

Model IHSS Health Benefits Programs: Four County Case Studies



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MODEL IHSS HEALTH BENEFITS

PROGRAMS: FOUR COUNTY CASE STUDIES

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INTRODUCTION

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

One challenge for in-home services is the maintenance of a reliable, stable workforce. In the past, homecare workers have been paid low wages and received few if any benefits. In the 1990s, California began implementing a new and innovative program, the IHSS Public Authority. In 1991, California gave counties the option to develop Public Authorities to serve as employers of record for independent provider (IP) homecare workers, enabling counties to raise IHSS workers' wages and provide benefits. Later, California Assembly Bill 1682 mandated that every county establish an employer of record for IP mode IHSS workers, and most counties chose to implement a Public Authority to fulfill that role. By spring 2005, almost all of the 58 California counties had implemented Public Authorities, and approximately half of these Public Authorities have begun offering health benefits to IHSS workers.

STUDY FOCUS

This report focuses on the implementation and operation of health benefits programs for the independent provider IHSS worker population, which has traditionally lacked adequate health coverage. An earlier report, *The State of IHSS Health Benefits in California: A Survey of Counties*,¹ provided a statewide summary of IHSS health benefit programs in California. The current report presents Case Studies of model health benefits programs for IHSS workers in four California counties: San Francisco, Los Angeles, Sacramento and San Bernardino – each with lessons to share. It begins with background information about State policy innovations that facilitated the creation of these county programs. It then describes the development of benefit programs in each of the four highlighted counties, presents operational data on medical benefits enrollments and costs, and discusses lessons learned. The final section of the report compares the benefits programs in the four counties, and analyzes common challenges in developing those programs. The terms “IHSS worker” and “homecare provider” in this report refer specifically to independent providers (IPs), or those IHSS workers for whom the PA is the employer for purposes of collective bargaining, but who are legally hired by IHSS consumers. The IP mode contrasts with the contract mode, in which IHSS workers in some counties are fully employed by homecare agencies.

This report is aimed at two audiences. First, it is intended to help counties with IHSS worker benefits programs to better understand their options for maintaining and enhancing those programs. Second, this report is designed to assist counties and States without benefit programs for homecare workers to better understand the ‘benefit of benefits,’ to provide new communities with working models, and to share lessons learned.

DATA SOURCES AND METHODS

This report is based on data from a number of sources:

- *Impacts of Medical Benefits on Service Use and Satisfaction: A Survey of IHSS Homecare Workers in Los Angeles*, a survey of Los Angeles County independent provider homecare workers, conducted for the Personal Assistance Services Council of Los Angeles County by RTZ Associates in May 2005. The survey and its analysis yielded data concerning workers’ use of medical services, worker satisfaction with the medical benefits program and the extent, methods and costs of providing health benefits to IHSS workers.
- The California Management Information and Payrolling System (CMIPS), which includes individual records of IHSS workers’ hours and payment. CMIPS data files and reports from 1997 through 2005 were used to determine worker eligibility for health benefits.
- HomCarefids, RTZ Associates’ benefits administration system, which processes monthly CMIPS data to calculate benefits eligibility and record, track and process benefits enrollments. Monthly HomCarefids reports on worker eligibility and enrollment for each county were used to calculate program growth and the impacts of eligibility requirements on enrollment.
- Telephone interviews with IHSS Public Authority directors, conducted during July and August 2005.

BACKGROUND

In-Home Supportive Services

California’s In-Home Supportive Services (IHSS) program began in 1973; today, it is a \$2+ billion per year program, funding a workforce of over 300,000 direct service providers. It is the nation’s largest Medicaid-funded program for consumer-directed long-term care. IHSS provides personal care services to low-income elderly and disabled Californians, enabling them to remain in their homes and communities. The vast majority (more than 96%) of California’s IHSS workers are independent providers – that is, they are hired, fired and supervised directly by service recipients or consumers. Many consumers prefer this mode of receiving services, because it offers them the greatest flexibility and choice. However, IPs have been plagued with low wages, no benefits, and little training. Not surprisingly, turnover is high, creating chronic provider shortages, low skill levels, and compromised quality of care.

