# THE IMPACTS OF MEDICAL BENEFITS ON THE LOS ANGELES COUNTY IHSS WORKFORCE: A FOUR-YEAR STUDY

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# The Impacts of Medical Benefits on the Los Angeles County IHSS Workforce: A Four-Year Study


## STUDY ABSTRACT

This study builds on three years of research evaluating the **impacts of the PASC-SEIU medical benefit program on worker retention and stability in the Los Angeles County In-Home Supportive Services (IHSS) program**. Studies commissioned by PASC in 2003[1] and 2004[2] indicated that medical benefits reduced worker turnover. Based on this research, PASC increased the number of workers eligible for benefits by reducing the benefit eligibility requirement from 112 authorized hours per month to 80 authorized hours per month over two consecutive months. In 2005, a third study showed that enrollment in the medical benefit program was indeed continuing to reduce worker turnover in the Los Angeles County IHSS workforce, both for those homecare workers enrolled under the 112-hour eligibility requirement and for those enrolled under the newer 80-hour requirement.[3]

The present study extends these analyses by 1) evaluating worker turnover for enrolled and non-enrolled workers from the original 2002 study group over an additional year, from August 2005 to July 2006; 2) evaluating work patterns (continuing, returning and exiting) for enrolled and non-enrolled workers; 3) conducting a subgroup analysis of returning workers to measure the importance of medical benefits in their decision to return; and 4) comparing eligibility and enrollment differences between family and non-family workers.


## BACKGROUND

The State of California, through its In-Home Supportive Services (IHSS) program, has been providing consumer-directed homecare services since the early 1970s. 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 collective bargaining possible by functioning as the employer of record for IHSS workers, arrange training and support services for workers and consumers, and offer

[1] 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).
[2] 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).
[3] Zawadski, R. (2005). *Expanding health benefit eligibility: Impacts on the IHSS workforce.* Prepared for the Personal Assistance Services Council of Los Angeles County (PASC).

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. In 1999, California Assembly Bill 1682 was enacted, mandating that counties serve as employers of record or create public authorities to serve as 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 healthcare 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. Public authorities implemented medical benefits in order to 1) reduce unnecessary worker hospitalization by promoting preventive health care, and 2) enhance workforce stability as well as the 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. In April 2002, PASC, in conjunction with the Los Angeles County Board of Supervisors, the Department of Public Social Services (DPSS), Community Health Plan (CHP), and Service Employees International Union Local 434B (SEIU), the union which represents homecare workers in Los Angeles County, 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 hours eligibility requirement was reduced from 112 hours to 80 hours per month. This expansion, together with the overall growth in the program, increased the number of eligible homecare workers from 30,302 in 2003 to 58,561 in 2004. In June 2006, the number of eligible homecare workers reached 70,463.

## STUDY RATIONALE

The PASC-SEIU Plan has been of significant benefit to workers by providing comprehensive medical coverage for a minimal premium during a time of escalating healthcare costs nationwide. The Plan also benefits the county's IHSS consumers by reducing worker turnover, a phenomenon that has traditionally lowered quality of care and posed a serious problem for the IHSS program in general.

In order to examine factors, including the availability of medical benefits, which may influence workforce retention and consistency, the 2006 study seeks to answer five major questions:

1) What are the enrollment rates for the PASC-SEIU Plan over time?
2) Does the positive impact of medical benefits on retention, identified in the 2003, 2004, and 2005 studies, continue over the four-year study period?
3) What are the major factors influencing workers' decisions to exit and return to the workforce?
4) Does the availability of health benefit coverage influence workers' decisions to return to the field?
5) What differences and similarities in eligibility and enrollment patterns can be found between family and non-family workers?

## STUDY POPULATIONS

### Original 2002 Study Group

This study includes a four-year retention analysis of the original study group: workers entering the workforce in each of the six months from February 2002 through July 2002. This cohort constitutes the same study group used in PASC's 2003, 2004, and 2005 health benefit impact analyses. Using the original study group results in a powerful longitudinal analysis of medical benefits and retention.

### 2004 80-Hour/112-Hour Worker Groups

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. The current study extends this analysis by tracking work patterns over an additional year, from July 2005 to June 2006.

### Returning Workers Subgroup

The population of all workers who left the workforce, then returned, was identified as a subset of the total active worker population. Both those workers enrolled in the Plan and those not enrolled in the Plan were included in the sample, which numbered 1,961 workers. All workers in the sample were telephoned, and 202, or 10%, provided responses.

## DATA SOURCES

### CMIPS Data

The number of authorized work hours and the benefit eligibility status for each worker were obtained from the California 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 February 2002 through July 2006 were obtained and analyzed to identify workers entering the Los Angeles County IHSS workforce in each month.

Secondly, CMIPS data were used to compile a history of work activity and health plan enrollment for both newly eligible and re-invited workers from April 2004 to July 2006.

Thirdly, CMIPS data were used to identify the telephone survey sample of workers who exited and returned to the workforce for three months or more during the study period of February 2002 to June 2006. Workers who had current CMIPS work authorizations in a given month were considered active, and those who did not were considered inactive.

### 2005 Worker Survey

In addition, direct worker feedback obtained from a Los Angeles County IHSS worker survey conducted in May 2005[4] is included in this study. The 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 workers, 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.

## STUDY METHODOLOGIES

### Calculating Rates 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) workers (both enrolled and non-enrolled), and for re-invited (112-hour criterion) workers (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.

### Differentiating Between Continuing 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

[4] 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).

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 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 to produce an indicator of how health benefit enrollment impacts workforce stability.

## PASC-SEIU Plan Enrollment Rates Over Time

### CURRENT ENROLLMENT OVERVIEW

PASC functions as the employer of record for over 124,200 IHSS workers in Los Angeles County (August 2006 CMIPS data). This number represents approximately 36% of all California IHSS workers. Of the total number of active workers, 70,463 are eligible for medical benefits, and 23,196 are enrolled in the program at this time. The county's enrollment rate, or the percentage of *eligible* homecare workers enrolled in the program, is 32%. The county's penetration rate, or the percentage of *total active* homecare workers enrolled in the program, is 19%. Appendix A, found at the back of this report, provides a breakdown of enrollment statistics for each of the five Los Angeles County Supervisorial Districts.

### ENROLLMENT GROWTH: 2002-2006

Figure 1 shows eligibility and enrollment growth for the PASC-SEIU Plan over time from 2002 to 2006. The bottom line shows the numbers of enrolled workers over time, the top line shows the total number of eligible workers over time, and the middle line shows the number of workers eligible under the previous 112-hour eligibility criterion.

The numerical difference between the top and the middle line results in the number of workers who became eligible due to the shift to the 80-hour eligibility requirement. For example, in June 2004, 33,332 workers were eligible for the PASC-SEIU Plan under the 112-hour eligibility criterion. The difference between that number and the total number of eligible workers (58,561) is 25,229, which is the number of additional workers who became eligible under the 80-hour criterion.

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 and a 32% enrollment rate in June 2006. 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 in June of 2006 was 2.6 times higher than the number of homecare workers eligible in 2002, and the Plan in June 2006 insured nearly four times the number of homecare workers it insured in June 2002, constituting a dramatic increase from 6,029 to 22,650.

