

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

STUDY ABSTRACT

This study builds on four years of research evaluating the impacts of the PASC-SEIU medical benefits program on worker retention and stability in the Los Angeles County In-Home Supportive Services (IHSS) program. Studies commissioned by PASC in 2003¹ and 2004² indicated that medical benefits reduced worker turnover. Based on this research, PASC increased the number of workers eligible for benefits by changing the eligibility requirement from working a minimum of 112 authorized hours per month for two consecutive months to working a minimum of 80 hours per month for two consecutive months. **Continuing studies in 2005³ and 2006⁴ showed that enrollment in the medical benefits 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.**

The present study extends these analyses by 1) evaluating worker turnover for enrolled and non-enrolled workers from the 2002 Original Study group, the 2004 80-Hour Group, and the 2004 112-Hour Group over an additional year, from August 2006 to July 2007; 2) evaluating work patterns (continuing, returning and exiting) for enrolled and non-enrolled workers; 3) comparing eligibility and enrollment differences between family and non-family workers; 4) identifying predictors of enrollment; and 5) tracking changes in enrollment over time.

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. These organizations help consumers find homecare workers by operating worker registries, promoting collective bargaining by functioning as the employer of record for IHSS workers, arranging training and support services for workers and consumers, and offering both workers and consumers a voice in program and policy development. In 1992, California amended its state Medicaid plan to make IHSS a Medicaid entitlement, establishing 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 2000-2001 California Budget Act created an additional incentive: state matching funds for counties to develop public authorities, increase IHSS wages, 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).

⁴ Zawadski, R. (2006). *The Impacts of Medical Benefits on the Los Angeles County IHSS Workforce: A Five-Year Study*. Prepared for the Personal Assistance Services Council of Los Angeles County (PASC).

health care coverage to IHSS workers. These were improvements for IHSS workers, who had been and continue to be plagued by low wages, no benefits, and little or no training or support. Public authorities implemented medical benefits programs in order to 1) reduce unnecessary worker hospitalization by promoting preventive health care and 2) enhance workforce stability. In 1997, Los Angeles County created a public authority, the Personal Assistance Services Council (PASC), which has over the ensuing years 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), United Long-Term Care Workers' Union (SEIU Local 6434) (previously 434B) – the union that 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 were required to be authorized to work 112 hours per month for two consecutive months to become eligible for coverage under the Plan. In 2004, the eligibility requirement was reduced from 112 hours to 80 hours per month. This expansion, together with 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 2007, the number of eligible homecare workers reached 75,079.

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 nationwide escalation in healthcare costs. 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 – that may influence workforce retention and consistency, the 2007 study seeks to answer four major questions:

- 1) How do enrollment rates change for the PASC-SEIU Plan?
- 2) Does the positive impact of medical benefits on retention, identified in the 2003, 2004, 2005, and 2006 studies, continue over the five-year study period?
- 3) What differences and similarities in eligibility and enrollment patterns are discernable between family and non-family workers?
- 4) Which factors predict the probability that an eligible worker will enroll?

STUDY POPULATIONS

Original 2002 Study Group

This study includes a five-year retention analysis of the original study group: workers entering the workforce in each of six months from February 2002 through July 2002. That cohort constitutes the same study group used in PASC's 2003, 2004, 2005, and 2006 health benefits 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 newly eligible for benefits because they were authorized to work 80 hours per month for two

consecutive months. Packets were also mailed to individuals who previously 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 June 2006. The current study extends this analysis by tracking work patterns over an additional year from July 2006 to June 2007.

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. Los Angeles County’s state employment data for the period of February 2002 through July 2007 was obtained and analyzed to identify workers entering the Los Angeles County IHSS workforce in each month. Secondly, CMIPS data was used to compile a history of work activity and health plan enrollment for both newly eligible and re-invited workers from April 2004 to June 2007.

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 criteria) workers (both enrolled and non-enrolled), and for re-invited (112-hour criteria) 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 (IP) of homecare may and do enter and exit the field frequently. As IHSS consumers go into or out of hospitals or nursing homes, some IPs may not work for a few days or even weeks while the person they care for is institutionalized. Thus, the number of hours 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.

Measuring Statistical Significance

A χ^2 test was used to assess the statistical significance of differing retention rates and work patterns across enrolled and non-enrolled workers from all cohorts. A χ^2 test that achieves a significance level of .01 or less is considered to indicate a significant difference between groups. A significance level of .01 indicates a 1 in 100 chance that response differences occurred by chance.

