention rates for workers for 36 months following their initial work authorization. Three groups of workers are tracked: **Group 1:** health benefits enrollees, **Group 2:** total eligible workers, meaning all enrolled and unenrolled workers eligible for benefits, and **Group 3:** all those workers eligible but not enrolled in benefits.

**Figure 5 shows a higher worker retention rate for enrolled workers than for eligible unenrolled workers across the entire three-year study period.** Fifty-six percent of

workers receiving health benefits (Group 1) remained active in the 36th month after initial entry into the workforce, compared with 47% of all enrolled and unenrolled workers eligible for benefits (Group 2), and 45% of eligible but unenrolled workers (Group 3).

The higher rate of enrollee retention found over the three-year study period confirmed the 2004 study findings which showed that 66% of workers enrolled in the PASC plan remained active in the 24th month after initial entry into the workforce, compared with 52% of eligible non-enrollees. Although retention rates generally decline over time, the retention rates of workers with health care were consistently higher, for every time period, than those without benefits. As expected, three-year retention rates were lower than previous two-year retention rates for both enrollees and non-enrollees. Lower rates reflect the fact that over a longer study period, more workers will naturally exit the workforce.



## CONTINUOUS VERSUS RETURNING WORKERS

Worker retention rates alone can be slightly misleading, because some Independent Providers of homecare may frequently enter and exit the field. Therefore, the following two figures chart employment patterns, including work entry and exit for enrolled and eligible non-enrolled workers. Figure 6 charts overall work patterns for enrolled workers, subdivided by 112-hour and 80-hour enrollment groups. Figure 7 charts overall work patterns for eligible but unenrolled workers, subdivided by 112-hour and 80-hour eligibility groups. Each column shows the percentage of that group that worked continuously, the percentage that exited but returned to the workforce, and the percentage that exited the workforce completely.

In summary, a significantly higher percentage of health plan enrollees than eligible non-enrollees in both 112-hour and 80-hour groups worked in all 16 months of the study, from April 2004 to July 2005. In the 112-hour group, 74% of enrollees worked during all study months, as compared to 60% of eligible non-enrollees. In the 80-hour group, 75% of all enrollees worked during all study months, as compared to 64% of eligible non-enrollees.

The higher levels of overall retention were reflected in both those providers who worked continuously and those who returned to the workforce. Individuals in both 80-hour and 112-hour enrollee groups exhibited an increased likelihood of returning to the workforce after exiting. In the 112-hour group, 9% of enrollees exited but returned to the workforce, while 6% of eligible non-enrollees did the same. In the 80-hour group, 7% of enrollees exited but returned to the workforce, while 5% of eligible non-enrollees did the same. These findings corroborate the preliminary 2003 analysis, which found that a larger percentage of enrollees (9%) than non-enrollees (5%) exited but returned to the workforce over a twelve-month study period.

A much smaller percentage of enrollees than eligible non-enrollees in both 112-hour and 80-hour groups exited the workforce completely. Seventeen percent of the 112-hour group and 18% of the 80-hour group of enrollees exited the workforce, while 34% of non-enrollees eligible under the 112-hour requirement and 31% of non-enrollees eligible under the 80-hour requirement exited the workforce completely.

These findings corroborate those of the two-year study conducted in 2004, which found that a higher percentage of enrollees than eligible non-enrollees (58% versus 43%) worked in all 24 study months.