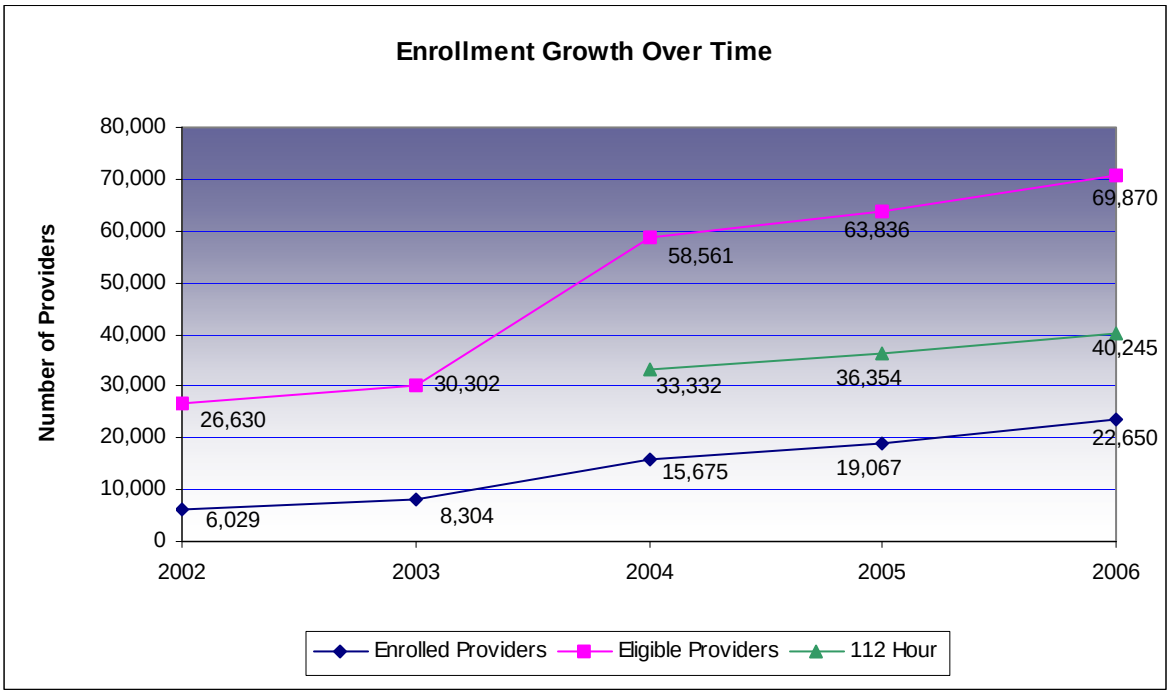



**Figure 1: PASC-SEIU Plan Enrollment Growth 2002-2006**

## 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 28 months of the expanded eligibility policy. As noted in the 2005 study, initial enrollment rates were relatively low. Just over 14% of newly eligible workers, referred to as "80-hour" workers in Figure 2, enrolled for benefits. Although they were invited at least once before, the enrollment rate for re-invitees was almost as high, at 11%. **From 2005-2006, rates for both these groups have remained fairly steady, with enrollment for newly invited workers rising to 15%, and enrollment for re-invited workers rising to 13%.**

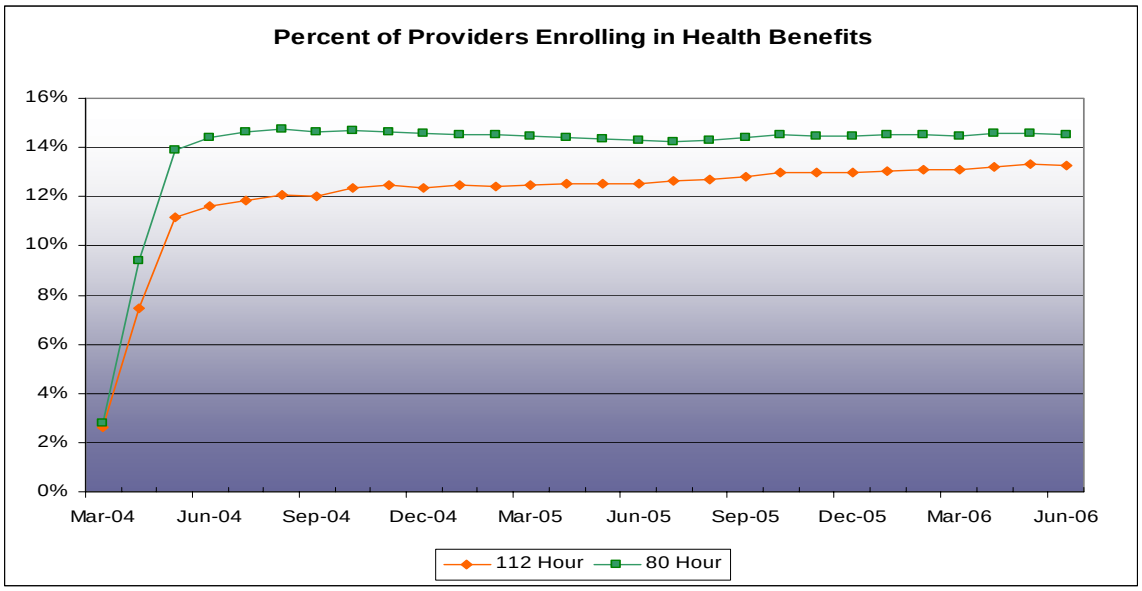



**Figure 2: Enrollment in Newly Eligible (80-Hour) and Re-invited (112-Hour) Workers**

# The Impacts of Medical Benefits on IHSS Retention and Work Patterns

## WORKER RETENTION OVER A FOUR-YEAR PERIOD

A steady increase in Plan enrollment means that medical benefits are affecting more homecare workers than ever. In order to provide an overall picture of how medical benefits impact work patterns, PASC has commissioned this new four-year longitudinal retention analysis of the original 2002 study group.

The retention patterns of this group were studied in 2003, 2004, 2005, and now 2006. 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 3, below, plots and compares the retention rates for workers for 48 months following their initial work authorization. Three groups of workers are tracked: **Group 1:** medical benefits enrollees, **Group 2**: total eligible workers, meaning all enrolled and non-enrolled workers eligible for benefits, and **Group 3:** all those workers eligible but not enrolled in benefits. The results of this analysis provide a consistent, historical foundation for understanding the impacts of medical benefits on IHSS worker retention.

**Figure 3 shows a higher worker retention rate for enrolled workers than for eligible non-enrolled workers across the entire four-year study period.** Fifty percent of workers receiving medical benefits (Group 1) remained active in the 48th month after initial entry

into the workforce, compared with 41% of all enrolled and non-enrolled workers eligible for benefits (Group 2), and 40% of eligible but non-enrolled workers (Group 3).

**The higher rate of enrollee retention found over the four-year study period continues to confirm previous retention findings.** The 2005 study shows a comparative retention rate of 56% and 45% for enrolled and eligible non-enrolled workers, respectively. Moreover, the 2004 study shows a comparative retention rate of 66% and 52% for enrolled and eligible non-enrolled workers, respectively.

Although retention rates generally decline over time, the retention rates of workers with healthcare were consistently higher, for every time period, than those without benefits. As expected, four-year retention rates were lower than previous three-year and 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.

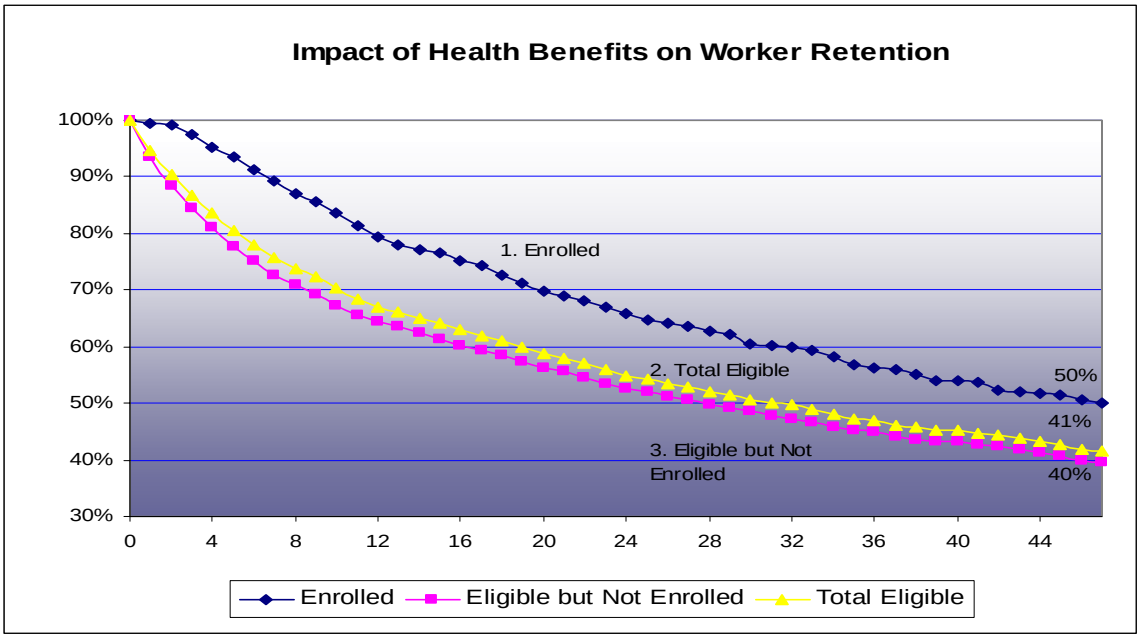



**Figure 3: The Impacts of Health Benefit Enrollment on Worker Retention 2002-2006**

## Comparing Worker Retention Rates of 112-Hour and 80-Hour Groups

Figure 3 above provides an overview of how worker retention rates are affected by medical benefits enrollment. To provide a more detailed picture, Figures 4 and 5 compare worker retention between enrolled and eligible non-enrolled workers across 112-hour and 80-hour eligibility groups during the study period of April 2004 to June 2006. **As shown 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, 75% of newly invited (80-hour requirement) enrollees were still working, whereas only 58% of eligible non-enrollees remained in the workforce (Figure 4). For re-invitees originally invited under the 112-hour requirement, 75% of those enrolled during the study were

still in the workforce in the final study month, whereas only 56% of eligible non-enrollees remained (Figure 5).