Consumers often have difficulty finding qualified, available providers. Harrington and Newcomer (2004) cited the large number of service hours that are authorized but not provided (15% fewer hours of services provided

¹ RTZ Associates, Inc. (2005). *The state of IHSS health benefits in California: A survey of counties*. Oakland, CA.

than are authorized) as evidence of the worker shortage in California.¹ In addition, some consumers need service hours that remain unrecognized and unauthorized. The State service shortage typifies a larger national problem. In the 2003 National Survey of State Initiatives on the Long-Term care Direct-Care Workforce, 79% of the 44 States that responded indicated that high vacancy rates continue in the direct-care workforce. In the early 1990s, California began to make some innovative policy and funding changes aimed at addressing these problems:

- 1991 – California gave counties the option to form Public Authorities to serve as employer of record to IP mode IHSS workers.
- 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.
- Mid 1990's – Counties began to implement Public Authorities – quasi-governmental, consumer-directed agencies designed to improve IHSS delivery.
- 1999– California Assembly Bill 1682 mandated counties to form employers of record for IP mode IHSS workers. Most counties chose to form Public Authorities as employer of record.
- 2001 – The 2000/01 California Budget Act provided an additional incentive – State matching funds – for counties to develop Public Authorities and to increase funding for wages and benefits (such as medical and dental coverage).

These innovations resulted in many improvements for counties, workers, and consumers of IHSS. Public Authorities (PAs) began to operate worker registries to provide consumers with lists of screened IHSS workers, arrange training and support services for workers and consumers, and offer consumers and workers a voice in program and policy development. PAs also function as the employer of record for independent providers, which makes collective bargaining possible.

Health Benefits

The first benefits program for IHSS workers was implemented by the San Francisco IHSS Public Authority in 1999. Since then, 44% of California's PAs, working with local unions and others, have developed benefits programs for IHSS workers. Health benefits have been implemented through 24 single-county or multi-county Public Authorities. According to adjusted CMIPS data, there were 317,709 IHSS workers in California as of March 2005. The survey of counties conducted in March 2005 showed that 53,846, or 17%, of these workers receive health benefits through IHSS. Since benefits are offered primarily in larger counties with denser provider populations, the vast majority of IHSS workers (92%) live in counties whose Public Authorities offer health benefits. Collectively, the counties examined in this report – San Francisco, Sacramento, Los Angeles, and San Bernardino – comprise 59.6% of all IHSS workers and 55.7% of all workers who receive health benefits through their employment as IHSS providers.

¹ Harrington, C. and Newcomer, R. (2004). *California long-term care budget issues for 2004*. Retrieved from <http://pascenter.org/news/calongtermcare> Center for Personal Assistance Services.

Summary Timeline

County	PA Created	Benefits Begun
San Francisco	1995	1999
Sacramento	2000	2001
Los Angeles	1997	2002
San Bernardino	2002	2004

Summary Population Data

County	Total Population ¹	IHSS Workers ²
San Francisco	751,682	12,525
Sacramento	1.33 million	15,000
Los Angeles	9.87 million	115,387
San Bernardino	1.86 million	15,600

¹ U.S. Census Bureau, 2003 estimate

² HomCarefids, July 2005

SAN FRANCISCO COUNTY

Benefits Implementation History

In 1995, San Francisco became the third California county, after San Mateo and Alameda, to establish a Public Authority. One of the first actions of the San Francisco Public Authority (SFPA) was to conduct a worker survey, which revealed that a health benefit was one of workers' top priorities. San Francisco County previously demonstrated an unusually strong commitment to universal health coverage. A community initiative in 1996, Proposition J, proposed universal healthcare for all San Franciscans, and in October 2000 the San Francisco Board of Supervisors enacted a Minimum Compensation Ordinance that called for employers with city contracts to offer health coverage. It was in this local political climate that the SFPA designed its health benefits program for IHSS workers. The State's inclusion of IHSS worker benefits in the Medicaid State Plan five years earlier secured the program's viability. In March 1999, this unique combination of factors, plus the cooperation of the local union and the San Francisco Departments of Public Health and Social Services, enabled the SFPA to become the first Public Authority to offer health benefits to its workforce. In its first month, March 1999, 974 workers enrolled in San Francisco's HealthyWorkers plan.