PASC-SEIU Plan Enrollment Rates Over Time

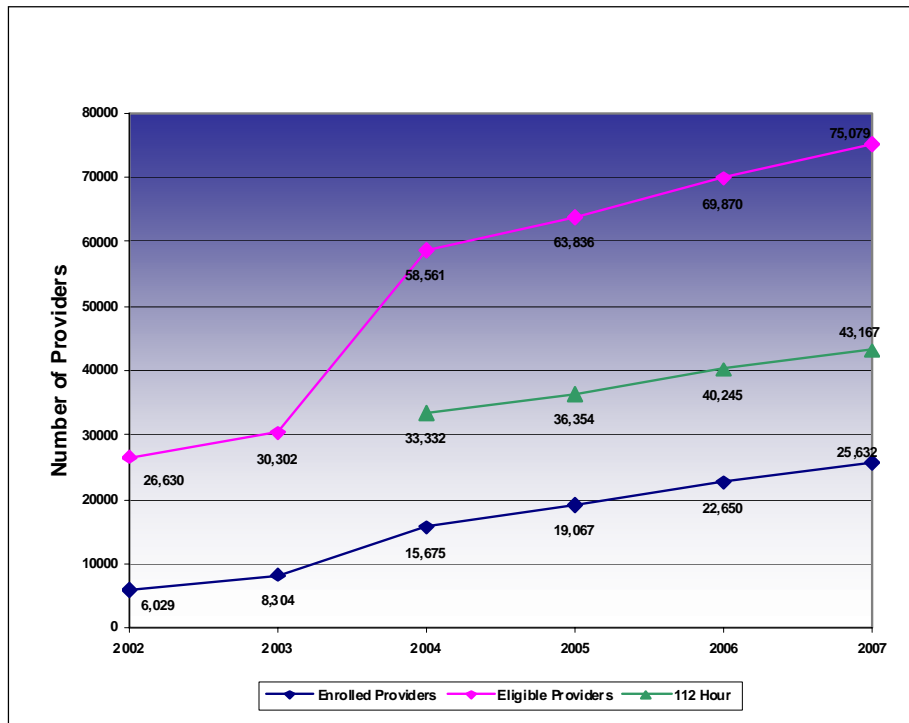
ENROLLMENT GROWTH: 2002-2007

Figure 1 shows eligibility and enrollment growth for the PASC-SEIU Plan over time from 2002-2007. The bottom line signifies the number of enrolled workers over time, the top line signifies the total number of eligible workers over time, and the middle line signifies the number of workers eligible under the previous 112-hour eligibility criteria.

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 criteria. 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 criteria.

IHSS benefit enrollment rates typically grow over time through increased worker exposure to and knowledge of the program. 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 34% enrollment rate in June 2007. Not only has the enrollment rate increased over time, the absolute number of homecare workers eligible for the plan has also increased considerably. The number of homecare workers eligible for the PASC-SEIU Plan in June 2007 was 2.8 times higher than the number of homecare workers eligible in 2002, and the plan in June 2007 insured nearly 4.25 times the number of homecare workers it insured in June 2002, constituting a dramatic increase from 6,029 to 25,632.

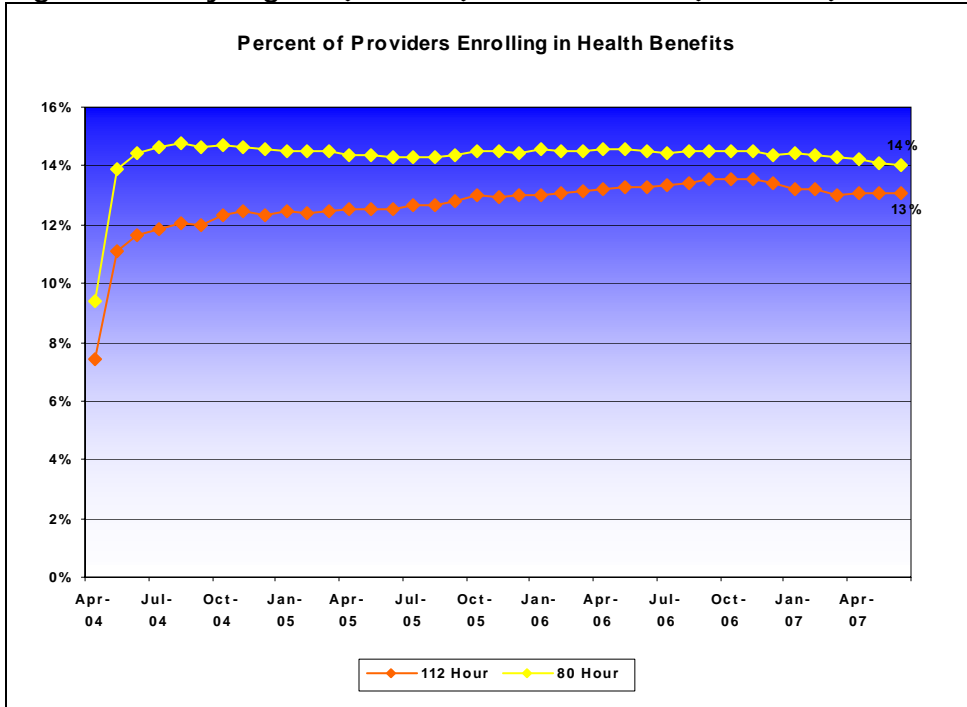
Figure 1: PASC-SEIU Plan Enrollment Growth 2002-2007