These data are consistent with the one-year study of retention rates of workers enrolling in medical 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 attrition and, therefore, a higher level of stability.**

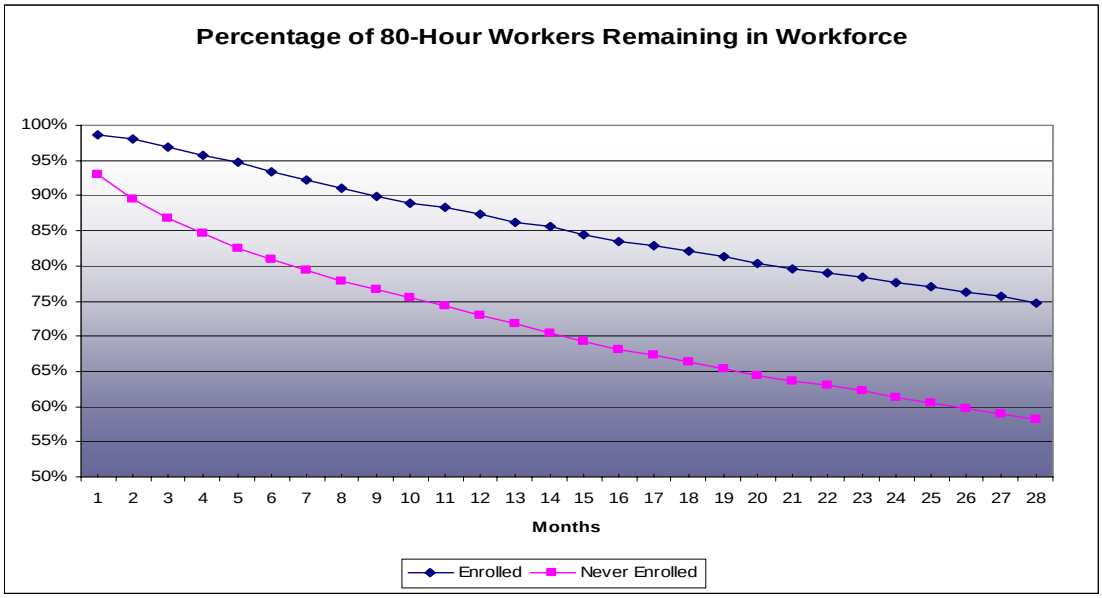



**Figure 4: Retention Rates 2004-2006 for Newly Eligible Workers**

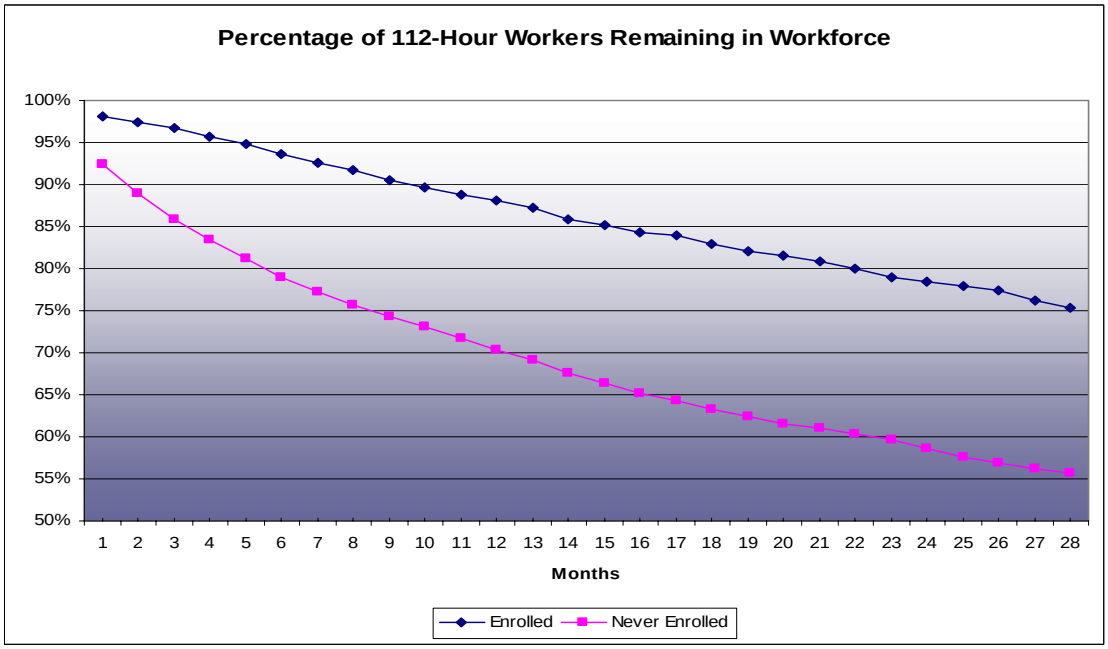



**Figure 5: Retention Rates 2004-2006 for Re-Invited Workers**

## WORK PATTERNS OVER A FOUR-YEAR STUDY PERIOD

Most significantly, findings from the 2006 study corroborate findings from previous analyses: A significantly larger percentage of enrolled workers (37%) than eligible non-enrolled workers (27%) worked in all 48 months of the study. Consistent with 2005 findings, the percentage of workers who exited and returned to the workforce was equal (12%) for both enrolled and eligible non-enrolled groups.

Because worker attrition tends to increase over time, it is not surprising that the number of workers employed in all study months decreased from the three-year to the four-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 workers exiting and returning to the workforce: 12% in the four-year study and 11% in the three-year study as compared to 5% and 6% in the two-year study.