The SFPA's pre-implementation survey indicated that IHSS workers were intensive users of the county health system. Almost half (42%) of providers surveyed reported using the county health system during 1997. More than half (51%) of uninsured IHSS workers considered San Francisco General Hospital their usual provider.² In other words, many IHSS workers relied on care for the uninsured, funded solely by the county. An IHSS benefits

² RTZ Associates, Inc. (1997). *A survey of San Francisco IHSS providers*. Conducted for the San Francisco IHSS Public Authority.

program was financially appealing because it transferred part of the cost of that care, formerly covered by the county, to the federal government, by making almost half the cost of those benefits reimbursable through Medicaid as part of the cost per hour for IHSS services. In San Francisco, the provision of health benefits addressed two county needs: 1) providing health coverage to a largely uninsured population, and 2) helping to strengthen the local public health infrastructure through the infusion of federal Medicaid funds.

Studies have since shown that the provision of health benefits, in combination with wage increases, has strengthened the workforce in San Francisco. Candace Howes’ 2002 study examined the effects in San Francisco and Alameda counties on the supply of the homecare workforce over four years when wages doubled from \$5 to \$10 an hour and health and dental benefits were added. The study found that the size of the county workforce grew at twice the rate of the statewide IHSS workforce, and turnover fell by 35%.³

San Francisco Benefits Overview

With broad support from the community, the SFPA and its partners designed a benefit program, HealthyWorkers, whereby eligible IHSS workers could receive a comprehensive health and vision benefit through the county health plan. Unlike some other counties, San Francisco has no enrollment cap for medical benefits for IP-mode IHSS workers; all eligible workers may enroll. In addition, San Francisco IHSS workers who work 6 months are also eligible for a default, county self-insured dental benefits plan –Delta Preferred Option or, if they opt for it, Delta PMI with dependent coverage.

Health Benefit Eligibility & Enrollment

In July 2005, San Francisco IHSS consumers received nearly 1.22 million hours of services from 13,092 IHSS independent providers. Eligibility for the health benefit is based on 25 hours of authorized work per month and two months of authorized work. More than 90% of San Francisco IHSS workers meet this requirement. The SFPA’s relatively low eligibility threshold reflects the county’s desire to provide coverage for the maximum number of workers possible. Low eligibility thresholds and the longevity of the program – are most likely the driving factors in San Francisco’s high enrollment rates. Approximately 63% of eligible workers (nearly 55% of the total workforce) enroll in the SFPA’s health benefits program.

HealthyWorkers Enrollment* at a Glance

Eligible	11,996
Enrolled	7,197

*Based on HomCarefids data for July 2005

IHSS work is often part-time, and the number of hours worked varies depending on consumers’ changing needs. One challenge for Public Authorities, then, is to limit turnover in benefit enrollment; frequent entrances and exits from the program are costly and unproductive. In order to address this challenge, the SFPA requires two

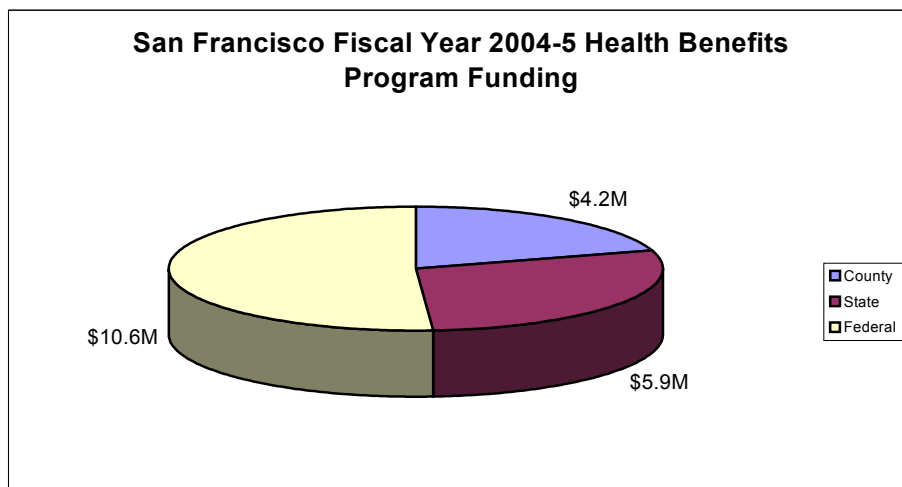
³ Howes, C. (2002). *The Impact of a large wage increase of the workforce stability of IHSS homecare workers in San Francisco County*. Berkeley: UC Institute for Labor and the Economy and the University of California, Berkeley, Center for Labor Education and Research.

months of work for eligibility and extends health benefits for three months beyond work tenure. In other words, when workers fall below the eligibility threshold or lose employment, they have three months in which to meet eligibility requirements again– during which they retain their HealthyWorkers benefits.