Figure 6: Work Patterns in Enrolled Workers

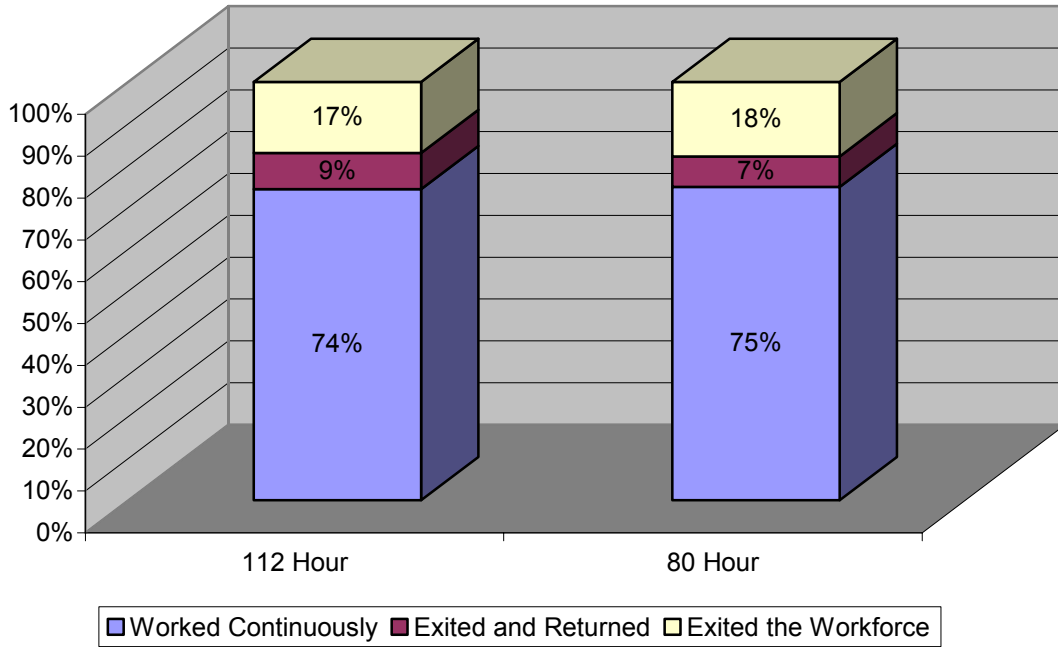
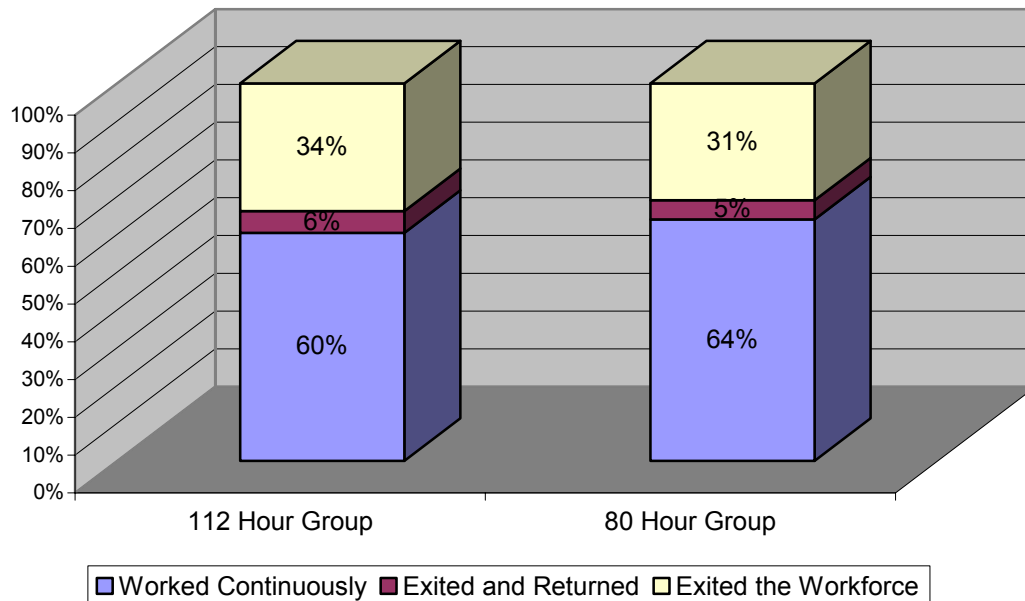


Figure 7: Work Patterns of Eligible Non-Enrollees



### *Three-Year Comparison of Workforce Retention*

Figures 6 and 7, above, chart work patterns over a period of 16 months. In order to ascertain the longer-range impact of benefits, PASC also commissioned a follow-up longitudinal study of work retention patterns over a total of 36 months. To examine the longer-term impact on retention, the current study revisited cohorts from the 2003-2004 study and observed retention rates in the third-year. Figure 8, below, charts work patterns over three years for two groups: 1) enrolled workers and 2) eligible but unenrolled workers. Each column shows the percentage of that group that worked continuously, the percentage that exited but returned to the workforce, and the percentage that exited the workforce completely.

