

**Impact of Health Benefits on Retention of Homecare Workers:  
A Two-Year Study of the IHSS Health Benefits  
Program in Los Angeles County**

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(PASC)  
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**BACKGROUND**

**History of the LA PASC**

Across the nation, states and counties are striving to maximize consumer direction, and applying this tenet to in-home services for frail, elderly consumers and adults with disabilities. Policymakers are trying to replace institutional care with consumer-directed, in-home services whenever possible. The State of California has spearheaded this effort with legislation and funding incentives for counties that work to improve delivery of In-Home Supportive Services (IHSS). IHSS is a county-administered program funded primarily by Medicaid with federal and state dollars, that provides personal care services to low-income elderly and disabled Californians, enabling them to remain in their homes and communities. The vast majority of IHSS services are provided by independent providers (IPs), who are hired directly by consumers.

In the early 1990s, California legislation gave counties the option of creating Public Authorities – quasi-governmental, consumer-directed agencies designed to enhance the IHSS program. Public Authorities facilitate worker/consumer matches by operating homecare 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 1993 the California State Medicaid plan was amended to allow Title 19 Medicaid funding for personal care services delivered through IHSS. This change to the Medicaid plan enabled Public Authorities to use federal Medicaid funds to cover costs related to IHSS employee taxes, support services, wages, and benefits.

In 1997, Los Angeles County created a Public Authority called the Personal Assistance Services Council (PASC), and the agency has made significant headway in its efforts to enhance and improve the county's IHSS program. The agency's exclusive purpose is to enhance the delivery of personal assistance services to consumers and improve working conditions for independent IHSS workers. It functions as the employer of record for more than 110,000 homecare workers in Los Angeles County, who are hired directly by service recipients. Los Angeles County is home to more than 140,000 IHSS consumers.

The 2000/01 California Budget Act created an incentive for counties to both develop Public Authorities and have those Public Authorities offer health care coverage. The Act offers both wage and health insurance incentives that, when coupled with existing federal incentives, result in increased wages and the addition of a health care benefit being economically feasible for counties. The Los Angeles County Public Authority, beginning in April 2002, embarked on an innovative effort to improve homecare worker retention and workforce stability: it became the largest county in California to offer healthcare benefits to qualified IHSS independent providers. To become eligible for the benefit, providers must have worked 112 hours per month for two consecutive months. In early 2003, PASC commissioned a study to examine the feasibility of lowering benefit eligibility requirements from 112 hours per month for two consecutive months to 80 hours per month for two consecutive months. The conclusion of that study indicated that it was affordable and desirable, from both economic and pragmatic viewpoints, to lower the benefit eligibility requirement and thereby increase the number of workers covered by health benefits. Shortly thereafter, PASC, in concert with Los Angeles county and SEIU Local 434B, lowered the health benefits eligibility criteria from 112 to 80 hours per month for two consecutive months.

#### **THE NEED FOR DATA AND ANALYSIS ON HEALTH BENEFIT IMPACTS**

The implementation of health benefits is considered a pivotal improvement for independent providers who have been plagued by low wages, no benefits, and little or no training or support. Both the 2003 and the current 2004 studies show that implementing health benefits in this workforce lowers **worker turnover**, a phenomena which creates chronic provider shortages, low skill levels, state financial loss, and compromised quality of care.

Benefits were implemented on evidence that access to health benefits reduces unnecessary worker hospitalization, improved clinical outcomes, and promotes preventative health care. By reducing turnover, benefits also enhance the stability of the quality of cost-effective home and community-based alternative to institutional care.

The recent California proposal to eliminate benefits and cut provider wages by 30% would have resulted in a loss of available workers, a higher rate of worker turnover, a loss of services, and very likely a reduction in the quality of care. Proposed cuts such as these highlight the need for accurate documentation of the cost-effective nature of the IHSS program, **which costs only 21% of what is spent to keep a person in a nursing home.** They also highlight the growing need for individual states to collect turnover data in a systematic and longitudinal way to assess the impacts of health benefits on the stability of the direct-care workforce.

Until recently, federal policymakers have focused most of their attention on how

to control expenditures associated with the Medicare home health benefit. Little attention has been paid to the availability and quality of the workforce that provides the services and support (Stone, 2004). Because personal assistant health benefits is a relatively recent phenomenon, longitudinal data on the impact of those benefits has only recently become available for analysis. Up until now, studies which have concentrated on workforce quality and satisfaction have mainly emphasized, a priori, the need for benefits, or studied the overall impact of wage and benefit increases combined. For example, Howes' 2002 study examined the effects in San Francisco and Alameda counties on the supply of the home care workforce over four years when wages doubled from \$5 to \$10 an hour and health and dental benefits were added. She found that the size of the county workforce grew at twice the rate of the statewide IHSS workforce, and turnover fell by 35 percent.