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 39 months of the expanded eligibility policy. As noted in previous studies, 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 2006-2007, rates for both of these groups have remained fairly steady, with enrollment for newly invited workers falling slightly to 14%, and enrollment for re-invited workers remaining near 13%.**

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



ENROLLMENT CHANGES WITHIN AND BETWEEN STUDY GROUPS

Initially Enrolled Study Group Workers

This study tracks three groups: 1) the 2002 Original Study group, 2) the 2004 80-Hour Newly Eligible group, and 3) the 2004 112-Hour Re-Invitee group. Initially enrolled workers from each of these groups were re-examined in June 2007 in order to determine, among those workers still active, the number who were still enrolled in health benefits. Findings were as follows:

- 1495 workers were initially enrolled in benefits in 2002; 674 were still active in June 2007, and, of those active workers, 76% (513) were enrolled in benefits. For the remaining 24%, fluctuations in hours worked may have contributed to loss of benefits eligibility.
- 4394 80-Hour workers were initially enrolled in benefits in 2004; 2724 were still active in June 2007, and, of those active workers, 87% (2360) were enrolled in benefits.

- 1555 112-Hour workers were enrolled in benefits in 2004; 934 were still active in June 2007, and, of those active workers, 84% (795) were enrolled in benefits.

Of active workers formerly enrolled in health benefits but not in June 2007, lack of eligibility was the main reason for change in benefit enrollment status. In each group, slightly more than one-half of workers initially enrolled in medical benefits but not enrolled in June 2007 did not meet the eligibility criteria; slightly less than one-half of workers initially enrolled in medical benefits but not enrolled in June 2007 did meet the eligibility requirement.

Initially Non-Enrolled Study Group Workers

Among initially non-enrolled workers from the three sample groups (the 2002 Original Study group non-enrollees, the 2004 80-Hour non-enrollees, and the 2004 112-Hour non-enrollees), it was determined what percentages of those still active were enrolled in health benefits in June 2007. For those initially not enrolled, a significant number of active workers were enrolled in health benefits in June 2007. Findings were as follows:

- Of the 6749 initially non-enrolled workers from the 2002 Original Study group, 2331 were active in June 2007, and 29% (665) were enrolled. The importance of benefits upon retention is belied by the high number of initially non-enrolled workers who subsequently enrolled, which further demonstrates that health benefits may have been a factor in these workers continuing to work and establishes the overall growing interest in health benefits.
- Of the 27,146 initially non-enrolled workers from the 2004 80-Hour group, 14,410 were active in June 2007, and 14% (2070) were enrolled.
- Of the 12,294 initially non-enrolled workers from the 2004 112-Hour group, 6206 were active in June 2007, and 16% (1015) were enrolled.

IDENTIFYING PREDICTORS OF ENROLLMENT

In order to calculate the likelihood of a provider enrolling in health benefits, a logistic regression procedure was performed on all active workers in June 2007. Logistic regression is a statistical method used to forecast the chance an event will occur. For example, the probability that a person has a heart attack within a specified time period might be predicted from knowledge of that individual's age, gender, and body mass index.

In an attempt to predict a worker enrolling in health benefits, a statistical model was created to identify significant predictors of enrollment. The regression procedure chosen uses forward selection, which entails an absence of variables at the outset. Individual variables are then evaluated independently of other variables, and included if proven statistically significant. Forward selection identified the following variables as statistically significant predictors of enrollment: age, number of authorized hours, gender, relation to consumer (family provider/non-family provider), and ethnic group (Black, White, and Chinese). By using the parameters of

this model, a specific group's likelihood of enrollment can be calculated and compared to its reference.⁵ Analysis reveals the following major points:

- Males are 1.12 times as likely to be enrolled as females.
- Non-family providers are 1.18 times as likely to be enrolled as family providers.
- Non-Whites are 1.04 times as likely to be enrolled as Whites.
- Chinese are 2.12 times as likely to be enrolled as non-Chinese.
- Non-Blacks are 1.38 times as likely to be enrolled as Blacks.
- The likelihood of enrolling in health benefits increases with increase in age (0.4% increase per unit).
- The likelihood of enrolling in health benefits increases with increase in number of hours worked per month (0.9% increase per unit).

The Impacts of Medical Benefits on IHSS Retention and Work Patterns

WORKER RETENTION OVER A FIVE-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 five-year longitudinal retention analysis of the original 2002 study group.