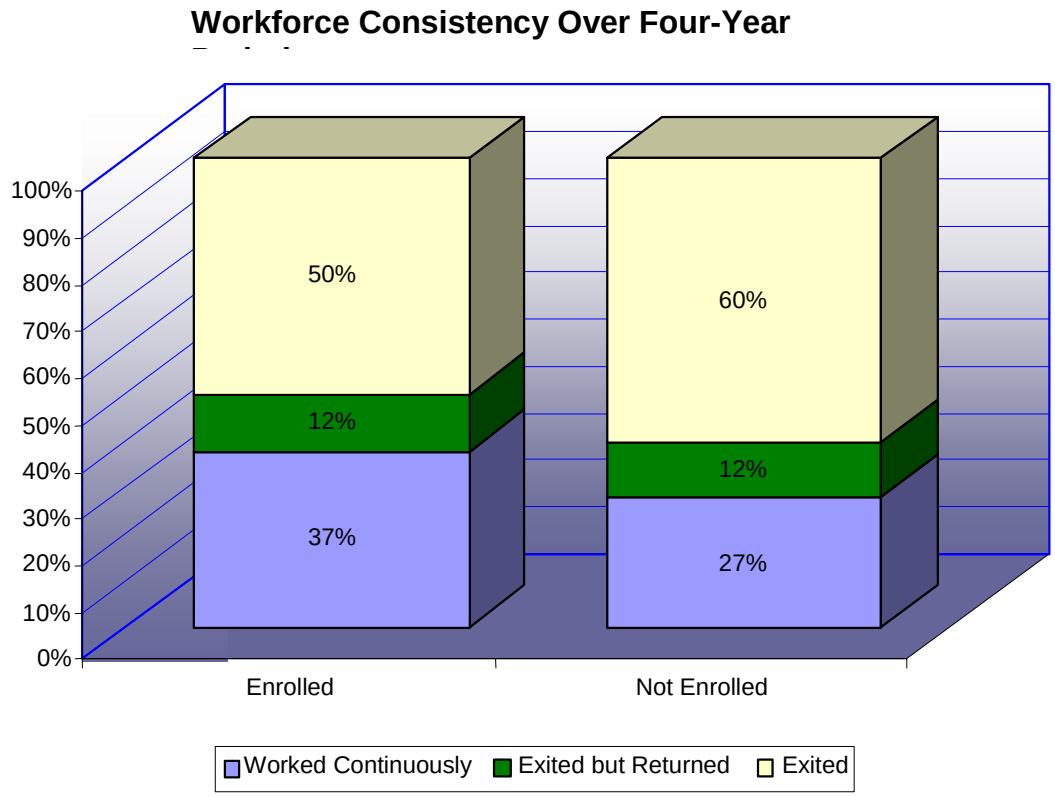



**Figure 6: Impact of Health Benefit Enrollment on Work Patterns 2002-2006**

### Comparing Work Patterns Across 112-Hour and 80-Hour Groups

Figure 6 above gives an overview of work patterns for enrolled and non-enrolled groups from 2002-2006. To provide a more detailed analysis, the following figures chart how work patterns compare across 112-hour and 80-hour enrollment groups. The study period for this analysis extends from January 2004 to June 2006.

Figure 7 charts overall work patterns for enrolled and non-enrolled workers eligible for benefits under the 112-hour criterion. Figure 8 charts overall work patterns for enrolled and non-enrolled workers eligible for benefits under the 80-hour eligibility criterion. Each column shows the percentage that worked continuously, the percentage that exited but returned to the workforce, and the percentage that exited the workforce completely.

## Continuous Workers

In summary, a significantly higher percentage of health plan enrollees than eligible non-enrollees in both 112-hour and 80-hour groups worked continuously during all study months. In the 112-hour group, 61% of enrollees worked across all months, as compared to only 49% of eligible non-enrollees. These comparisons corroborate and strengthen 2005 study findings, which showed that 74% of 112-hour enrollees worked across all months as compared to 60% of eligible 112-hour non-enrollees.

In the 80-hour group, 62% of all enrollees worked during all study months, as compared to only 52% of eligible non-enrollees. Again, these findings corroborate 2005 findings, which showed that 75% of all 80-hour enrollees worked during all study months, as compared to 64% of eligible 80-hour non-enrollees.

## Exiting Workers

Conversely, a smaller percentage of enrollees than eligible non-enrollees in both 112-hour and 80-hour groups exited the workforce completely. Thirty percent of the 112-hour group and 30% of the 80-hour group of enrollees exited the workforce, while 42% of non-enrollees eligible under the 112-hour requirement and 40% of non-enrollees eligible under the 80-hour requirement exited the workforce during the study period.

### Returning Workers

The 2005 study found that ratios of returning workers were higher for enrollees than non-enrollees. However, in the current study, this is no longer the case: Equal percentages of returning workers are found across both enrolled and non-enrolled groups. This is an interesting change in workforce behavior. To better understand the factors which influence workforce exit and return for this subgroup, PASC commissioned a telephone survey sampling both English- and Spanish-speaking returning workers. Results of this survey are presented and analyzed in the next section.

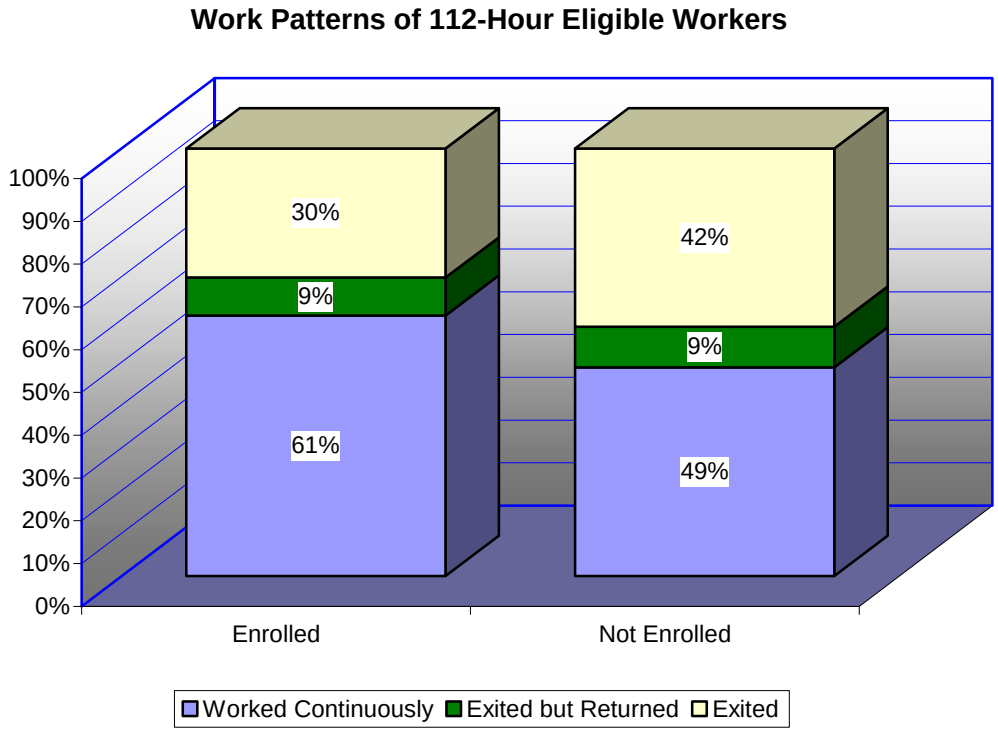



**Figure 7: Work Patterns of 112-Hour Eligible Workers**

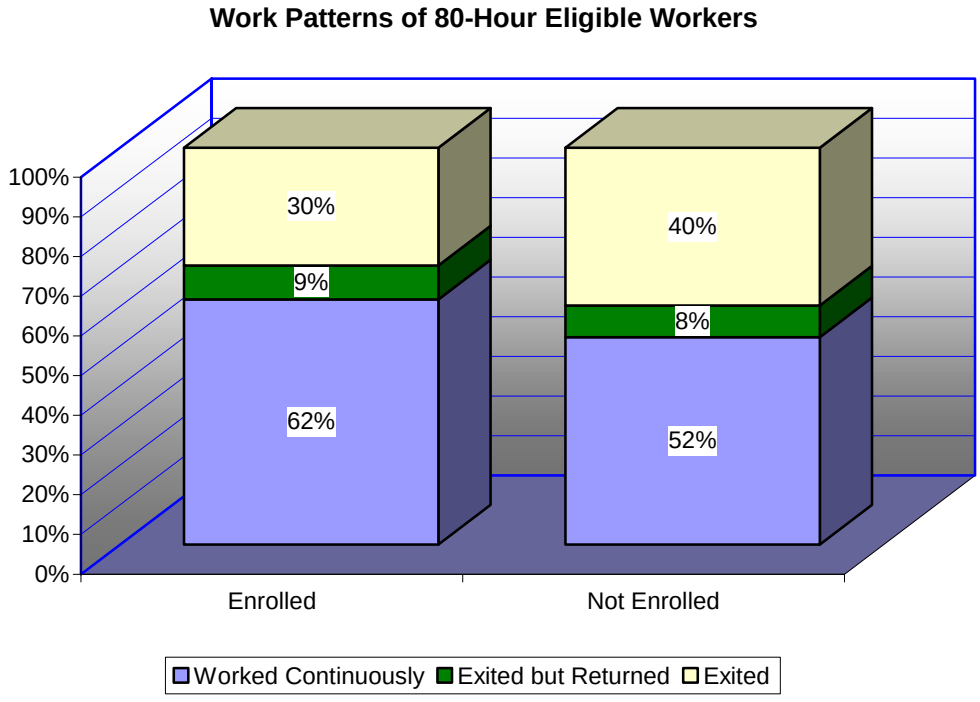



**Figure 8: Work Patterns of 80-Hour Eligible Workers**

# Subgroup Analysis of Returning Workers

To better understand the factors which influence workforce exit and return, a subgroup analysis of workers who left the workforce and returned during the study period from February 2002 to June 2006 was conducted. A worker was considered to have exited the workforce if he/she remained inactive for three months or more over the study period. A phone survey was then conducted with this subgroup to identify reasons for leaving and returning to IHSS, the role medical benefits plays in decisions to return, as well as overall levels of satisfaction with the Plan.