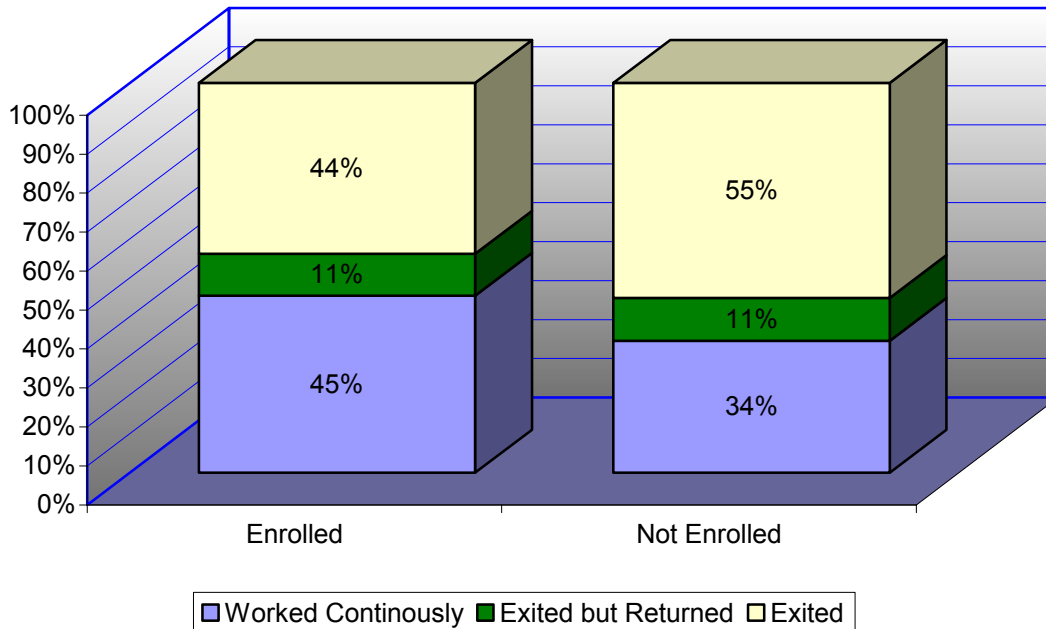
### *Findings*

Most significantly, findings from the three-year study period corroborated findings from previous analyses: **a significantly larger percentage of enrolled providers (45%) than eligible non-enrolled providers (34%) worked in all 36 months of the study.**

Because worker turnover rates tend to increase over time, it is not surprising that the number of workers employed in all study months decreased from the two-year to the three-year analysis. In addition, over a longer period of time, more workers will tend to exit and return to the workforce. This increase results in a higher percentage of exit and return (11%) in the three-year study as compared to the two-year study (5% and 6%).

The percentages of workers who exited and returned to the workforce was equal (11%) for both enrolled and eligible non-enrolled groups. **However, 21%, or nearly a quarter of those who exited and returned to the workforce, enrolled in benefits after reentry.** In other words, a considerable proportion of workers actively seek Plan enrollment upon return, suggesting that medical benefits are a likely inducement for homecare providers to reenter the workforce.

Figure 8: Three-Year Comparison of Work Patterns



### THE IMPACT OF HEALTH BENEFITS

PASC is not only committed to evaluating the impacts of medical benefits on worker retention and stability, but also to studying the impacts of medical benefits on the providers’ quality of life, which includes medical use and satisfaction. A homecare worker survey was conducted in May 2005 that compared medical use and satisfaction between workers enrolled in the PASC-SEIU Plan, workers with alternative coverage such as spousal benefits or Medicare/Medi-Cal, and eligible workers who remained uninsured. Analysis of the data showed that enrollees used more medical services and were more satisfied with their medical care.

#### *Increased Use of Medical Services*

Workers were asked how many visits they had made to medical providers within the previous twelve months. **The results showed that a higher percentage of covered homecare workers sought medical care in the previous 12 months than their uninsured counterparts.** Sixty-five percent of homecare workers enrolled in the PASC Plan reported seeking medical care at least once in the 12 months prior to responding to the survey. In comparison, only 51% of uninsured homecare workers made one or more

visits to a medical provider in the 12 months prior to responding to the survey. This pattern reflects an increase in proactive, preventive medical care and demonstrates that PASC is meeting its goal of improving health care and working conditions for IHSS homecare workers in Los Angeles.

### *Higher Satisfaction with Medical Care*

**Satisfaction with the PASC-SEIU health plan is high overall.** Seventy-five percent of homecare workers enrolled in the PASC-SEIU Plan report being satisfied with the plan, 34% report being very satisfied, and 41% report being somewhat satisfied. Of the nine health plan and medical care features homecare workers were asked to rate in terms of satisfaction, five features drew very satisfied and somewhat satisfied combined ratings of at least 70%.

Health care enrollees especially liked program costs, with 78% reporting they were very satisfied with the low monthly premium and 72% reporting they were satisfied with the amount they paid out of pocket for medical services.