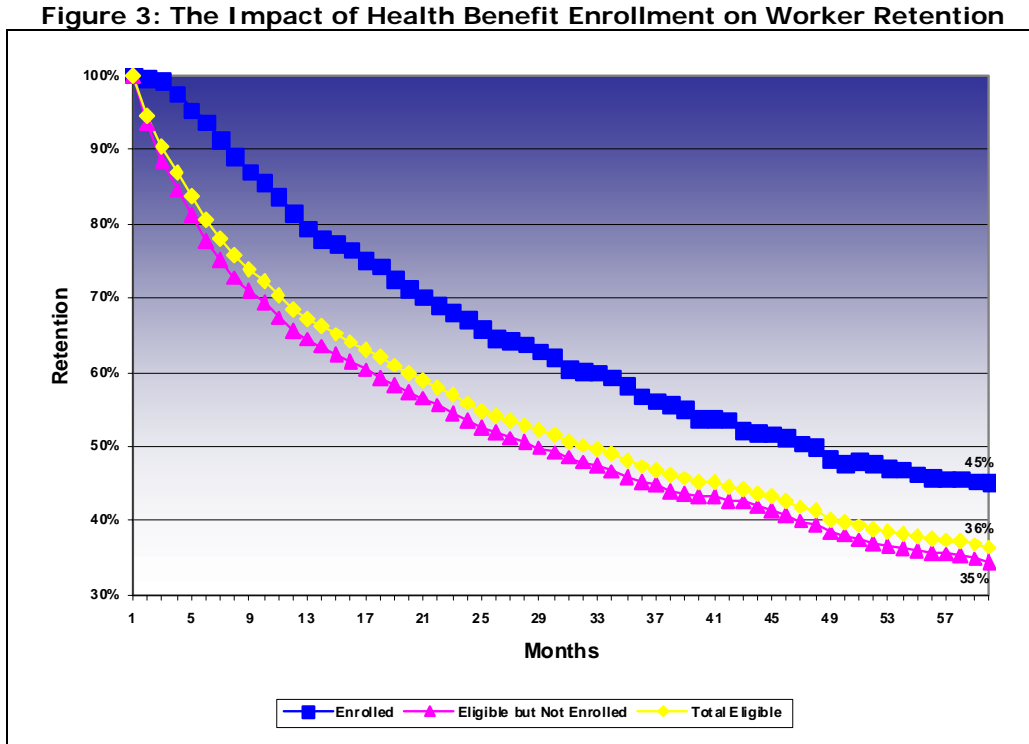
The retention patterns of this group were studied in 2003, 2004, 2005, 2006, and now 2007. Data from the six original cohorts (new workers for each month from February through July 2002) were compared, found to be similar, and combined for analysis. Figure 3, below, plots and compares the retention rates for 60 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 for 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 five-year study period. 45% of workers enrolled in medical benefits (Group 1) remained active in the 60th month after initial entry into the workforce, compared with 36% of all enrolled and non-enrolled workers eligible for benefits (Group 2), and 35% of eligible but non-enrolled workers (Group 3). A χ^2 test confirmed statistically significant differences in retention rates between the enrolled and non-enrolled groups.

The higher rate of enrollee retention found over the five-year study period continues to confirm previous retention findings. The 2006 study showed a comparative retention rate of 50% and 40% for enrolled and eligible non-enrolled workers, respectively. Moreover, the 2005 study showed a comparative retention rate of 56% and 45% for enrolled and eligible non-enrolled workers, respectively.

⁵ In order for the model to provide a better fit to the data, the original data set was trimmed to include only workers who were authorized to work between 80 and 160 hours a month.

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, five-year retention rates were lower than previous four-year and three-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, which is very transient by nature.



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

Figure 3 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 2007. **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, 62% of newly invited (80-hour requirement) enrollees were still working, whereas only 53% of eligible non-enrollees remained in the workforce (Figure 4). For re-invitees originally invited under the 112-hour requirement, 61% of those enrolled during the study were still in the workforce in the final study month, whereas only 50% of eligible non-enrollees remained. **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.** A χ^2 test confirmed statistically significant differences in workforce retention between the Enrolled and Non-Enrolled groups for both the 112-Hour and 80-Hour groups.