In contrast, the PASC studies isolate health benefits as a separate variable, thereby examining benefits' particular impact on worker recruitment and retention. They also track individual workers over time in the form of cohorts as opposed to tracking total county percentages. These methodological shifts constitute a significant step forward in workforce benefits research.

### **2003 PRELIMINARY ANALYSIS**

Last year's preliminary analysis, focusing on worker retention and stability, revealed two suggestive trends: 1. workers who enrolled in the PASC's health benefits program were more likely to remain in the workforce in month 12 than workers who do not enroll, and 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. Last year's study findings suggested that the PASC has progressed toward its goal of creating a more permanent, stable IHSS workforce to meet Los Angeles County's growing consumer demand for in-home services.

### **2004 ANALYSIS**

The current analysis develops the previous study in three important ways. 1. It extends the study period from 12-24 months, thereby assessing the impacts of health benefits on worker retention over a longer period of time. 2. It expands the scope of the study by examining health benefits impacts on six cohorts as compared to four cohorts. 3. It isolates 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 current study addresses four major questions:

- 1) Worker Retention:** Are workers who enroll in the PASC's health benefits program more likely to remain in the workforce in month 24 than workers who do not enroll?

- 2) **Worker Stability:** Are health plan enrollees who leave the workforce during the 24 month period more likely to return to the workforce within those 24 months than non-enrollees?
- 3) **Demographic Factors and Enrollment:** What are the demographic factors that influence a worker's choice to enroll or not enroll in LA PASC's health benefits program?
- 4) **Demographic Factors and Retention:** What are the demographic factors that influence a worker's length of tenure in the field?

## **METHODS**

### **Study Population**

This study analyzed 8242 provider work histories from the California Case Management Information and Payrolling System (CMIPS). CMIPS is a state information system that tracks provider work hours and processes payment for the IHSS program. This study analyzed provider work histories in order to ascertain work patterns for enrolled and non-enrolled populations across demographic subgroups. The study population included all providers newly eligible for the health benefits program from February to July 2002. During the study period, eligibility required the authorization of 112 IHSS work hours for two consecutive months in addition to authorization of 112 hours at the month of enrollment. Each new group that became eligible each month formed a study cohort and these cohorts were tracked over 24 months. Cohorts were divided into those providers enrolled and not enrolled in the benefits program.

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

For purposes of this study, retention rate is defined as percentage of new workers that 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 each cohort, for each of months 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.

### **Calculating the Influence of Worker Demographics on Retention**

This study uses subgroup analyses to examine the role of moderator variables on the relationship between health benefits and worker tenure. Moderator variables for purposes of this study include the provider characteristics of age, gender, race and family/non-family provider status. Subgroup analyses are meant to answer questions such as: Does the relationship between enrollment and tenure vary by age or ethnic group? Is it different for family and non-family providers? For example, the relationship between benefits and tenure may be stronger for non-family providers who view homecare as a career; or the relationship may be less strong for workers in a particular language group.

These findings can help shape PASC decisions about how to effectively market its benefits program. A  $\chi^2$  test was used to verify the statistical significance of these comparisons.

### **Calculating Workforce Consistency**

Worker retention rates alone can be slightly misleading, because some independent providers of homecare may enter and exit the field frequently. As IHSS beneficiaries go into or out of hospitals or nursing homes, some IP's 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, a consistency percentage is calculated for workers in each cohort who remained active in month 24. Workers remaining active in all 24 months received a consistency rate of 100%, those remaining active in 23 of the 24 months were assigned a lower consistency rate, and so on. Health plan enrollees and non-enrollees are then compared, using the consistency rate as a rough indicator of workforce stability.

### **RESULTS**

The results of the current study validate and expand the results of the 2003 study. The design of the Los Angeles IHSS health benefits program was predicated on the idea that benefits are valuable to IHSS workers and therefore are an incentive to enter and remain in the workforce. ***The current analysis therefore focuses on worker retention and stability.*** The analysis revealed three striking trends:

- 1) Workers who enroll in the PASC's health benefits program are far more likely to remain in the workforce in month 12 than workers who do not enroll.
- 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.