Cost

County, State, and federal governments share the cost of IHSS health benefits. The Federal Financial Participation Rate is 51.5% for counties whose service costs per hour are up to \$13.50/hour, or double the minimum wage (\$6.75 in California). The State pays two-thirds of the balance, to a maximum of \$11.10/hour (up from \$10.10 as of July 1, 2005). The county pays the remaining cost of health benefits, but even this local share is subsidized by California’s Realignment Fund, which reimburses counties through State sales tax dollars. However, because the reimbursement process is lengthy, many counties are wary of advancing local dollars for IHSS health benefits. During fiscal year 2004-2005, San Francisco’s total health benefit program costs were \$20,728,951. The federal share was \$10,623,587; the State share was \$5,913,702; and the county share was \$ 4,191,661. Because San Francisco County’s service hour costs exceed the maximum dollar amount matched by the State, the county pays a higher proportion of the benefits costs than other counties.

The total monthly premium for enrollees is \$250.80, with the worker paying \$3 and the SFPA paying \$247.80. The relatively low worker share was designed to maximize enrollment. Compared to other medical benefit programs San Francisco’s monthly premium is about mid-range while the PA’s share of workers’ monthly premium falls in the low range. Because of the high percentage of workers receiving benefits, overall benefit costs are high, \$1.47 per hour.



Cost of Health Benefit per Hour of IHSS Work*

\$1,805,858	÷	1,223,282	=	\$1.47
total cost		hours service		per hour

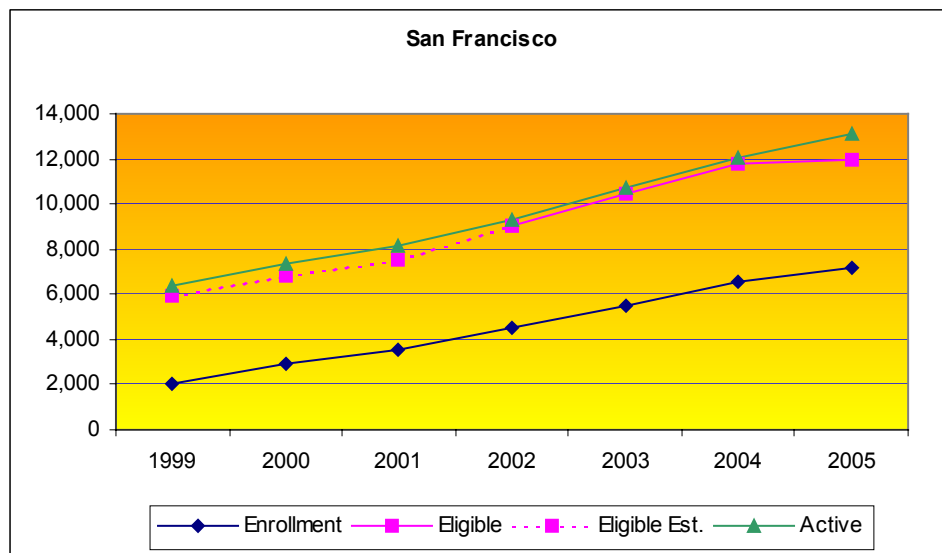
*For July 2005

Lessons Learned

The experience of San Francisco's Public Authority suggests several lessons regarding health benefits for homecare workers. First, buy-in from multiple parties – including the county, Public Authority, and local union – is important. Since the SFPA's health benefit program was implemented prior to the availability of State matching funds, it initially required significant local investment to supplement federal Medicaid funds. The commitment of the San Francisco Board of Supervisors, Departments of Public Health and Human Services, community and labor union was therefore especially critical. The benefits program succeeded, in part, because each party recognized the advantages of health coverage for this worker population – and the benefits to the county of leveraging State and federal funds for that coverage. Since the SFPA's benefits are provided through the county's existing health plan, these funds actually represented an infusion of external moneys for local health infrastructure.