Figure 4: Retention Rates 2004-2007 for Newly Eligible Workers

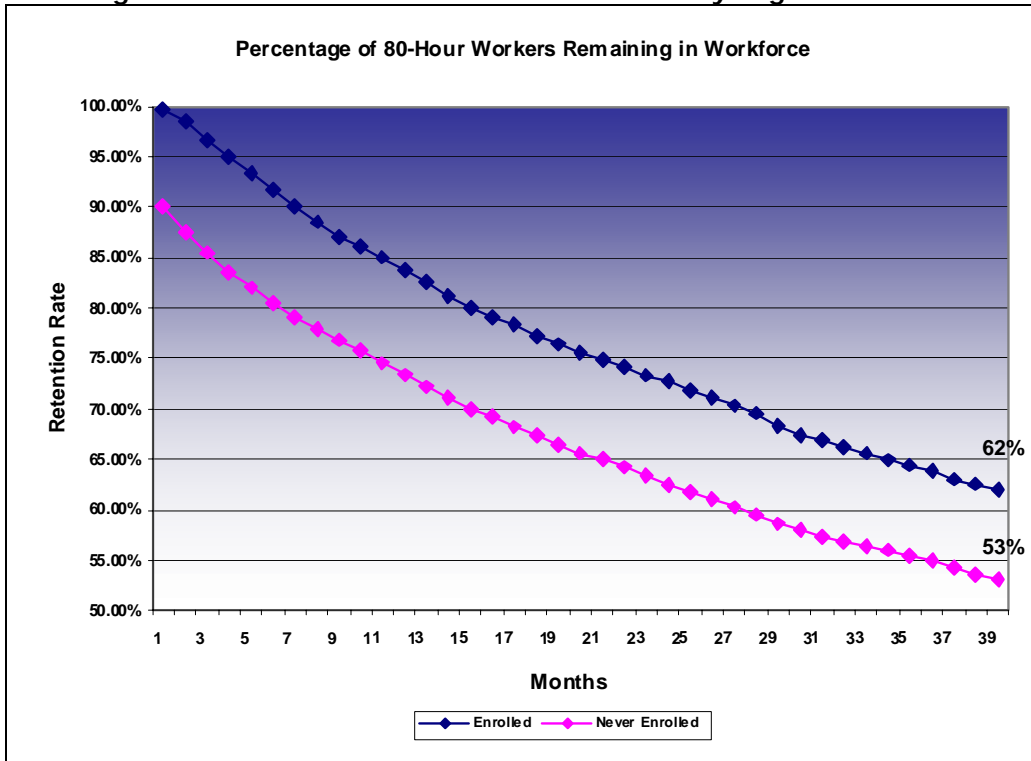
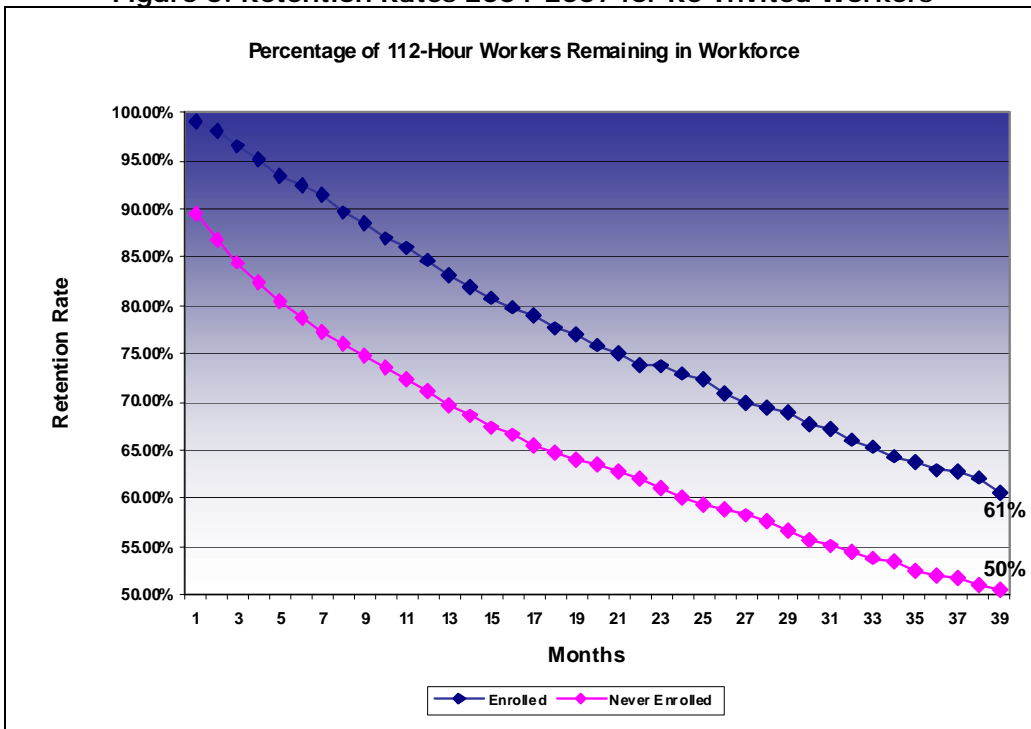