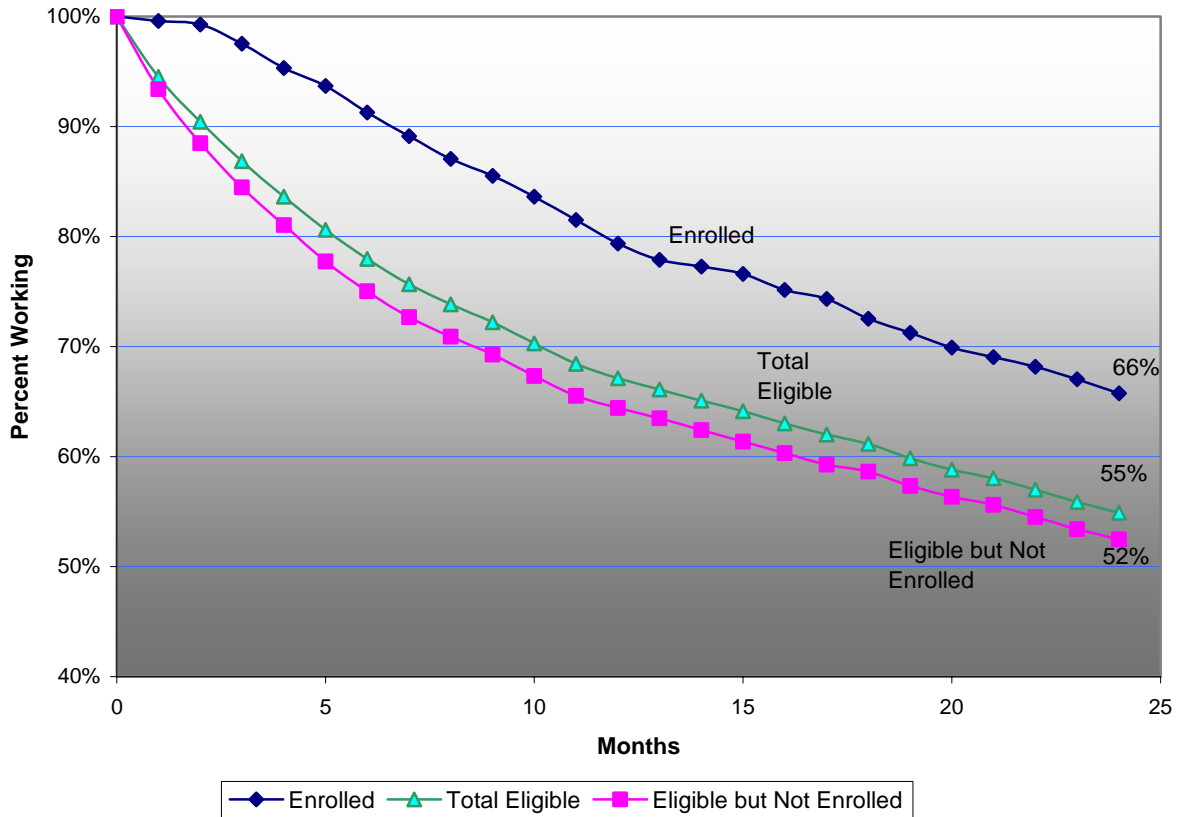
### **WORKER RETENTION**

Figure 1 (below) plots and compares, by month, the retention rates for workers for 12 months following their initial work authorization. Four groups of workers are tracked: Group 1. health benefits enrollees, Group 2. all enrolled and unenrolled workers eligible for benefits, and Group 3. all those workers eligible but unenrolled in benefits.

Data from the six cohorts, new workers for each month from February through July 2002, were compared, found to be similar and combined for analysis. Figure 1 shows that 66% of workers receiving health benefits (Group 1) remained active in the 24<sup>th</sup> month after initial entry into the workforce, compared with 55% of all

enrolled and unenrolled workers eligible for benefits (Group 2), and 52% of eligible but unenrolled workers (Group 3).

**Figure 1: Impact of Health Benefits on Worker Retention**



It should be noted that the higher retention rate for enrollees during the first three months of employment may be a function of the benefits eligibility requirements and enrollment process. Eligibility requires two consecutive months' work, of at least 112 authorized hours per month. During month 3, eligible workers are offered the benefit, and enrollment commences at the beginning of month 4. Therefore, workers who enroll at that point *must* have remained in the workforce. It is therefore important to focus on disparities in the retention rate from the third month forward.

**INFLUENCE OF DEMOGRAPHICS ON BENEFITS ENROLLMENT AND WORK RETENTION**

The current study shows that Los Angeles County workers, like personal assistants nationwide, are predominantly women, (78%); middle aged and older (72% are aged 40 and above and 44% are aged 50 and above); racially and ethnically diverse (26% Latino, 21% African American and 12% Asian or Pacific Islander); and not immediate family members of the consumers they work for (72% not close family providers).

The following two charts outline the relationship between provider demographics such as race, age, family or non-family relation to consumer, and gender on 1. benefits enrollment and 2. worker retention.

**Figure 2 charts the relationship between provider demographics and benefits enrollment.** The sum of each column equals 100% as it represents the entirety of the enrolled, unenrolled or total eligible worker population. For example, the first column shows that 16% of the enrolled population is Asian, 20% is Black, 30% is Hispanic and 34% is White.

