Health Care Benefits Program
Impact of Reducing Eligibility Requirement

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In April 2002, the Los Angeles Personal Assistance Services Council (PASC) began to offer IHSS workers a health insurance package. Workers authorized to work at least 112 hours per month for two consecutive months qualify for the County Community Health Plan benefit, and those who consent are enrolled in the program. A proposal has been made to lower the authorization requirement from 112 to 80 hours per month. The purpose of this analysis is to review the initial health enrollment data and investigate the effects of a reduced 80-hour requirement on enrollment and health benefit costs.

Background: Health Benefits and the 112-Hour Requirement

One of PASC's original goals in adopting the health benefits program was to provide an incentive for existing members of the large and heterogeneous IHSS workforce to remain in the field. At the same time, offering affordable health insurance would attract additional workers into the IHSS workforce. For the county, an added benefit of IHSS worker health benefits was to come in the form of a reduced burden on indigent care services. The efficacy of the IHSS program depends in large part on the quality and reliability of the IHSS workforce. PASC's health benefits program was implemented to address these issues.

The program is supported by a combination of federal, state and local funds. The Los Angeles County Board of Supervisors, in authorizing the health benefit program, used the state-approved reimbursement rate of $0.60 per authorized work hour as a guideline to allocate funds to pay for the program. Based on projected costs, a 112-hour authorization requirement was adopted to insure that the cost of providing health insurance to every eligible worker would never exceed the $0.60/hour ceiling. It should be noted that this $0.60 per hour ceiling has been increased by more recent legislation.

Method of Analysis

Table 1 draws upon CMIPS data from April 2002 through November 2002 to provide a historical context for evaluating a reduced authorization scenario. The number of eligible workers is divided by the total number of active workers to yield the rate of eligibility under the current 112-hour-per-month requirement. "Enrollment rate" refers to the percentage of eligible workers who chose to enroll in the benefits program.

To simulate the effects of a reduced authorization requirement, the number of eligible workers for November 2002 was recalculated using an eligibility requirement of 80 authorized hours per month for the months of August and September 2002. Then the

number of would-be health care enrollees was determined for each of ten potential rates of enrollment. Using CMIPS data to determine the total number of authorized work hours for the entire active workforce, the total cost per premium and cost per premium per authorized hour was calculated for each of the ten rates of enrollment. The results of this analysis are shown in Table 2.

Findings 1: Historical Context

Table 1: Current Eligibility Requirements

Month/Year	Active Providers	Providers Eligible for HealthyWorkers (112 hrs)	% of Eligible Active providers	Eligible Providers Enrolled in HealthyWorkers	Penetration rate: % of Eligible Providers enrolled	% of Active Providers Enrolled
April-02	92,761	26,090	28.13%	4,084	15.65%	4.40%
May-02	93,471	26,343	28.18%	5,362	20.35%	5.74%
June-02	94,063	26,630	28.31%	6,040	22.68%	6.42%
July-02	94,833	27,016	28.49%	6,710	24.84%	7.08%
August-02	95,378	27,364	28.69%	7,057	25.79%	7.40%
September-02	96,050	27,644	28.78%	7,375	26.68%	7.68%
October-02	96,880	27,867	28.76%	7,560	27.13%	7.80%
November-02	97,612	28,305	29.00%	7,680	27.13%	7.87%

Table 1 summarizes the first eight months of IHSS workers' health benefits eligibility and enrollment information. Since the plan's inception in April 2002, worker enrollment has grown steadily. As workers have gained familiarity with the program, increasing numbers have chosen to enroll. The size of the workforce has increased, as has the percentage of the workforce receiving the health care benefit.

Specifically, from April through November 2002:

- The number of active providers increased 5%, from 92,716 to 97,612.
- The percentage of eligible providers, those working at least 112 hours in two consecutive months, has increased 3%, from 28.13% to 29%.
- The enrollment rate has increased 74% since inception, from 15.65% to 27.13%.
- As of November 2002, 7,680 workers, or 7.9% of the workforce, are currently enrolled in the benefits program, making PASC the state's largest provider of IHSS health benefits.