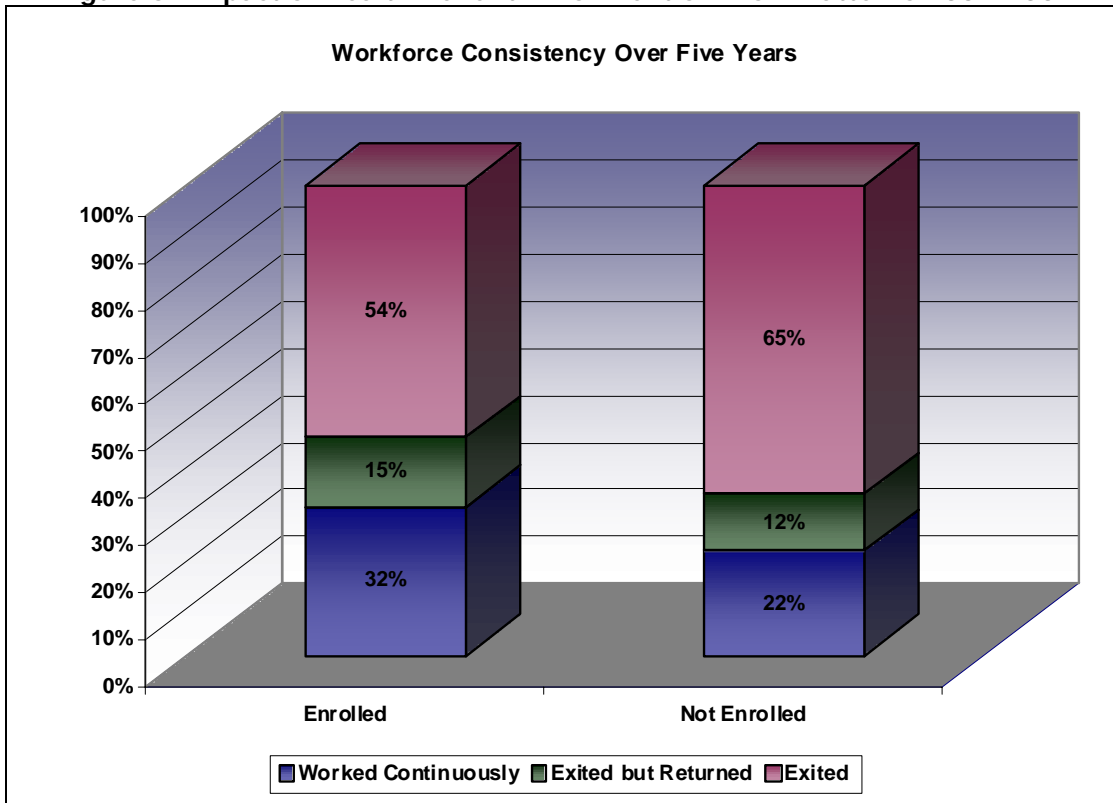
Figure 5: Retention Rates 2004-2007 for Re-Invited Workers



WORK PATTERNS OVER A FIVE-YEAR STUDY PERIOD

Most significantly, findings from the 2007 study corroborate findings from previous analyses: A significantly larger percentage of enrolled workers (32%) than eligible non-enrolled workers (22%) worked in all 60 months of the study. 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 four-year to the five-year analysis. A χ^2 test showed statistically significant differences in workforce consistency between the Enrolled and Non-Enrolled groups.

Figure 6: Impact of Health Benefit Enrollment on Work Patterns 2002-2007



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 2002-2007. To provide a more detailed analysis, the following figures register how work patterns compare across 112-Hour and 80-Hour enrollment groups. The study period for this analysis extends from January 2004 to June 2007.

On the following page, Figure 7 charts overall work patterns for enrolled and non-enrolled workers eligible for benefits under the 112-hour criteria. Figure 8 charts overall work patterns for enrolled and non-enrolled workers eligible for benefits under the 80-hour eligibility criteria. 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. A χ^2 test showed statistically significant differences in workforce consistency between the enrolled and non-enrolled groups for both the 112-Hour and 80-Hour Groups.

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, 49% of enrollees worked across all months as compared to only 39% of eligible non-enrollees. These comparisons corroborate and strengthen 2006 study findings, which showed that 61% of 112-Hour enrollees worked across all months as compared to 49% of eligible 112-Hour non-enrollees.

In the 80-Hour group, 51% of all enrollees worked during all study months, as compared to only 43% of eligible non-enrollees. Again, these findings corroborate 2006 findings, which showed that 62% of all 80-Hour enrollees worked during all study months, as compared to 52% 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. 39% of enrollees in the 112-hour group exited the workforce, compared to 50% of non-enrollees. 38% of enrollees in the 80-Hour group of enrollees exited the workforce, compared to 47% of non-enrollees.

Returning Workers

Nearly equal percentages of returning workers are found across both enrolled and non-enrolled workers for both the 112-Hour and 80-Hour groups. Although in the 2005 study the percentage of returning workers was higher for the enrollees than non-enrollees for both groups, results from the last two years show nearly equal percentages of returning workers across both enrolled and non-enrolled workers.