Since the SFPA operates California's oldest health benefits program for IHSS workers, it offers longitudinal data about the growth and impact of such programs. The chart below shows the steady growth in the number of enrolled, eligible and total active providers over time. The number of enrolled providers is currently 3.5 times what it was in July 1999 and more than 7 times what it was during the first month of program operation (March 1999). This growth rate reflects a growing awareness of and trust in the program as well as workers' increasing familiarity and proficiency with navigating health benefits programs.

The chart also reflects San Francisco's policy of covering as many workers as possible: more than 90% of active providers are eligible for health benefits. In 2005, the process of eligibility determination was refined to include not only authorized hours, but also a combination of authorized and paid hours – thus slowing the increase in eligible workers.⁴ This shift is reflected in the slightly higher ratio of eligible to active providers in 2005 than in 2004.



- Eligible Estimate is based on historical data calculated according to current ratios of eligible to active providers.

⁴ Homecare work hours used for eligibility determination are based either on the number of hours authorized by IHSS, the number of hours actually paid or a combination of both authorized and paid hours.

SACRAMENTO COUNTY

Benefits Implementation History

In 1993, the Sacramento County Board of Supervisors created the IHSS Task Force to provide recommendations for improving the county's IHSS program. In February 1994, the Task Force presented the Board of Supervisors with a report recommending the creation of a Public Authority. The Board considered this recommendation several times during the 1990s. Despite 1992 State legislation authorizing counties to establish Public Authorities, no State funding was made available for enhanced wages and benefits. When the State in its 2000/2001 budget authorized State financial participation of 65 % of the non-federal share of IHSS wages, the Board of Supervisors moved quickly to establish the Public Authority in September 2000. Demonstrating its commitment to healthcare, one of the first actions of the Sacramento County Public Authority was the implementation of a medical benefits program. In January 2001, the SCPA entered into benefit negotiations with union representatives. In August 2001, Kaiser enrollment was offered to 4,000 eligible caregivers. The successful development and implementation of a benefits program within this short time period is one of the SCPA's major accomplishments.

Sacramento Benefits Overview

The SCPA was the first Public Authority to offer IHSS workers health benefits through a large private health maintenance organization (HMO). Because Sacramento County's county-run health program was already overburdened, and because stakeholders were committed to providing worker health benefits as soon as possible, the SCPA opted to provide workers with healthcare through Kaiser Permanente as opposed to a county health program. A dental benefit was added in January 2005. Dental services are provided through another private company, Pacific Union Dental, and dental coverage granted automatically to individuals receiving the health benefit. The benefit program does not currently offer spouse or dependent coverage.

Health Benefit Eligibility & Enrollment

Sacramento County IHSS workers become eligible for benefits when they are paid for 85 hours per month (approximately half-time) for 3 consecutive months. Eligibility requirements in Sacramento have been determined partially by the fact that the HMOs in the area were not willing to underwrite for less than half-time work. Workers continue to receive benefits for up to 3 months after termination or after they no longer meet eligibility requirements, minimizing the fluctuation in and out of the benefit program. SCPA enrollees pay \$15 a month of the \$308.29 monthly premium, which includes both health and dental benefits. The State match for benefits was initially limited to \$.60 per hour and Sacramento County allocated funds and designed their program to meet that amount. To keep within budget, the SCPA set a cap on the total number of workers who can enroll in the program. The initial enrollee limit of 2,900 was reached within two years of program implementation, and on January 1, 2005, the cap was increased to 3,150.