**Figure 2: Demographic Characteristics of Enrolled and Non-enrolled Worker Populations**

<b>Race</b>	<b>Enrolled</b>	<b>Not Enrolled</b>	<b>Total Eligible</b>
n=	918	4302	5220
Asian	16%	10%	11%
Black	20%	27%	25%
Hispanic	30%	31%	32%
White	34%	32%	32%
<b>Gender</b>	<b>Enrolled</b>	<b>Not Enrolled</b>	<b>Total Eligible</b>
n=	1486	6718	8204
F	80%	79%	79%
M	20%	21%	21%
<b>Relationship</b>	<b>Enrolled</b>	<b>Not Enrolled</b>	<b>Total Eligible</b>
n=	1491	6751	8242
Close	20%	21%	21%
Other	80%	79%	79%
<b>Age</b>	<b>Enrolled</b>	<b>Not Enrolled</b>	<b>Total Eligible</b>
n=	6745	1489	8234
0-22	2%	3%	3%
23-35	14%	19%	18%
36-45	22%	25%	25%
46-55	34%	28%	29%
56-64	24%	16%	17%
65+	4%	10%	9%

**Race:** Hispanic and Caucasian providers make up a majority of the workforce. They also make up nearly identical percentages of both the enrolled and unenrolled workforces (Hispanic 34% and 32% respectively and Caucasian 30% and 31%.) African Americans make up a larger percentage of the unenrolled than the enrolled provider population. Although Asians make up the smallest percentage of both the enrolled and unenrolled workforces, they compose a larger percentage of the enrolled than the unenrolled workforces, suggesting that although the number of Asians in the workforce are smaller, they are more likely to be eligible for and enroll in health benefits than other groups. All enrollment disparities for the race subgroup were found to be statistically significant.

**Gender:** An overwhelming majority of the enrolled and non-enrolled provider population is female (80% and 79% respectively). Enrollment disparities between males and females were found to be statistically significant.

**Provider/Consumer Relationship:** An overwhelming majority of both enrolled and nonenrolled providers are not close family members of the consumer (80% as compared to 20%).

**Age:** Providers from the age 46-55 make up the largest percentage of both enrolled and unenrolled groups. Providers from 46-55 and from 56-64 make up a larger percentage of the enrolled than the nonenrolled population, while age groups from 0-22, 23-55 and 36-45 make up a larger percentage of the unenrolled than the enrolled population. The 65+ provider population makes up a larger percentage of the unenrolled group than the enrolled group, perhaps due to their eligibility for Medicaid benefits. All enrollment disparities between age groups were found to be statistically significant.

**Figure 3 below charts the relationship between provider demographics, enrollment status and work retention rates.** The sum of each column does not equal 100%, as each percentage represents the fraction of each subgroup remaining in the workforce in month 24 of the study period. For example, the first column shows that 72% of enrolled Asian providers, 57% of enrolled African-American providers, 65% of enrolled Hispanic providers and 74% of enrolled White providers remained in the workforce after 24 months.

**Figure 3: Demographic Influence on Work Retention Rates**

Race	Enrolled	Not Enrolled	Total Eligible Retention Rate
Asian	72%	60%	64%
Black	57%	50%	51%
Hispanic	65%	54%	56%
White	74%	62%	64%



Gender	Enrolled	Not Enrolled	Total Eligible Retention Rate
F	66%	53%	55%
M	64%	50%	52%

Relationship	Enrolled	Not Enrolled	Total Eligible Retention Rate
Close Family Provider	75%	63%	65%
Other	63%	50%	52%

Age	Enrolled	Not Enrolled	Total Eligible Retention Rate
0-22	50%	39%	40%
23-35	61%	45%	48%
36-45	68%	54%	56%
46-55	70%	57%	60%
56-64	62%	55%	57%
65+	63%	49%	50%

**In summary, benefits enrollees from all demographic subgroups were more likely to remain in the workforce after 24 months than non-enrollees.**

**Race:** Retention rates for enrolled Caucasian and Asian providers in the study were the highest, at 74% and 72% respectively. The difference in retention rates between enrolled and nonenrolled providers was the largest for Hispanic, Asian and Caucasian providers, suggesting that health benefits may be seen as more of a retention incentive by these subgroups than by the African-American provider population. All retention differences between enrolled and nonenrolled populations for racial subgroups were found to be statistically significant.

**Gender:** Retention rates for women and men were similar (66% for women as compared to 64% of men). The proportional drop in retention from enrollees to non-enrollees was also similar across gender, dropping from 66% to 53% for females and 64% to 50% for males. The study shows that although fewer men enter the provider workforce, the ones who do so continue on in the workforce.

**Provider's Relationship to Consumer:** Enrolled close family providers exhibited a higher retention rate than providers not closely related to their employers (75% as compared to 63%).