Figure 7: Work Patterns of 112-Hour Eligible Workers

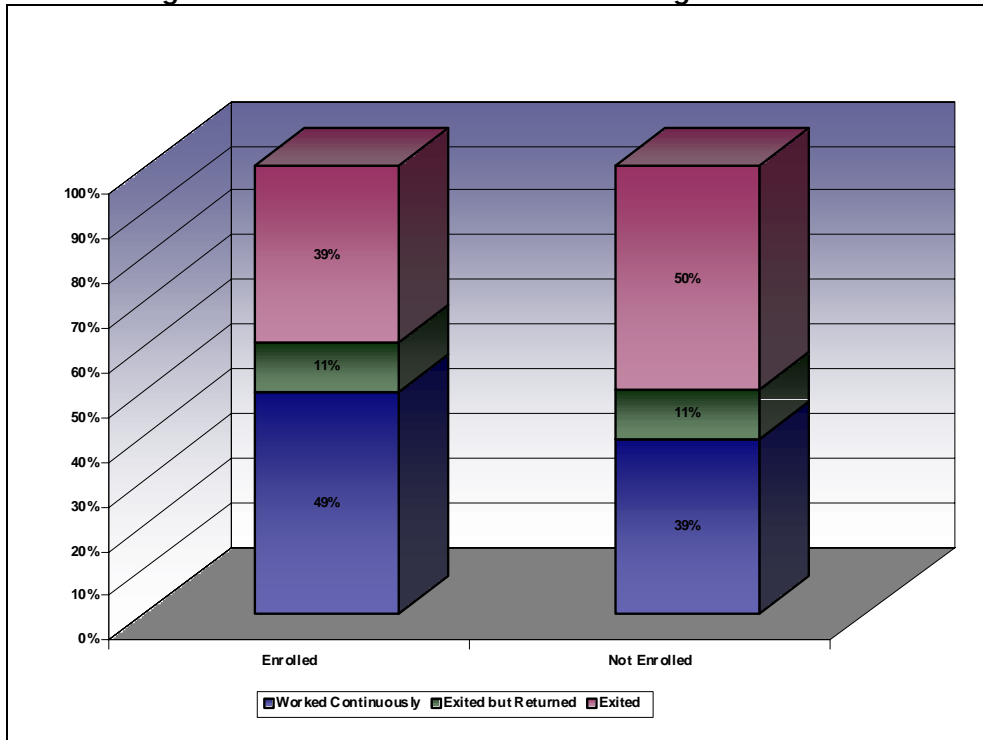
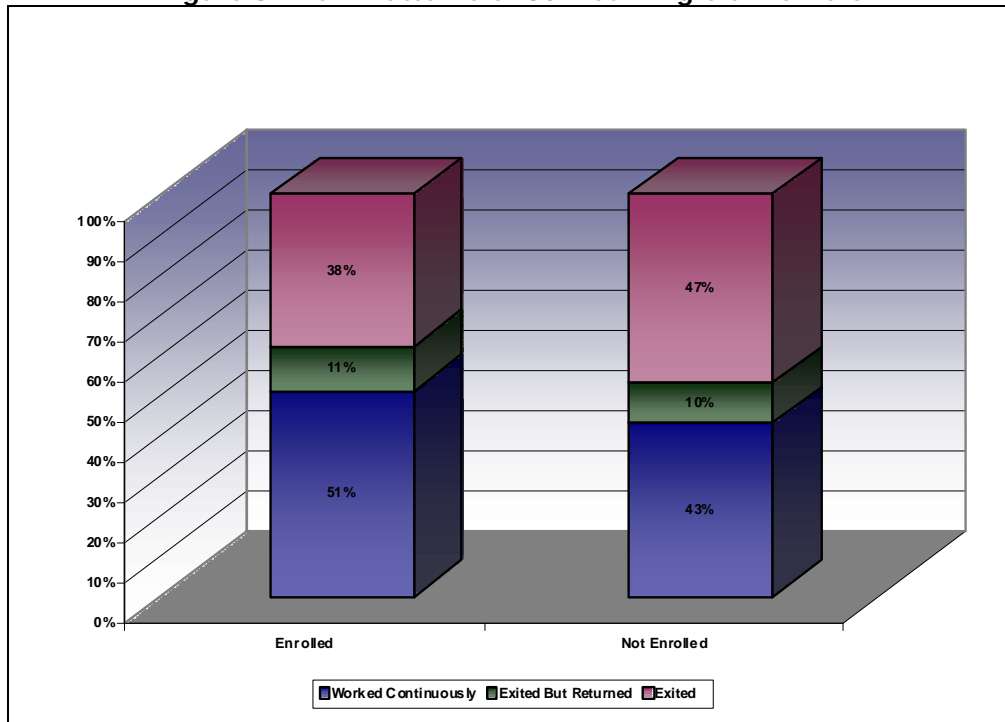


Figure 8: Work Patterns of 80-Hour Eligible Workers



COMPARING FAMILY AND NON-FAMILY WORK 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 family members and close relatives, 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.

The following tables provide four 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, 2006, and 2007.

| Worker/Consumer Relationship | | |
|------------------------------|----------|----------|
| June 2007 | | |
| | Eligible | Enrolled |
| Family Member | 43% | 42% |
| Other Relative | 18% | 16% |
| Non-Family | 39% | 42% |

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

| Worker/Consumer Relationship | | |
|------------------------------|----------|----------|
| June 2005 | | |
| | Eligible | Enrolled |
| Family Member | 34% | 32% |
| Other Relative | 17% | 15% |
| Non-Family | 49% | 53% |

| Worker/Consumer Relationship | | |
|------------------------------|----------|----------|
| June 2004 | | |
| | Eligible | Enrolled |
| Family Member | 31% | 30% |
| Other Relative | 16% | 14% |
| Non-Family | 53% | 56% |

This analysis reveals two major points:

- The eligibility pool for medical benefits consists of more workers serving either family members or close relatives compared to workers serving non-family members. This reflects a shift from previous periods where the eligibility pool had been split fairly evenly between the two groups.
- Of all those enrolled in benefits, the percentage of family workers has risen significantly since 2006, while the percentage of non-family workers has decreased significantly over the same time period. Future studies ought to examine this trend.