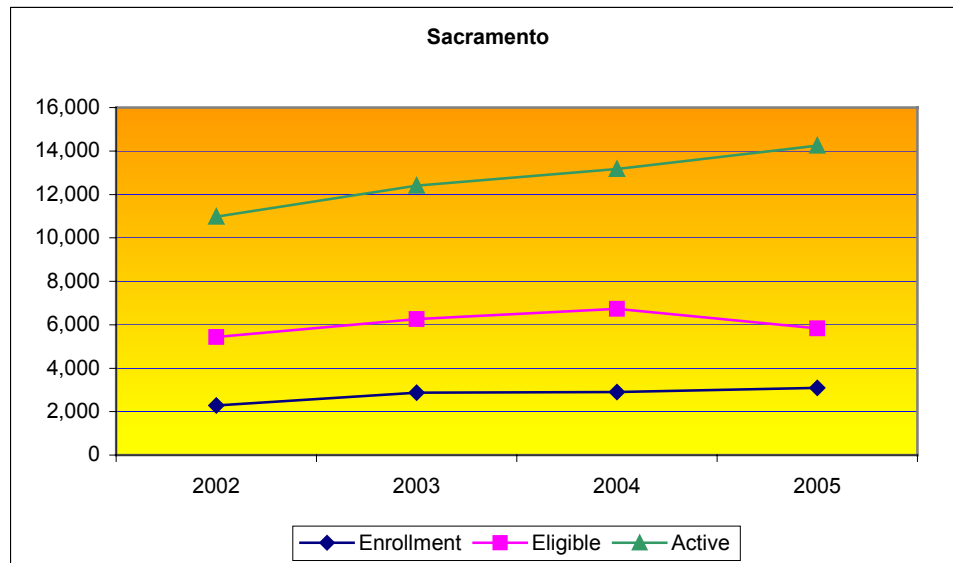
Sacramento Enrollment* at a Glance

Eligible	5,836
Enrolled	3,092

*Based on HomCarefids data for July 2005

The chart below shows that Sacramento County's total active provider population has been growing steadily since July 2002 from 10,972 to 14,252 over the three-year period. During initial enrollment, 1,682 providers enrolled; two years later, in 2003, the 2,900-worker enrollment cap was reached. Since then, the numbers of enrollees has remained constant until the enrollment cap was increased in January 2005, to 3,150.

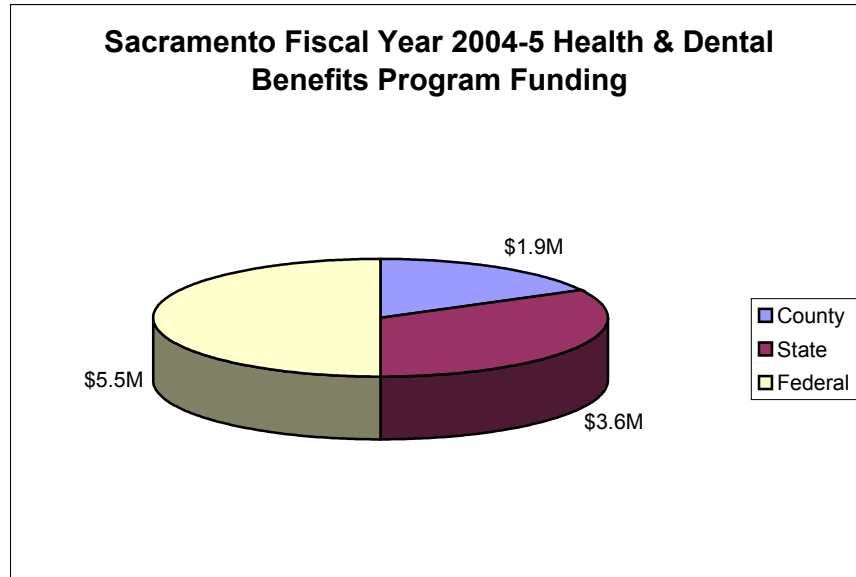
As of July 2005, approximately 53% of eligible workers (21% of the county's IHSS workers) were enrolled in the benefits program. This is a relatively high benefit penetration rate despite the enrollment cap, and reflects the Public Authority's success in identifying the segment of the worker population likely to enroll. Excluding counties with automatic enrollment policies, Sacramento's enrollment rate (percentage of eligible workers who choose to enroll) is the third highest in the State. This high rate of enrollment reflects the SCPA's success at structuring eligibility criteria to limit the pool of eligible workers to the number of available enrollment slots. From 2004 to 2005, the number of eligible workers dropped slightly, due to a change in the eligibility determination from authorized hours to eligibility based only on paid hours.⁵



Cost

As stated above, the worker share of the \$308.29 monthly premium is \$15, which includes health and dental benefits. The total annualized cost of health and dental programs for FY 2004-05 was \$11,038,571. The federal share was \$5,519,286; the State share was \$3,587,535 and the county share was \$1,931,750.