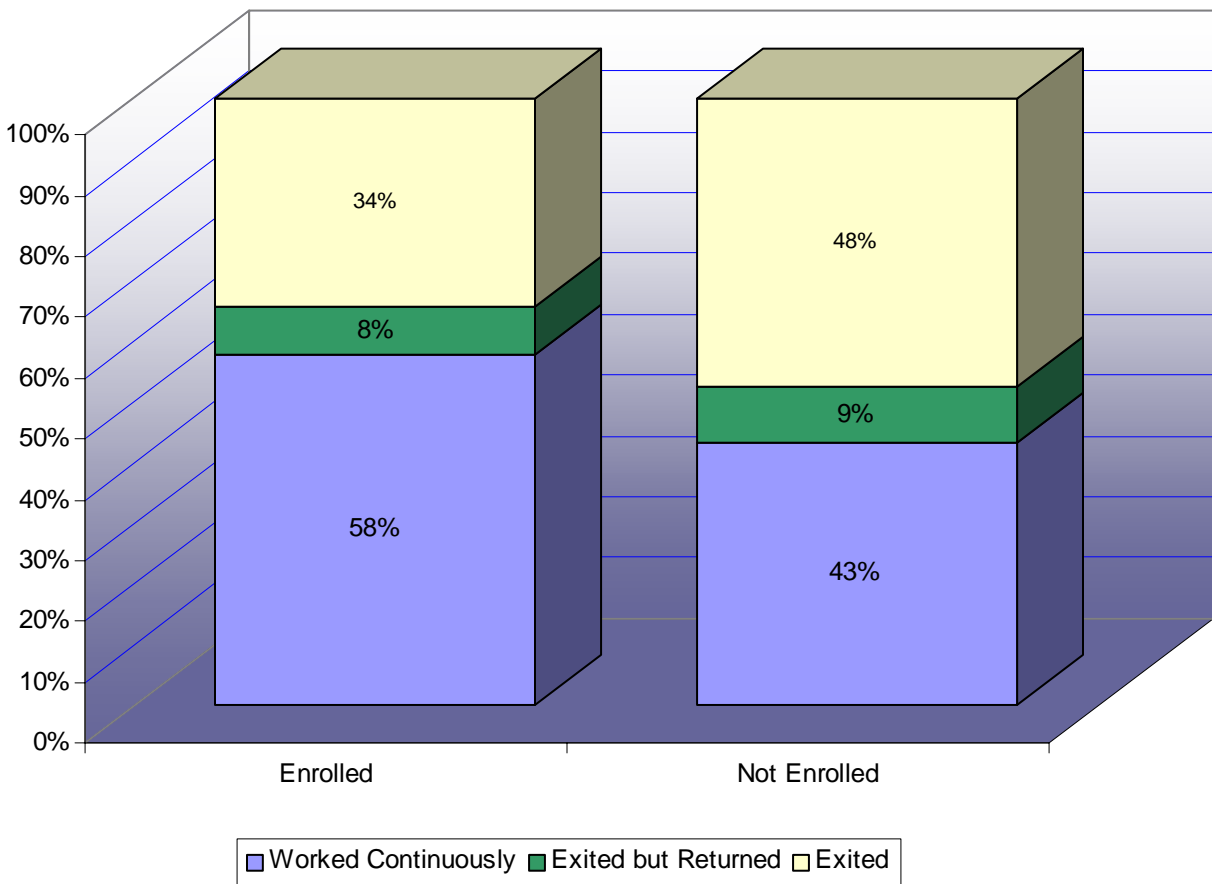
**Age:** Enrollee age groups exhibiting the highest retention rates were the 46-55 group (70%) and the 36-45 (68%). Both enrollee and non-enrollee retention rates rose as providers' ages increased, peaked at the 46-55 age group, then dropped. The 23-35 age bracket and the 65+ age bracket exhibited the largest differences in retention between enrolled and unenrolled providers and the 56-64 exhibited the least retention differences. The retention differences between

enrolled and nonenrolled populations for age set subgroups were found to be statistically significant.

**WORK PATTERNS OF ENROLLEES VERSUS NON-ENROLLEES**

Figure 4 below charts overall work patterns for two groups: 1. eligible and 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.