The survey instrument included questions concerning 1) workers' reasons for leaving and for returning to the workforce, 2) what role the availability of medical benefits played in decisions to return, 3) use of and satisfaction with Plan services, 3) medical benefit enrollment status before leaving and after returning to the workforce, and 4) status as a family/non-family worker before leaving and after returning to the workforce.

### Survey Respondent Profile

Both those workers enrolled in the Plan and those not enrolled in the Plan were included in the sample, which numbered 1,961 workers. All workers in the sample were telephoned, 278 were reached, and 202, or 10% of the total sample, completed the survey. As is common with telephone surveys, some workers were not available and some had wrong numbers listed. In addition, 42 workers reported working continuously although CMIPS records show them leaving and returning to the workforce. These workers were excluded from the survey. Of the workers who were reached and who reported actually leaving and returning to the workforce, the response rate was 73%. Seventy-four percent of respondents were English-speaking, and 26% were Spanish-speaking. The survey sample was evenly divided between workers providing services for family members, and those providing services for non-family members.

### WHY LOS ANGELES COUNTY PROVIDERS EXIT & RETURN TO THE HOMECARE WORKFORCE

The phone survey first asked respondents their reasons for leaving and for returning to the IHSS workforce. The reasons respondents reported for *leaving* the workforce are given in Table 1. Half of the respondents provided answers coded in the categories listed in the table below. However, approximately half of study participants did not respond to this question or provided responses that were too vague to code. Codable responses were grouped into two categories: those that cited consumer-based reasons for leaving the workforce and those that cited worker-based reasons for leaving the workforce.

**Of the codable responses, 64% identified changes in a consumer's health status as the reason for leaving the workforce.** This feedback indicates that level of tenure and

workforce stability are often decided by consumer health situations, rather than by the career decisions of the workers themselves.

However, it is necessary to be cautious about drawing conclusions from this data, due to the low response rate and to the fact that this sample represents a distinct subgroup motivated by specific factors. For example, it is reasonable to assume that for workers who exit the field completely, more worker-oriented factors, such as moving to a different career and the pursuit of higher wages, are stronger motivators in the decision to leave.

| Why IHSS Providers Leave the Workforce | |
|---|---|
| **Consumer-Based Factors** | |
| Consumer death | 42% |
| Consumer hospitalization | 22% |
| Consumer changed providers | 12% |
| TOTAL | 76% |
| **Worker-Based Factors** | |
| Took other job | 13% |
| Family-related reasons | 8% |
| Financial reasons | 3% |
| TOTAL | 24% |

**Table 1: Reasons for Leaving the Workforce**

Table 2 lists codable reasons provided for returning to the workforce. A large proportion (46%) of respondents did not provide answers or provided answers that were too vague to code. Of codable responses, the reasons most often given were job satisfaction, wages, and family-related factors, followed by the discharge of a consumer from the hospital.

| Why IHSS Providers Return to the Workforce | |
|---|---|
| **Consumer-Based Factors** | |
| Consumer discharged from hospital | 15% |
| Consumer rehired provider | 8% |
| TOTAL | 23% |
| **Worker-Based Factors** | |
| Job satisfaction | 22% |
| Wages | 20% |
| Family related | 20% |
| Health benefits | 5% |
| Good career | 5% |
| No other job | 4% |
| TOTAL | 76% |

**Table 2: Reasons for Returning to the Workforce**

## Consumer Hospitalization and Worker Tenure

In order to obtain a more detailed picture of worker exits and returns, the study isolated one group: respondents who left the workforce due to consumer hospitalization.

Although the sample size of this group is relatively small, the data provide valuable insight into the behavior of the larger workforce.

**As shown in Table 3, over 70% of respondents who report leaving the workforce due to consumer hospitalization return to the workforce because their employer is released from the hospital.** Table 3 also shows that a surprisingly high proportion (53%) of respondents who left IHSS due to consumer hospitalization spent six or more months away from the workforce before returning. This may indicate that some consumers are entering nursing facilities and institutions for long-term care, then being discharged back into the community as soon as is appropriate. These data suggest that the IHSS program is successfully supporting home and community-based care by providing consumers with readily available in-home supports when they return to the community.

This analysis also raises interesting questions concerning the grace period during which workers may remain enrolled in medical benefits although they are not actively working. Currently, the medical benefit grace period is two months. After this time, workers are terminated from coverage. Preliminary eligibility and enrollment analyses of January through June 2006 indicate that, if the grace period were extended to three months, the number of benefit terminations in the Los Angeles IHSS workforce would decrease by 15%. For the 41% of respondents who report leaving the workforce for up to three months due to consumer hospitalization, extending the grace period may provide the support they need to maintain their coverage.

| Respondents Who Left the Workforce due to Consumer Hospitalization | |
|---|---|
| **Reason for Return to Workforce** | |
| Released from hospital | 71% |
| Wages | 6% |
| Job satisfaction | 6% |
| Client rehired provider | 6% |
| Family issues | 6% |
| Other | 6% |
| TOTAL | 100% |

| Time away from Workforce | |
|---|---|
| 0-3 months | 41% |
| 4-6 months | 18% |
| 6-12 months | 29% |
| More than a year | 24% |
| TOTAL | 100% |

**Table 3: Time Away from Workforce & Reasons for Return**

## WHAT ROLE DO MEDICAL BENEFITS PLAY IN PROVIDERS' DECISIONS TO RETURN TO THE WORKFORCE?

### Enrollment Patterns of Returning Workers

As shown in Table 2, 5% of subgroup respondents report returning to the workforce specifically to take advantage of health benefits coverage. In addition, of the total phone survey respondents, 54% report being enrolled in the Plan *after* returning to the workforce as compared to only 32% reporting enrollment *before* leaving the workforce. **This significant 22% difference suggests a tangible link between medical benefits and workers' decisions to return to the workforce.**

It is useful to divide total respondents between 1) workers who were not enrolled prior to leaving the workforce, and 2) workers who were enrolled before leaving the workforce. These data reveal two striking statistics: 77% of workers enrolled in health benefits before leaving the workforce report continuing their benefits due to the grace period or actively enrolling in benefits upon return to the workforce. **In addition, 42%, or nearly half of all respondents who were not enrolled before leaving the workforce, report enrolling in medical benefits upon their return.**

| Respondents Enrolled Before Leaving Workforce | | |
|---|---|---|
| Have Benefits After Returning to Workforce | Terminated From or Dropped Benefits After Returning | TOTAL |
| 49 | 15 | 64 |
| 77% | 23% | 100% |
| **Respondents Not Enrolled Before Leaving Workforce** | | |
| Enrolled After Returning to Workforce | Did Not Enroll After Returning to Workforce | TOTAL |
| 55 | 76 | 131 |
| 42% | 58% | 100% |

**Table 4: Worker Benefit Enrollment Before and After Returning to Workforce**

## Survey Respondents Rate the Importance of Medical Benefits

In addition to recording enrollment activity, the telephone survey asked workers to rate the importance of medical benefits in their decision to return to the workforce. The overall percentage of workers who report that PASC-SEIU medical benefits played a Somewhat Significant, Significant or Very Significant role in their return to homecare is 29%. **Of the respondents who enrolled in the Plan upon returning to healthcare, 30% felt that the PASC-SEIU coverage played at least a Somewhat Significant role in their return to the IHSS workforce. In addition, 54% of workers who were enrolled in the Plan during both time periods rate medical benefits as at least Somewhat Significant to their return.**

These data suggest a familiar conundrum: Those who have healthcare understand its value and are more likely to make job decisions based on that value. However, those who don't have healthcare are less likely to make decisions based on the value of services they haven't yet received.

| Enrollment Status Before/After Return to Workforce | Percent of Respondents Citing Benefits as Somewhat Significant, Significant, or Very Significant in Return to Workforce |
|---|---|
| TOTAL Population | 29% |
| Not Enrolled/Not Enrolled | 6% |
| Not Enrolled/Enrolled | 30% |
| Enrolled/Not Enrolled* | 47% |
| Enrolled/Enrolled | 54% |
| *"Non-enrollees" includes workers currently in the process of re-applying and those who were previously eligible but have become ineligible for the Plan. | |

**Table 5: Measure of Medical Benefits' Significance in Workers' Return to the Workforce**

## Subgroup Respondents' Awareness of the PASC-SEIU Plan

Fourteen percent of all telephone respondents not currently enrolled in the PASC health plan report being unaware of the plan after returning to the workforce. This proportion is considerably lower than the 23% who cite ignorance of the plan before leaving the workforce, but does represent a sizeable percentage of those not currently enrolled.

| | Not Enrolled Prior to Leaving Workforce | Not Enrolled After Returning to Workforce |
|---|---|---|
| Not Eligible | 13% | 12% |
| Covered Under Another Benefits Plan | 26% | 34% |
| Unaware of the PASC-SEIU Plan | 23% | 14% |

**Table 6: Reasons for Non-Enrollment**

PASC has made sustained efforts to increase awareness of the Plan among the IHSS workforce. These outreach efforts include multiple mailings, telephone outreach, and surveys. More information on upcoming outreach endeavors is provided in the Next Steps section.