Findings 2: 80-Hour Eligibility Requirement

*Table 2: Projected Enrollment and Cost at 80 hours**					
Scenarios : Eligibility Rate *n* %	Number of Providers Enrolled at *n* % eligibility	Increase over Number of Providers currently Enrolled	% of Active Providers Enrolled	Total Cost of Premiums**	Cost per authorized hour
60%	29,859	22,179	30.59%	$ 6,188,875	$ 0.65
55%	27,371	19,691	28.04%	$ 5,673,135	$ 0.60
50%	24,883	17,203	25.49%	$ 5,157,396	$ 0.54
45%	22,394	14,714	22.94%	$ 4,641,656	$ 0.49
40%	19,906	12,226	20.39%	$ 4,125,917	$ 0.43
35%	17,418	9,738	17.84%	$ 3,610,177	$ 0.38
30%	14,930	7,250	15.29%	$ 3,094,437	$ 0.33
27.13%	**13,501**	**5,821**	**13.83%**	**$ 2,798,403**	**$ 0.29**
25%	12,441	4,761	12.75%	$ 2,578,698	$ 0.27
20%	9,953	2,273	10.20%	$ 2,062,958	$ 0.22

* Projections based on an 80-hour work authorization requirement and provider data for November 2002.
**NOTE ON CONSTANTS USED IN CALCULATIONS: Based on an 80-hour work authorization requirement, 49,765 workers would be elig accounting for 50.98% of all active workers. The current price per premium is $207.27. For the month of October, the total number of authorized work hours totaled 9,499,895.

If the 80-hour eligibility requirement were applied to the current month, November 2002:

- 51% of the IHSS workforce, or 49,766 workers would be eligible for the health benefit, compared with 28,300 or 29% under the current 112 hour authorization requirement.

Further, if the 80-hour eligibility requirement were applied to the current month of November 2002, at the current enrollment rate of 27.13%:

- A total of 13,501 workers, or 13.83% of the active workforce, would receive the health benefit.
- Benefit enrollment would increase by 5,821 workers 81%.
- The cost per authorized hour for the heath benefit would be $0.29.
- The cost of premiums per hour would not exceed the budgeted $0.60 per authorized hour, unless the enrollment rate grew to more than 55%.

Recommendations

These findings suggest that, in the context of November 2002, maintaining the current system but lowering the eligibility requirement from 112 to 80 hours per month would increase the number of workers covered from 7,680 to 13,501, an increase of nearly 43% at the current enrollment rate of 27.13%. Costs for health benefits would amount to approximately $0.29 per authorized hour, still well under the originally budgeted $0.60 per hour.

The enrollment rate in Los Angeles County is expected to grow, as it has in other counties with similar health care programs, such as Sacramento and San Francisco. For example, the HealthyWorkers program of San Francisco County, now in its fifth year, boasts an enrollment rate of 52%. It is unlikely that Los Angeles' enrollment rate will approach such levels in the foreseeable future. However, even at an enrollment rate of 52%, the cost per authorized hour would not exceed the original state-allocated level of $0.60. Recent changes to state legislation has increased the level of funding available for health care to a combined total of $11.10 per hour in wages and benefits. That means that even after the upcoming wage increase from $6.75 to $7.50 per hour, significantly more funds are available for health care. There is little chance of running over state matching limits by lowering the requirement to 80 hours per month.

Lowering the eligibility requirement is both reasonable and affordable. Over 40% of the cost of premiums is now covered by Federal Medicaid dollars, another 40% is covered by the state, and the remaining local share can be paid for with Realignment dollars. Under this existing financing arrangement, health care benefits can be increased and extended to a larger portion of the workforce at little or no additional cost to Los Angeles County. As such, lowering the requirement is an excellent opportunity for Los Angeles County to greatly increase the number of workers receiving health benefits and the benefit will likely attract new workers into the field. By making home care a more attractive employment opportunity, the County can increase the work force, reduce its cost for indigent care and make it easier for disabled and aged consumers find the assistance they need.

PostScript

In January 2003, Governor Davis proposed an expanded realignment initiative that would switch state costs for IHSS services to realignment funds. If implemented, this change would alter the source of funds but not alter the rules or levels of allowable reimbursement. Essentially, all costs for IHSS services including PASC operations and benefits would still be covered by federal dollars and state-wide funding pools. Due to changing interpretations of potential cost savings Interest in expanded realignment has been fading and today, March 2003, it seems unlikely.

In the first year of benefits operation the County advanced the local share of health care costs. That local share is now eligible for Realignment reimbursement under the Caseload Growth sub-account. Due to the state budget deficits and lower sales tax revenues, the Growth Fund Payments under realignment will, however, likely be delayed. If growth fund payments are not made in the year due, the obligation and claim will carry-forward to future years. State H&W Code recognizes IHSS services as a State mandated entitlement and makes it a priority and ongoing obligation of Realignment Growth Funds. Even if Growth fund payments under realignment are delayed, Baseline payments for Health care, which are based on current year expenses, will become available with the next fiscal year. Baseline realignment payments will cover an estimated two-thirds of the local share of current health care costs for next year and a growing share of the local cost in future years.

RTZ/PASC