**Figure 4: Work Patterns of Health Plan Enrollees vs. Non-Enrollees**



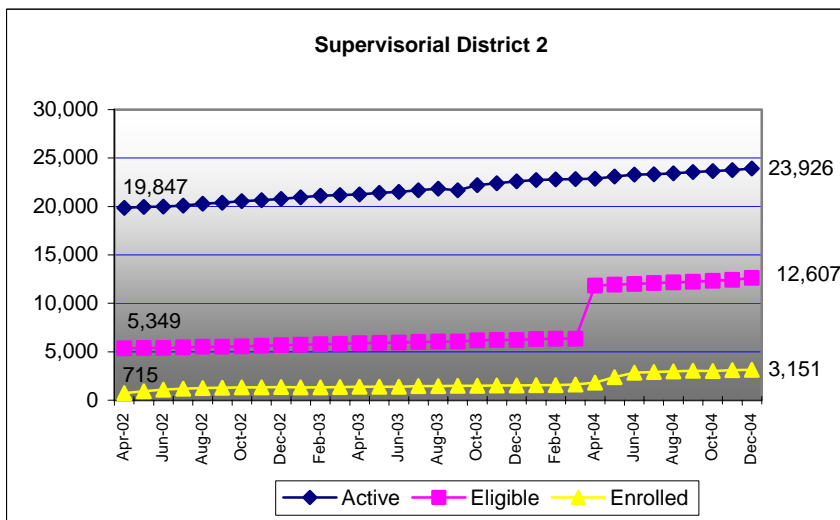
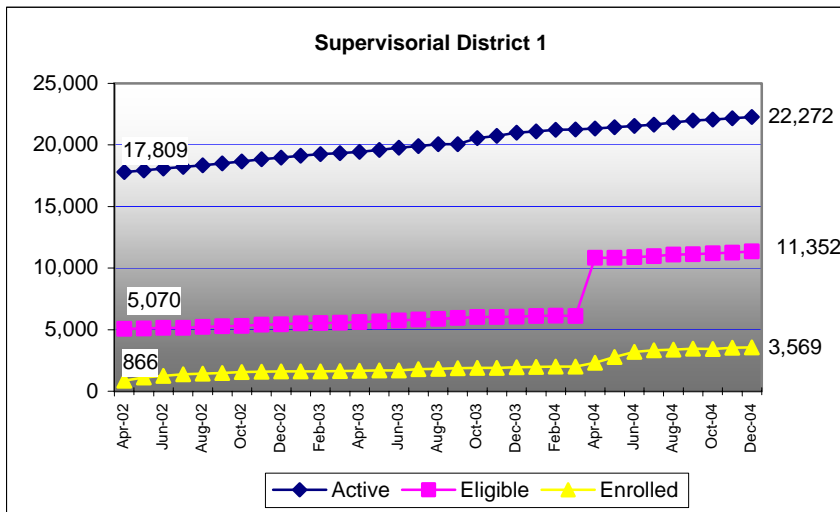
In summary, a higher percentage of health plan enrollees than eligible non-enrollees (58% versus 43%) worked in all 24 months of the study. A previous analysis of a twelve-month impact of health benefits on work patterns showed a larger percentage of enrollees than non-enrollees exiting but returning to the workforce. (9% as compared to 5%).

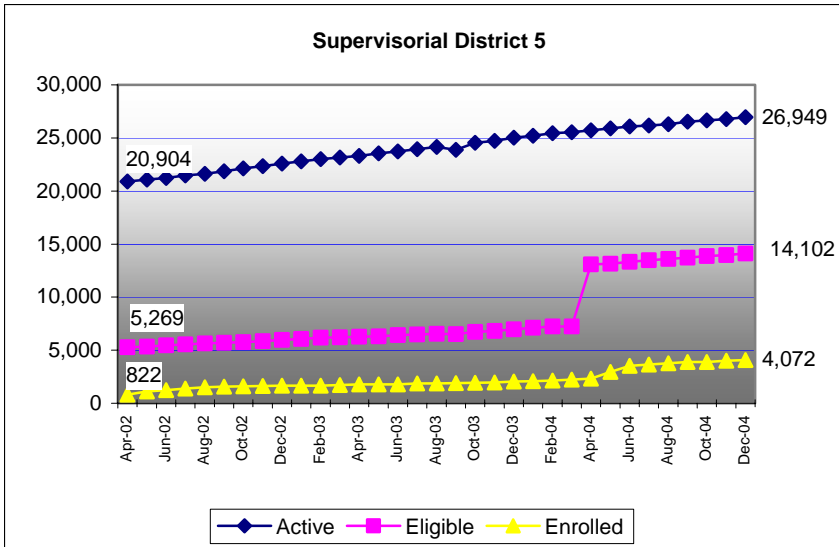
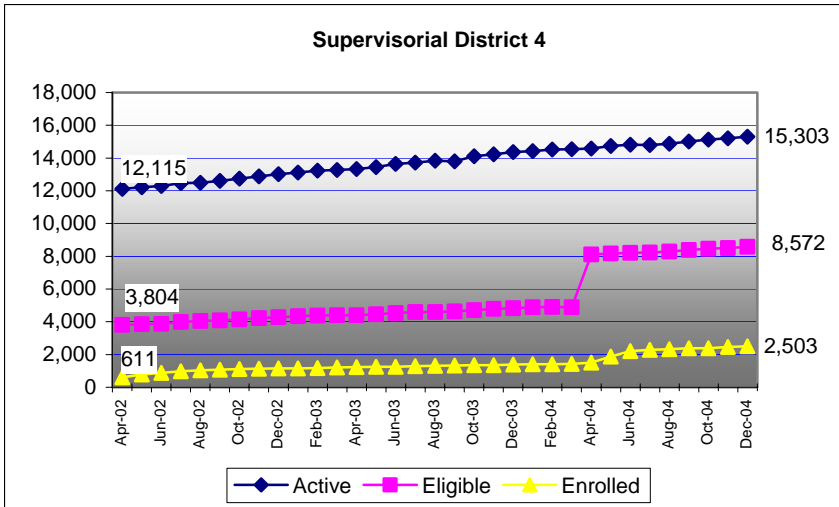
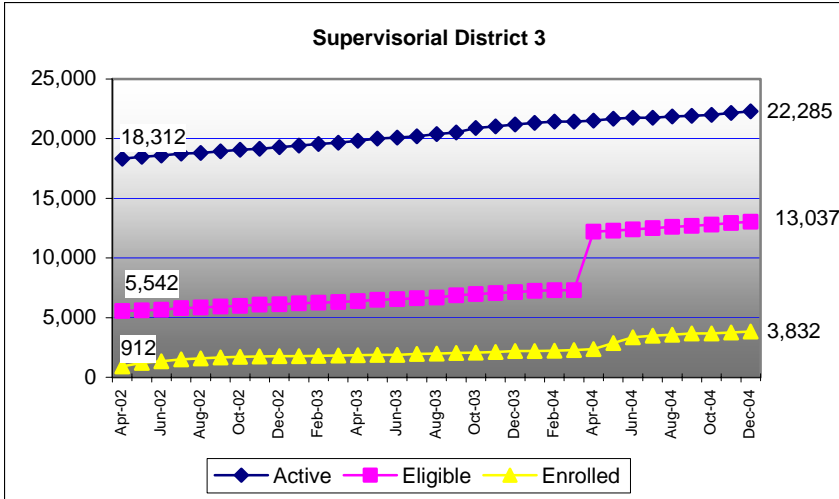
This effect was not seen in the current study; the percentage of enrolled and non-enrolled workers who exited but returned were essentially the same. Health