## WORKER SATISFACTION WITH PASC-SEIU MEDICAL BENEFITS

As part of its commitment to quality assurance, PASC periodically surveys workers to obtain feedback on Plan quality and to measure reported service use. Toward this end, a phone survey was used to gauge workers' overall satisfaction with the Plan.

**Sixty-two percent of returning workers surveyed reported being satisfied with their PASC-SEIU benefits.** Of those who reported dissatisfaction, the majority cited access to care issues, such as wait times, distance from facilities, and the inability to access non-network physicians, rather than more serious quality of care issues.

Due to the limited survey sample size, and the anecdotal nature of some of the information gathered, it is helpful to supplement these data with findings from a more comprehensive mail survey of IHSS homecare workers conducted in Los Angeles County in 2005. The mail survey found satisfaction with the Plan to be high overall. Seventy-five percent of workers enrolled in the Plan reported being satisfied with the plan (34% Very Satisfied and 41% Somewhat Satisfied).

More specifically, 64% reported being Very Satisfied or Somewhat Satisfied with the quality of medical care and with the benefits covered under the Plan. Seventy-eight percent report being Very Satisfied or Somewhat Satisfied with premium costs for the plan. Consistent with the telephone survey, the earlier mail survey showed existing dissatisfaction to be focused on access to care, rather than quality of care. Of the nine Plan 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%.

## Comparing Family and Non-Family Worker Enrollment Patterns

There have been longstanding questions in the IHSS program concerning differences in work patterns and benefit enrollment behavior between workers who provide services for close family members, such as children, parents or spouses, and workers who provide services for non-family consumers. This study provides an analysis of family and non-family worker behavior, using the entire active Los Angeles County IHSS worker population as its study group.

Table 7 provides three snapshots in time comparing family workers and non-family workers. In this analysis, **family members are defined as children, parents, or spouses of a worker.** Eligibility and enrollment rates for each group are measured for June of 2004, 2005, and 2006.

This analysis reveals two major points:

- The eligibility pool for medical benefits has been split fairly evenly between 1) workers serving non-family consumers, and 2) workers serving either close family members or other relatives.

- Of all those enrolled in benefits, the percentage of family workers has risen slightly since 2004, while the percentage of non-family workers has decreased slightly over the same time period.

Several factors may affect the slight shift currently seen from non-family to family workers. In particular, the availability of medical benefits may act as an inducement for family members to become caregivers. Further study on this issue, to be included in the 2007 study, will clarify differences in family and non-family work patterns, and will elucidate factors which draw both groups into and out of the workforce.

| Worker/Consumer Relationship | | |
|---|---|---|
| June 2006 | | |
| | Eligible | Enrolled |
| Family Member | 35% | 33% |
| Other Relative | 18% | 16% |
| Non-Family | 47% | 51% |
| Total | 100% | 100% |

| June 2005 | | |
|---|---|---|
| | Eligible | Enrolled |
| Family Member | 34% | 32% |
| Other Relative | 17% | 15% |
| Non-Family | 49% | 53% |
| Total | 100% | 100% |

| June 2004 | | |
|---|---|---|
| | Eligible | Enrolled |
| Family Member | 31% | 30% |
| Other Relative | 16% | 14% |
| Non-Family | 53% | 56% |
| Total | 100% | 100% |

**Table 7: Family/Non-Family Worker Eligibility and Enrollment**

# Next Steps

Four years of retention and work pattern studies have clearly demonstrated the value of medical benefits both to workers, who directly benefit through improved healthcare, and consumers, who indirectly benefit from improved worker stability. As the research on independent IHSS providers in Los Angeles County enters its fifth year, several promising approaches have emerged for further leveraging the valuable relationship between medical benefits and the IHSS workforce.

## Continuing and Refining Worker Outreach

Plan enrollment is rising steadily over time. Yet 14% of non-enrolled workers who've left and returned to IHSS still report being unaware of the existence of the Plan. In addition, many workers surveyed by telephone do not understand how the medical benefits are administered. Some workers believe their share of the premium is over $30/month, rather than $1/month, which is the actual worker contribution. It has also been reported that some workers misrecognize enrollment packets as junk mail and throw them away without reading them.

In the coming year, PASC plans to increase targeted Plan outreach to ensure that more workers understand benefit offerings and therefore, that enrollment continues to rise. In addition, the enrollment rate for re-invitees has risen over the past year, and continues to be nearly as high as the enrollment rate for the newly invited, suggesting that multiple mailings, calls, and other forms of outreach are productive methods for increasing enrollment.

## Focus on Consumer Hospitalization and Worker Tenure

The current study reveals that a significant proportion of workers report leaving and returning to the workforce due to consumer hospitalization. Although the small sample size limits the conclusions that can be drawn from this finding, it does indicate that worker retention and work patterns are influenced by consumer health status.

Research using a larger study sample would further clarify the relationship between consumer health and worker tenure. Additional research to determine the frequency and average length of consumer hospitalization across the county's total IHSS consumer population would also shed light on the appropriate grace period for workers to receive before their medical benefits are terminated. Currently, workers are given two months before their coverage is terminated; preliminary analysis suggests that extending the grace period by one month would decrease benefit terminations by 15%.

## Analyzing Enrollment Across Supervisorial Districts

Appendix A, which follows this section, provides a breakdown of active, eligible, and enrolled providers for each Supervisorial District over time. This analysis shows some

Supervisorial Districts to have consistently higher enrollment and eligibility rates than others. A study focusing on examining these differences may clarify the factors and make for more successful benefits penetration. In addition, a Supervisorial District study would assist PASC in designing District-specific strategies for enrollment outreach.

### Examining Access to and Quality of PASC-SEIU Plan Care

Findings from both the May 2005 IHSS homecare worker survey and the 2006 telephone survey indicate that further examination of service delivery and worker access to medical care would enhance the program. Joint research undertaken by PASC and Community Health Plan (CHP), which delivers Plan medical services, could provide a clearer picture of strengths and weaknesses, and assist the program in targeting areas for enhancement. Specifically, a worker survey designed specifically for this purpose with comprehensive satisfaction measures would update and expand the valuable satisfaction data collected in the 2005 mail survey.

### Analyzing Service Use & Costs

The 2005 mail survey of homecare workers also yielded important data on the frequency of worker medical use. However, because these are reported data rather than actual data, they may not reflect accurate service use and costs. In order to better assess the impacts of medical benefits on medical use, and particularly use of preventive care, PASC plans to propose a joint study with Community Health Plan examining IHSS worker medical service use and costs. 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.