Next Steps and Conclusion

The last five studies have looked at how health benefits affect rates of worker retention. The findings from this study are consistent with findings from previous studies, which show a clear correlation between enrollment in health benefits and longer worker tenure. This 2007 study documents that the impact of health benefits on retention extends over a five-year period.

In addition to demonstrating the impact of health benefits on worker retention, this study incorporated two additional analyses. The first new analysis was an examination of current enrollment patterns for those who initially enrolled and those who did not enroll in benefits. Of the active workers who initially enrolled for health benefits, more than three-quarters were still enrolled after five years. For those who dropped coverage, doing so was largely due to loss of eligibility because of reduced hours. Of those workers who initially chose not to enroll, 665 workers, or 29% of workers in the non-enrolled cohort who were still active, have since enrolled in benefits. Over time, a growing number of workers are choosing health benefits. Growing health benefit enrollment among the non-enrolled cohort suggests that the impact of health benefits is even greater than stated in the core analysis, serving as a factor in retention rates among these workers in the non-enrolled cohort as well.

Health benefit enrollment in Los Angeles County has been growing steadily. At the end of the fifth year of program operation, over 35% of eligible IHSS providers were enrolled in benefits, up from 17% when the program first launched. Still, a question remains why more workers aren't taking advantage of this valuable program. A second new analysis added for this report focused on factors that predict enrollment. Specifically, the study looked at five factors as predictors of benefit enrollment: gender, provider relation to consumer, ethnicity, age, and authorized hours. The analysis found that workers with more authorized hours were more likely to enroll, males were more likely to enroll than females, Chinese workers were almost twice as likely to enroll, and Black workers were slightly less likely to enroll. While this analysis identifies predictors of enrollment, it does not explain why these factors made a difference. A supplemental survey of eligible benefit enrollees and non-enrollees should be included in future studies to better understand the factors influencing enrollment and how outreach can be refined to address them.

While the current study looked at the impact of benefit enrollment on worker retention and stability, it did not address the question of the value of health benefits. Does enrollment in health benefits change the health care services received? Do workers with health benefits receive more health services; do workers with routine access to primary care use less emergency services? Determinations about how IHSS benefits enrollees use their benefits and what this means are important new directions to pursue. Service use data collected under the health plan and/or health diaries can be used to address these important questions and should be part of future analyses.

The study has demonstrated the positive impact that health benefits have had on retention of a traditionally low-wage, under-insured homecare workforce. Health benefits are an incentive to homecare workers and encourage these workers to continue providing homecare services, a job that has been traditionally difficult to fill and plagued with high turnover. Health benefits have many benefits. Improving the health of this low-income workforce improves their work consistency, which plays a

key role in supporting the consumers they serve. Health benefits also help the consumers who need these homecare services attract and retain good workers. Finally, providing funded health benefits reduces the indigent care burden on the county health system and can improve the overall health of the community.

Los Angeles County leads the state in providing health insurance to more IHSS workers than any other county. Studying PASC's IHSS benefits program can improve the Los Angeles County program, and the lessons learned can be applied to homecare workers in other counties and other states. Today, in California and across the nation, there is a growing interest in universal health care and in increasing health care benefits to more low-wage workers. Los Angeles County's health care benefit program is a significant step in expanding health care coverage, and its experience can serve as an example and a guide for other communities and other uninsured populations.

Appendix A: Supervisorial District Enrollment Analysis

The following figures chart the number of active, eligible, and enrolled workers by Supervisorial District from February 2002 to June 2007. "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 2007 enrollment and benefits penetration rates for each Supervisorial District. Benefits penetration is a summary measure that calculates the number of enrollees as compared to the percentage of all active workers residing in the district. From 2006-2007, rates have risen fairly evenly across all Supervisorial Districts.

Table 1: Benefit Enrollment and Penetration Rates Across Supervisorial Districts

| District | Enrollment Rate | Benefits Penetration Rate |
|--------------------------|-----------------|---------------------------|
| Supervisorial District 1 | 38% | 20% |
| Supervisorial District 2 | 29% | 16% |
| Supervisorial District 3 | 36% | 23% |
| Supervisorial District 4 | 34% | 19% |
| Supervisorial District 5 | 35% | 20% |

OVERVIEW OF FINDINGS

- As of June 2007, Supervisorial District 5 contains the largest number of active workers (31,879), eligible workers (18,367), and enrolled workers (6,342).
- The second largest number of active workers (26,107) is found in Supervisorial District 2.
- The second largest number of eligible workers (16,249) is found in Supervisorial District 3.
- From 2002-2007, Supervisorial District 5 and 3 have experienced the highest growth in eligible workers. Supervisorial District 5 contains over 3 times the number of eligible workers it contained in 2002 and Supervisorial District 3 includes nearly 3 times the number of eligible workers it contained in 2002.
- Supervisorial Districts 5 and 3 currently possess the largest number of enrolled workers: 6,342 and 5,783, respectively.