benefits may be a factor in the increased return of eligible non-enrolled workers. In fact, preliminary analysis shows that 17% of those who return *do* enroll in the health benefits program. We don't know if the remaining percentage of returning workers do not work enough hours to be eligible or are choosing not to enroll for other reasons. A provider survey would be necessary to assess these causal factors.

**PROVIDER STATUS BY SUPERVISORIAL DISTRICT**

The following figures chart the numbers of active, eligible and enrolled providers by Supervisorial District over a 32-month study period from April 2002 to December 2004. Supervisorial District 5 experienced the largest increase in active providers, eligible providers and enrolled providers.





## **DISCUSSION**

### **Worker Turnover and its Costs**

#### **Financial Costs**

High turnover rates, particularly in the three months posthire, and high vacancy rates have negative effects on providers, consumers, and workers. In a well-known 1992 study, L.M. Zahrt documented the costs of replacing home care workers, including the costs of recruiting, orienting, and training the new employee and the costs related to terminating the worker being replaced (e.g. exit interview, administrative functions, separation pay, unemployment taxes). The total cost associated with each turnover was \$3362. In addition, frequent hires and terminations increase costs associated with lost productivity during the time it takes for each new hire to complete the learning curve.

#### **Costs to the Provider**

High turnover and short staffing also places undue burdens on individuals who remain on the job. In home care, short staffing may limit aides' personal interaction with their clients. Short staffing may also result in increased rates of injury and accidents in an occupational group which, according to 2002 U.S. Department of Labor statistics, has the second-highest number of occupational injuries and illnesses resulting in missed workdays, compared to all other occupational groups. The Bureau of Labor Statistics (BLS) job classification "Nursing Aides, Orderlies, and Attendants" includes workers in both home-based and institutional settings.

#### **Costs to the Consumer**

High worker turnover and worker shortage also negatively impacts the consumer through unmet need for personal assistance services. The current California shortage of hours is already associated with a large amount of unmet need in hours (15 percent less than authorized), (Harrington, 2004). The consequences of unmet need are: pain and discomfort, mobility restriction, going hungry, running out of food, getting burned, unintentional weight loss, dehydration, falls, staying in bed most of the time, soiled self, skin problems, and even death.

The state shortage typifies a larger national problem. The results of the 2003 National Survey of State Initiatives on the Long-Term care Direct-Care Workforce shows that 79% of the 44 states that responded indicated that high vacancy rates continue in the direct-care workforce. A national study designed to evaluate perceived unmet need in ADL's and instrumental IADLs and its association with reduced hours of help uses data from the 1994-97 National Health Interview Survey on Disability. The study found a shortfall of 16.6 hours of help per week, with the shortfall being twice as great for persons who live alone as for those who live with others. Both groups were more likely than those whose needs are met to experience the adverse consequences listed above. (LaPlante, 2004).

### **Effects of Lack of Insurance on Los Angeles County Personal Assistants**

The state of California currently has the highest number of people in the nation without insurance—11.9 million. In 2000, nearly half of Los Angeles home care workers were uninsured. The overall effects of lack of insurance are as follows: 1. IHSS workers are more likely than other Los Angeles County adults to utilize county health care facilities. 2. Many uninsured home care workers delay care and have chronic medical conditions that go untreated and 3. Home care workers lack access to preventive care.