# Appendix A: Supervisorial District Enrollment Analysis

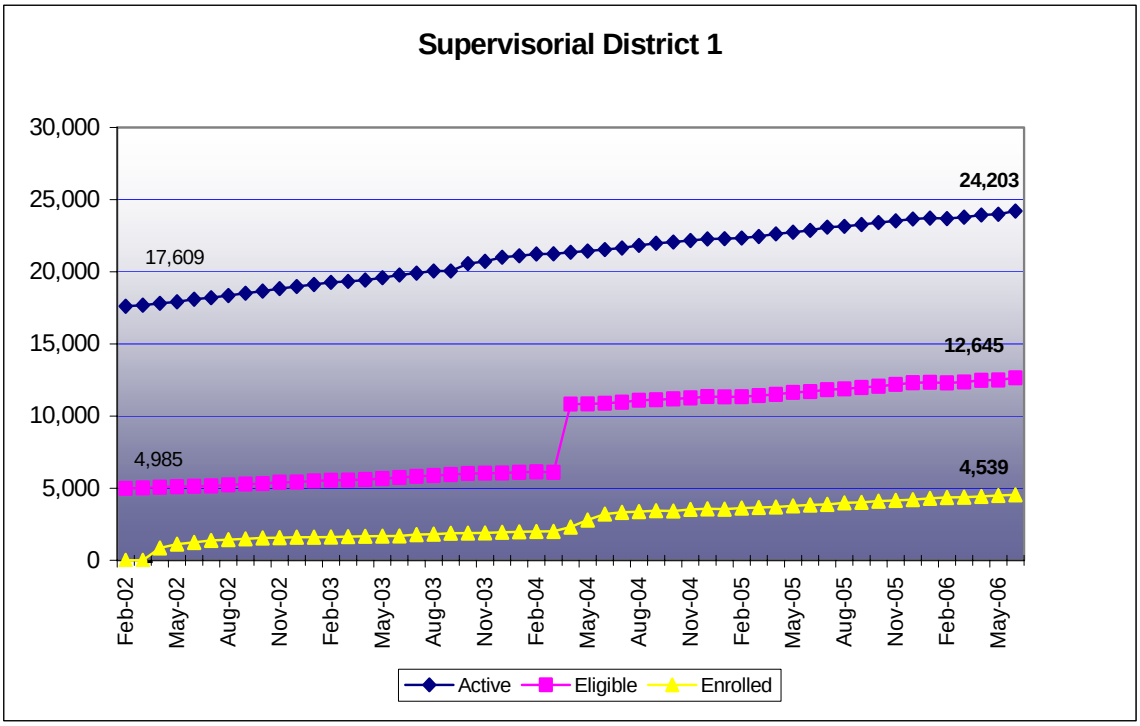
The following figures chart the numbers of active, eligible, and enrolled workers by Supervisorial District from February 2002 to June 2006. "Active" denotes all workers authorized to work, "eligible" denotes workers eligible for the benefits program, and "enrolled" denotes workers enrolled in the benefits program. The table below shows June 2006 enrollment and benefits penetration rates for each Supervisorial District. From 2005 to 2006, rates have risen evenly across all Supervisorial Districts.

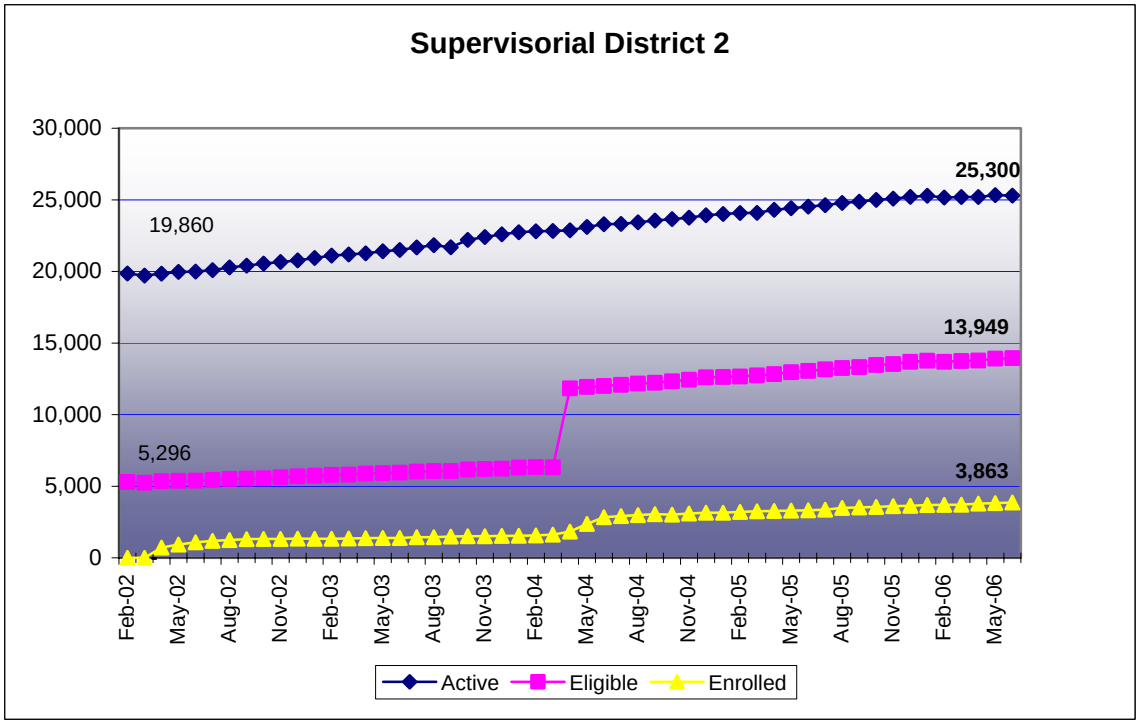
| District | Enrollment Rate | Benefits Penetration Rate |
|---|---|---|
| **Supervisorial District 1** | **36%** | **16%** |
| **Supervisorial District 2** | **28%** | **15%** |
| **Supervisorial District 3** | **34%** | **21%** |
| **Supervisorial District 4** | **33%** | **19%** |
| **Supervisorial District 5** | **32%** | **18%** |

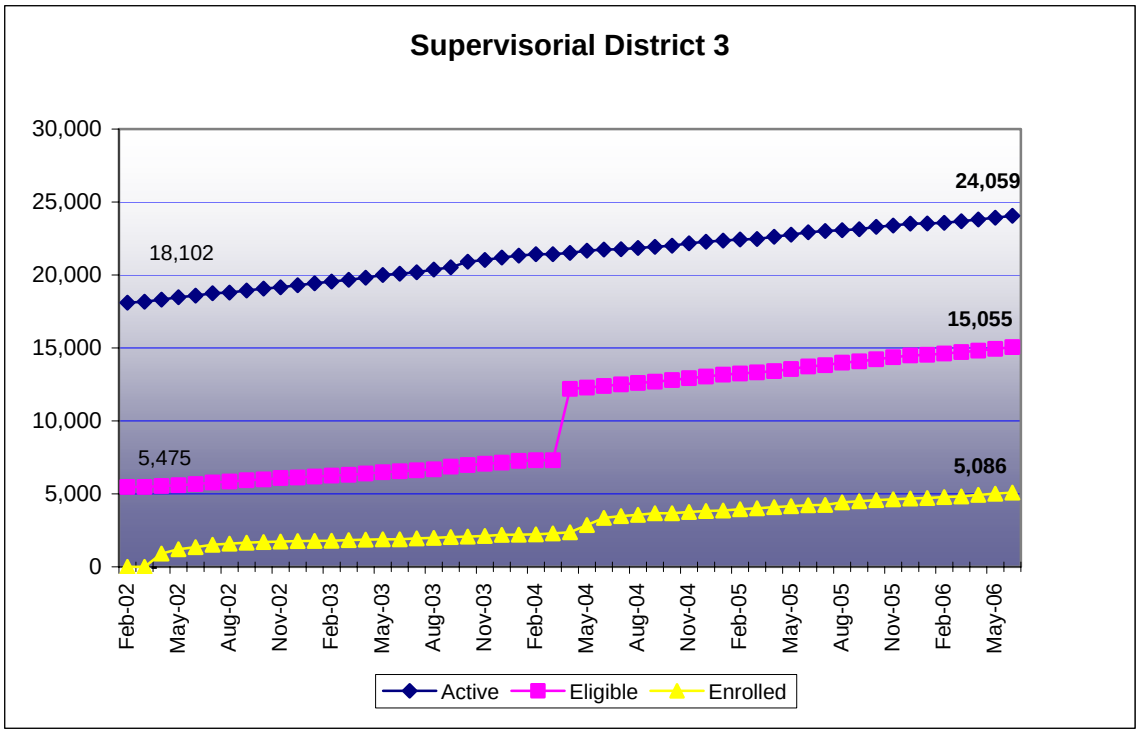
**Table 1: Benefit Enrollment and Penetration Rates Across Supervisorial Districts**