In comparison, medical care satisfaction ratings from uninsured homecare workers were generally much lower than satisfaction with PASC. Thirty-five percent of uninsured homecare workers reported being satisfied with the medical care they receive, 20% reported being very satisfied with their medical care and 15% reported being somewhat satisfied. In every medical care satisfaction category, the PASC-SEIU Plan received higher ratings than medical care received by uninsured homecare workers. A considerably higher percentage of homecare workers with the PASC-SEIU Plan than homecare workers without insurance reported being very satisfied with general quality of care, locations of clinics/offices, the availability of translators, costs for medical services, premium costs, and benefits covered. When compared to workers who had enrolled in the Plan, non-enrollees with alternative health care coverage, such as Kaiser, reported even higher levels of satisfaction with their care.

## SUMMARY

### Enrollment Findings

Findings from the current study show PASC's expansion of the eligibility pool, by reducing the eligibility criterion from 112 to 80 authorized hours, has significantly increased the number of workers eligible for and receiving health care. As shown in Figure 1, 25,229 workers became eligible under the 80-hour criterion in 2004, and that number rose to 27,482 in 2005. The accompanying jump in plan enrollment, from 8,304 workers in June 2003 to 15,675 workers in June 2004, can in large part be attributed to the increased numbers of workers who became eligible due to the lowered requirement.

As with many IHSS medical benefits programs, enrollment in the program has been initially low, but is increasing over time, and study data shows that enrollment will continue to increase as workers' awareness and trust increases. One-third of the surveyed non-enrollees without insurance expressed interest in receiving another enrollment packet – demonstrating the growing interest in health benefits.

### Retention Findings

The data from the current and two previous PASC studies of health benefits and turnover provide strong, consistent evidence that providing health benefits reduces turnover. Turnover is a major problem for this workforce and for consumers needing in-home personal assistance services. The cost of turnover is high: frequent hires and terminations increase costs associated with increased employment administration and lost worker productivity during the time it takes for each new hire to complete the learning curve. High turnover and short staffing also place undue burdens on individuals who remain on the job and negatively impact consumers' health through unmet need for personal assistance services. In addition, lack of in-home service providers has been cited as a factor in higher rates of nursing home placement.

Studies from 2003, 2004, and now 2005 consistently indicate that health benefits are an important factor in drawing and keeping Los Angeles homecare workers in the field. Individuals who enroll in the benefits program are more likely to remain in the workforce – easing worker shortages, increasing worker skill level, reducing State financial loss, and improving quality of IHSS services.

## *The Proven Impact of Health Benefits*

### **Higher Use of Medical Services:**

Data from the May 2005 worker survey showed that workers covered under the PASC-SEIU plan are more likely to seek medical services than their uninsured counterparts. The increase in medical service use suggests that workers are accessing preventive care. Access to steady health care constitutes a dramatic improvement in workforce conditions, increases the overall health and stability of the workforce, and has been shown to decrease emergency and urgent facility use in the long term.

### **Higher Satisfaction with Health Plan and Medical Services:**

Survey data shows that enrollees are generally satisfied with their benefits, in particular the premium rates and out-of-pocket expenses. Although PASC enrollees are not as satisfied with their benefits and medical care as LA homecare workers with alternative coverage, enrollees *are* much more satisfied with their medical care than eligible homecare workers who have chosen to remain uninsured. In nearly every medical care category, significantly more enrollees in the PASC-SEIU health plan reported being satisfied when compared to eligible non-enrollees without insurance.

## **NEXT STEPS**

The 2005 retention analysis study and the 2005 survey of homecare workers provide a better understanding of the impacts of benefits on workers. As an important next step, PASC will be updating and expanding this retention analysis study in 2006. In addition, the current findings suggest a number of ways to improve the Plan and create tools for ongoing quality improvement: 1) monitoring satisfaction, 2) refining worker outreach, 3) analyzing service use, and 4) calculating potential impacts to indigent care costs.

### **Monitoring Satisfaction**

The first step in quality improvement is the monitoring of worker satisfaction. PASC, in its commitment to continuous improvement, has already taken quality assurance steps based on satisfaction data from this year's studies and surveys. For example, PASC is communicating with health plan administrators about enrollees' overall satisfaction with medical care.

In addition, the following steps can be taken to organize, enhance, and sustain tools for monitoring satisfaction on an ongoing basis:

- a) Monitoring worker satisfaction *with the Plan enrollment and eligibility process* through monthly review of Call Tracker Reports processed by RTZ Associates, Inc. Reports include worker queries and complaints as well as problem resolutions.
- b) Expanding the monitoring of IHSS worker satisfaction *with medical services* by requesting and reviewing county health plan records of worker calls.
- c) Monitoring *overall worker satisfaction and reasons for enrollment and non-enrollment* through an annual worker survey.