### **GROWING CONSUMER DEMAND AND THE DIRECT CARE WORKFORCE**

Focus on the national worker shortage has increased in light of the coming increase in the size of the elderly population as the baby-boom generation ages. This population shift will undoubtedly translate into increased demand for home and community based-services, particularly in light of the fact that most people prefer to remain in their own homes.

The growing trend toward home- and community-based care can be seen in care patterns for consumers under the age of 65. Of the nation's long term care recipients under 65, well over 95 percent received care at home or in community settings. Of these, roughly three-fourths relied exclusively on family and friends for care.

Population aging, in and of itself, might present less of a problem if the supply of care providers were growing at approximately the same rate. However, it is growing at a significantly lower rate—not only are providers leaving the field for reasons of job dissatisfaction but the pool from which such providers have typically been drawn in the past has been dwindling. In 2000, there were 1.74 females between the ages of 25 and 54 for every person 65 and older; by 2030, that ratio is projected to drop to 0.92 (National Center for Health Workforce Analyses, 2004).

The Bureau of Labor Statistics estimates that personal and home care assistance will be the fourth-fastest growing occupation by 2006, with a dramatic 84.7% growth rate expected. The number of home health aide jobs is expected to increase by 74.6%, although these estimates will be tempered by the rate of economic growth and the extent to which purchasers are willing or able to pay (Stone, 2004).

### **IHSS AND THE HEALTHCARE BUDGET**

PASC has made striking improvements in the midst of challenges, insuring thousands more in Los Angeles county by instituting more liberal eligibility criteria despite tight budgets. Even maintaining the benefits status quo is a national

struggle in light of reimbursement cuts and continuing state budget deficits. In 2002 and 2003, 34 states made cuts or changes in Medicaid and SCHIP programs that led to between 1.2 and 1.6 million low-income people losing publicly-funded health coverage (Center on Budget and Policy Priorities, 2003). In addition, 35 states reduced benefits, 32 increased co-pays, and every state either froze or reduced rates to many provider groups. With long term care services accounting for 35% of Medicaid spending, cuts such as these inevitably affect wages and benefits in the long term care sector (Lipson, 2004).

## **NEXT STEPS**

More in-depth studies of PASC initiatives, including the health benefits program, are necessary to fully understand the nature of program impacts, establish causal relationships, and measure the impact of other factors on worker tenure and stability.

For instance, while the preliminary analysis reveals a strong relationship between health benefits enrollment and longer worker tenure, it does not rule out other causal factors. A formal worker survey would more clearly reveal individual workers' motivations and the role of healthcare benefits in their decision-making process. Similarly, while analysis reveals that enrollees are more likely to return after a work hiatus, it would be useful to determine – either directly through a survey, or indirectly, by examining whether the hiatus ended with a new worker/client match – whether this is due to the incentive of continued health benefits.

Researchers and policymakers would also benefit from longer, cross-county analyses. Multi-year longitudinal analyses would reveal the longer-term effects of benefits on workforce retention and stability. Cross-county analysis – for example, comparing work patterns in communities with large wage and benefit increases with those in communities with only benefits – would yield important information about the relative impacts of worker incentives implemented by California Public Authorities.

The initial study demonstrated that homecare workers with health benefits remain in the workforce longer and, if they leave, are more likely to return. However, it does not explain underlying causes. Do healthcare benefits attract a more professional, career-oriented workforce, or do benefits encourage members of an existing workforce to view personal care services as a long-term career? Additional analyses are necessary to evaluate whether factors other than employer incentives contribute to longer worker tenure. Comparing characteristics of workers hired before and after implementation of the health benefits program, and studying relationships between other worker characteristics and tenure, will contribute to a conceptual model for understanding how benefits affect tenure.

Finally it should be noted that the current study examines the impacts of one benefits program with the specific eligibility requirements, 112 hours of work for two consecutive months, that were in effect during the February to July 2002 study period. However, independent homecare providers are a unique workforce: many providers enter the field as part-time workers and wish to remain part-time. Workers tend to be women with outside responsibilities, such as childcare, that make them uninterested in full-time work. More in-depth research will compare the impacts of a variety of program designs, including lower eligibility requirements.

PASC is currently planning a study which will measure the impacts of health benefits with the current eligibility requirement of 80 authorized work hours for two months. This study will test the hypothesis that, given the idiosyncrasies of the homecare workforce, reduced eligibility requirements will produce not only an increase in number of insured workers, but also a greater impact on worker recruitment and retention.

Additional analyses will enable policymakers and program managers to refine benefit programs, making them more attractive in the eyes of current and prospective providers. Ultimately, this work will help Public Authorities and other entities to attract a larger, more permanent workforce to meet the nation's growing demand for in-home services. It may even form the basis of a multi-state, national policy.

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