⁵ Paid hours are tracked using the number of hours worked and paid during a given month, excluding late paychecks.



Cost of Health Benefit per Hour of IHSS Work

\$923,825 total cost*	÷	1,550,353	=	\$.60
		hours service		per hour

For July 2004-05

*Total cost includes operational and management costs for the benefits program.

Lessons Learned

The experiences of the Sacramento County Public Authority demonstrate that it is economically feasible to use an established, highly-regarded, private HMO to provide IHSS workers with healthcare. Kaiser health coverage, the same benefit offered to county employees, has a reputation of providing high-quality, timely care to individuals in need of services. The SCPA’s experiences also demonstrate that workers are willing to pay more than a token amount each month as their share of the premium to receive such care.

Sacramento County also provides a good example of successful fiscal management: Eligibility requirements were structured to draw only the numbers of providers the program has the budget to cover. Because eligibility requirements correspond to available funding, the program’s enrollment cap was not reached for two years, at which time the cap was increased to provide benefits to those on the waiting list. Today there is no waiting list and the actual benefit cost per hour is at the budgeted level.

LOS ANGELES COUNTY

Benefits Implementation History

Los Angeles County created its IHSS Public Authority – the Personal Assistance Services Council (PASC) – in 1997. There was significant support from the county and the Service Employees International Union (SEIU), which represents Los Angeles’ homecare workers, for implementing health benefits for IHSS workers. However, as

in most counties, there were fiscal concerns. Los Angeles faced additional challenges: providing benefits to an extremely large worker population distributed over a wide geographic area. Despite these challenges, in 2002 Los Angeles became the largest California county to offer health benefits to IHSS workers. Los Angeles is home to approximately one-third of California’s IHSS caregivers, making the PASC-SEIU medical plan the State’s largest health benefits program for homecare workers.

Los Angeles Benefits Overview

The PASC-SEIU Homecare Workers Health Plan is a comprehensive employer-funded county HMO. Services are provided through a combination of county health services and, in cases where no county clinic exists in the worker’s neighborhood, through contracts with other community-based clinics. Dental benefits are offered by the union and paid for entirely by the workers with no county, federal or State contribution or cost.

Health Benefit Eligibility & Enrollment

In order to manage the large number of workers in Los Angeles County, the PASC initially set relatively stringent requirements for benefits eligibility: caregivers needed to be authorized to work 112 hours per month for two consecutive months in order to qualify. This eligibility requirement was higher than that of many counties, yet more than 30,000 providers were eligible and more than 6,000 providers enrolled during its first year of operation. More than 4,000 workers enrolled in the program during the first month alone.

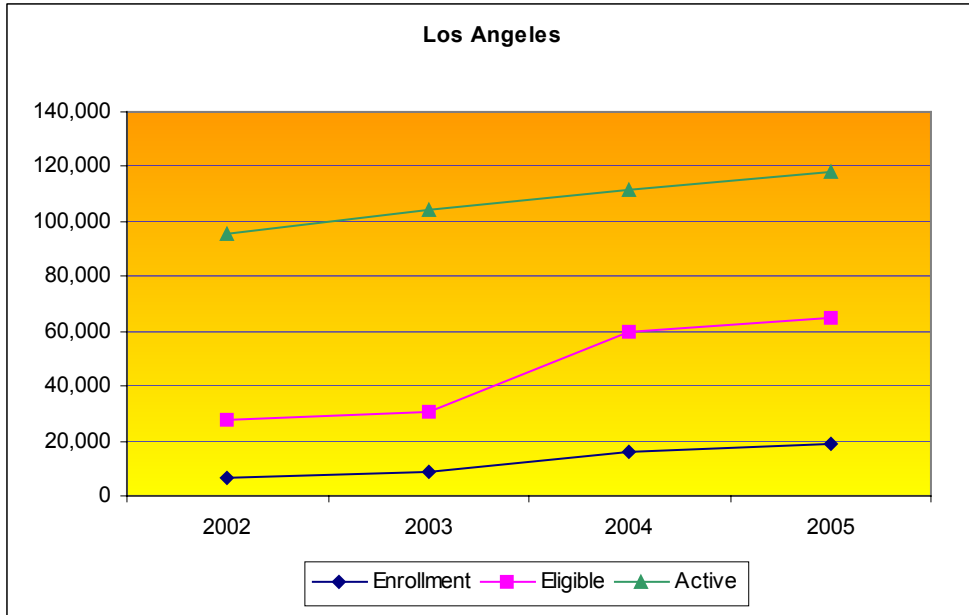
Based on its success with the initial pool of eligible workers, the PASC decided to pursue the possibility of lowering eligibility requirements to include a broader group of workers. Toward this end, in 2003, the PASC commissioned a feasibility study regarding lowering the eligibility requirement to 80 hours per month for two consecutive months. The study indicated that this was both affordable and desirable, from economic and pragmatic viewpoints.⁶ This program change was implemented in 2004 and resulted in a dramatic increase in the number of eligible workers. In June 2003, eligible workers numbered 30,302; in June 2004, that number had nearly doubled, reaching 58,561.