### **Refining Worker Outreach**

Based on survey feedback, PASC has begun to increase outreach to workers by increasing the frequency of enrollment and reminder card mailings. An important next step is to refine outreach by focusing attention on those workers most in need of coverage. Fifty-three percent of eligible non-enrollees report not enrolling in the Plan because they already have medical benefits, such as coverage under a spouse's plan. Therefore, return postcards allowing workers to notify PASC if they are already covered and not interested in PASC-SEIU benefits should be included in upcoming mailings. By narrowing the field of outreach, PASC will be able to focus resources on workers in need of coverage who may not be fully aware of the Plan, their eligibility, or the enrollment process.

### **Analyzing Service Use & Costs**

The 2005 survey of homecare workers yielded important data on the frequency of worker medical use. However, this data, as reported, may not reflect actual service use and cost. In order to more accurately assess the impacts of health benefits on medical use, and particularly use of preventive care, it would be desirable to study actual service use data and the costs of those services. Studying costs, service frequency, and types of services used by workers will enable PASC to better understand workers' health needs and how workers actually use their medical plan.

### **Calculating Potential Impacts to Indigent Care Costs**

The fiscal impact of health benefits programs is a question of utmost practical importance to counties. In general, because federal and State financial participation decrease the county's share of costs considerably, IHSS benefits prove to be a good value for the local community. Yet more specific fiscal questions, such as how benefits impact Los Angeles County indigent care costs, remain unanswered.



Because the PASC-SEIU Plan provides services through the county health system, Los Angeles County is ideally suited to compare indigent care costs before and after enrollment in the Plan. Eighty percent of Plan enrollees were previously uninsured, and presumably relied on the county's public health system for medical services. In other words, the county was most likely paying *more* for workers to go uninsured than to be covered under the Plan. Studying county health system cost data will enable PASC to compare individual workers' uninsured medical care costs to post-Plan costs, thereby factoring in public savings to overall IHSS costs.

In addition, it would be desirable to study the county health care costs of eligible workers who remain uninsured. Because medical costs increase rapidly over time, studying the *current* costs of uninsured workers will provide up-to-date information on real county expenditures for uninsured care.

Studying service use of the currently uninsured would also shed light on this group's health care profile. Results of the worker survey suggest that uninsured workers tend to either receive no medical care or make a large number of medical visits. This pattern suggests a lack of preventive care. However, without more data on the actual number and types of services received, it is difficult to give a definitive picture of the impact of medical benefits on worker health.

## **Conclusion**

PASC's ongoing commitment to health benefits for homecare workers is translating into a bigger and better pool of workers. As of October 2005, over 20,000 homecare workers in Los Angeles are insured through the PASC-SEIU Plan. Providing quality health care to an uninsured or underinsured workforce is a significant benefit for the workers and reduces costs for the community. A large pool of good homecare workers in turn benefits consumers who rely on personal assistance for the help they need to remain in their homes and in their communities. Finally, a strong consumer-directed personal assistance program also benefits the public service system, helping counties and states provide a more cost-effective alternative to institutional care.

### *Appendix A: Provider Status by Supervisorial District*

The following figures chart the numbers of active, eligible, and enrolled providers by Supervisorial District from February 2002 to July 2005. “Active” denotes all providers authorized to work, “eligible” denotes providers eligible for the benefits program, and “enrolled” denotes providers enrolled in the benefits program.

#### **Supervisorial District Enrollment and Benefits Penetration Rates**

<b>District</b>	<b>Enrollment Rate</b>	<b>Benefits Penetration Rate</b>
<b>Supervisorial District 1</b>	<b>33%</b>	<b>17%</b>
<b>Supervisorial District 2</b>	<b>26%</b>	<b>14%</b>
<b>Supervisorial District 3</b>	<b>31%</b>	<b>18%</b>
<b>Supervisorial District 4</b>	<b>30%</b>	<b>17%</b>
<b>Supervisorial District 5</b>	<b>30%</b>	<b>16%</b>

#### **Overview of Findings**

- Supervisorial District 5 experienced the largest increase in active providers, eligible providers, and enrolled providers over the study period.
- After Supervisorial District 5, Supervisorial District 2 contains the largest number (24,621) of active providers.
- After Supervisorial District 5, Supervisorial District 3 contains the largest number (13,812) of eligible providers.
- Supervisorial Districts 5 and 3 currently possess the largest numbers of enrolled providers: 4,488 and 4,244, respectively.