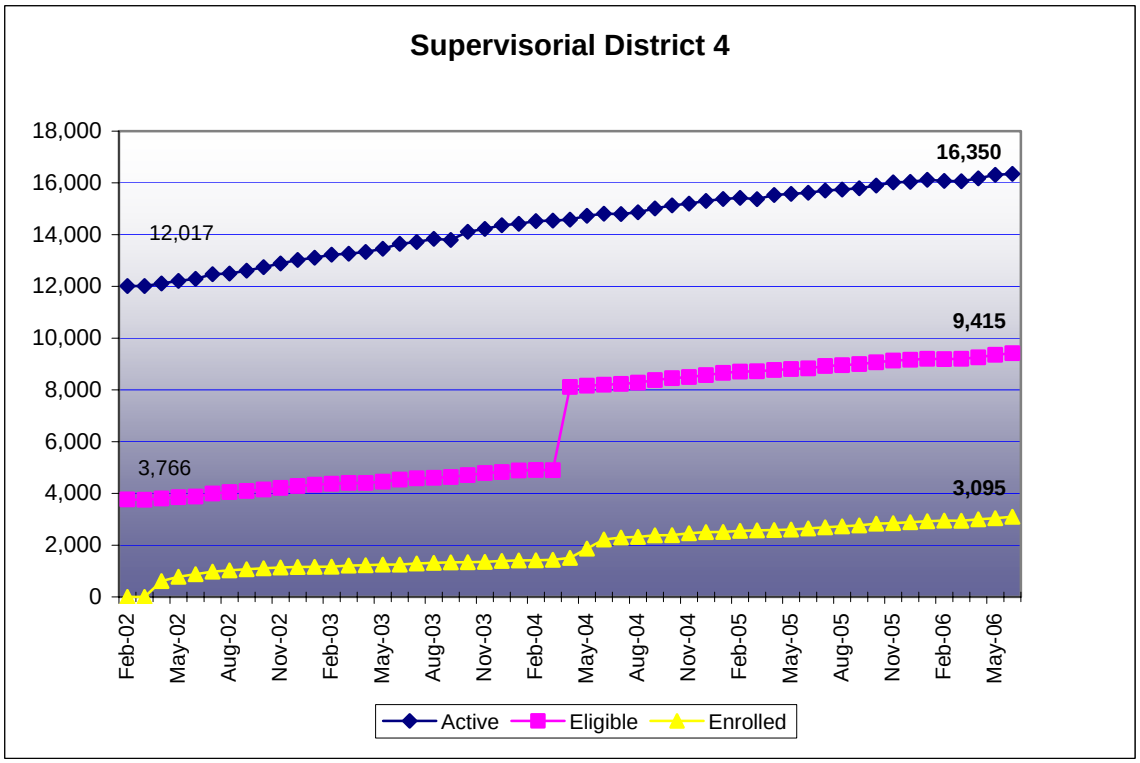
## OVERVIEW OF FINDINGS

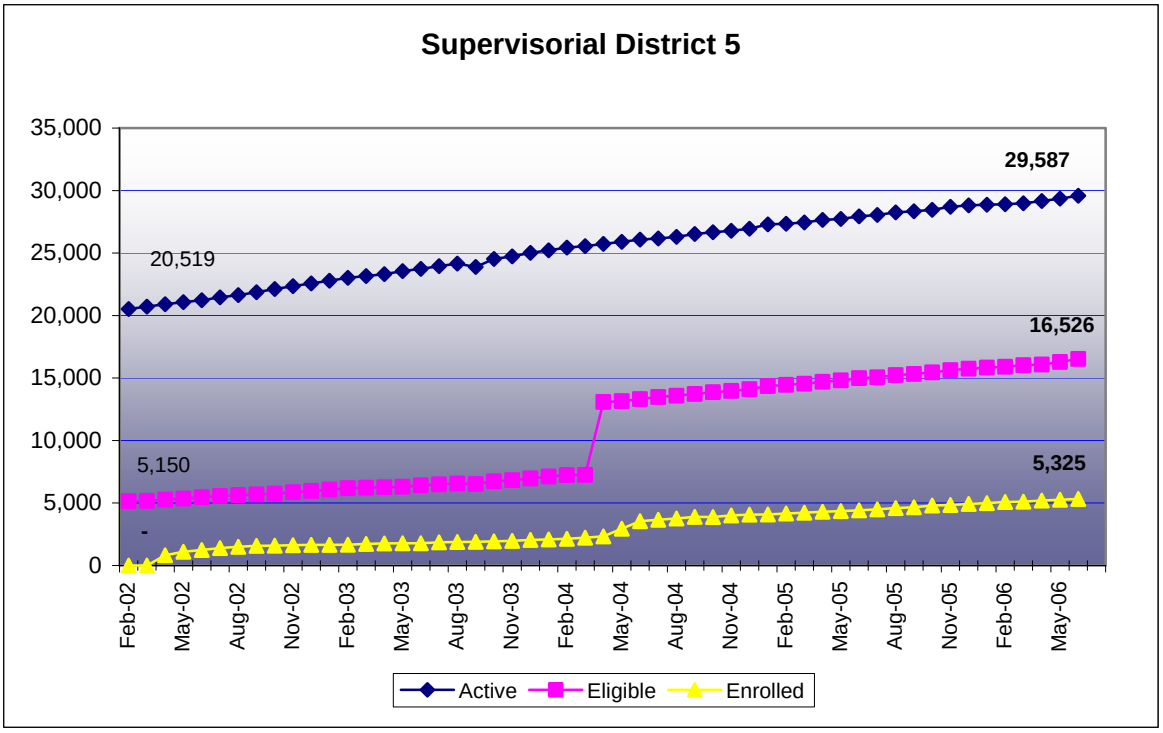
- Supervisorial District 3 contains the highest benefits penetration rate in the county.
- As of June 2006, Supervisorial District 5 contains the largest numbers of active workers (29,587), eligible workers (16,526), and enrolled workers (5,325).
- After Supervisorial District 5, Supervisorial District 2 contains the largest number of active workers (25,300).
- After Supervisorial District 5, Supervisorial District 3 contains the largest number (15,055) of eligible workers.
- From 2002-2006, Supervisorial Districts 5 and 3 have experienced the highest growth in eligible workers. Supervisorial District 5 now contains over three times the number of eligible workers it contained in 2002 and Supervisorial District 3 contains 2.7 times the number of eligible workers it contained in 2002.
- Supervisorial Districts 5 and 3 currently possess the largest numbers of enrolled workers: 5,325 and 5,086, respectively.


Supervisorial District 1
30,000
25,000
20,000
15,000
10,000
5,000
0
24,203
17,609
12,645
4,985
4,539
Feb-02
May-02
Aug-02
Nov-02
Feb-03
May-03
Aug-03
Nov-03
Feb-04
May-04
Aug-04
Nov-04
Feb-05
May-05
Aug-05
Nov-05
Feb-06
May-06
Active
Eligible
Enrolled


Supervisorial District 2
30,000
25,000
20,000
15,000
10,000
5,000
0
25,300
19,860
13,949
5,296
3,863
Feb-02
May-02
Aug-02
Nov-02
Feb-03
May-03
Aug-03
Nov-03
Feb-04
May-04
Aug-04
Nov-04
Feb-05
May-05
Aug-05
Nov-05
Feb-06
May-06
Active
Eligible
Enrolled


Supervisorial District 3
30,000
25,000
20,000
15,000
10,000
5,000
0
24,059
18,102
15,055
5,475
5,086
Feb-02
May-02
Aug-02
Nov-02
Feb-03
May-03
Aug-03
Nov-03
Feb-04
May-04
Aug-04
Nov-04
Feb-05
May-05
Aug-05
Nov-05
Feb-06
May-06
Active
Eligible
Enrolled


Supervisorial District 4
18,000
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
16,350
12,017
9,415
3,766
3,095
Feb-02
May-02
Aug-02
Nov-02
Feb-03
May-03
Aug-03
Nov-03
Feb-04
May-04
Aug-04
Nov-04
Feb-05
May-05
Aug-05
Nov-05
Feb-06
May-06
Active
Eligible
Enrolled


Supervisorial District 5
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
29,587
20,519
16,526
5,150
5,325
-
Feb-02
May-02
Aug-02
Nov-02
Feb-03
May-03
Aug-03
Nov-03
Feb-04
May-04
Aug-04
Nov-04
Feb-05
May-05
Aug-05
Nov-05
Feb-06
May-06
Active
Eligible
Enrolled