Los Angeles Enrollment* at a Glance

Eligible	64,880
Enrolled	19,293

*Based on HomCarefids data for July 2005

⁶ RTZ Associates. (2003). *Eligibility requirement feasibility study*. Conducted for the Personal Assistance Services Council of Los Angeles County.

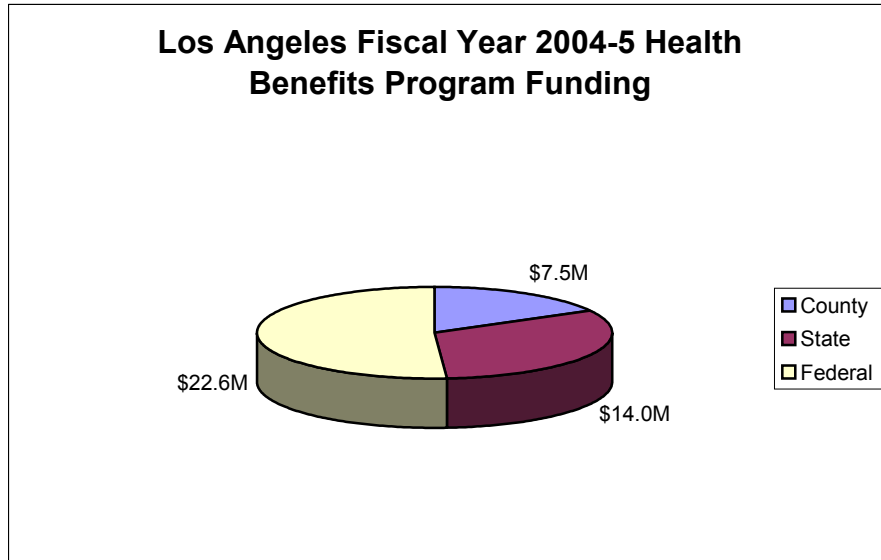


As of July 2005, 30% of eligible workers (16% of the entire Los Angeles IHSS workforce) had enrolled in the health benefits program. Enrollment has increased steadily in the program’s 3+ years of operation, from 4,000 when the program started in May 2002 to almost 20,000 in July 2005. Today, the Los Angeles PASC operates the largest IHSS health benefit program in the State, accounting for more than 25% of all covered workers.

Cost

Annual costs of Los Angeles IHSS workers’ medical benefits in FY 2004-05 totaled \$44,053,580. The federal share was \$22,577,450; State share was \$13,960,580; and county share was \$7,515,541. These figures do not include the cost of dental benefits (\$5/month), which is paid for in full by enrollees.

The monthly health benefit premium for each enrollee is \$207.27, of which the worker share is \$1. Although Los Angeles’ aggregate costs are the highest in the State, the number of paid hours is also the largest, making the cost of health benefits per paid IHSS hour relatively low, at \$.34 per hour.



Cost of Health Benefit per Hour of IHSS Work*

\$3,998,860	÷	11,855,975	=	\$.34
total cost		hours service		per hour

*For July 2005

Lessons Learned

The experiences of the Los Angeles PASC demonstrate that it is indeed possible to provide health benefits to a large, diverse, and geographically distributed worker population. The PASC-SEIU health benefits program is by far the largest such program in California and probably the nation and it continues to grow rapidly. This success is partially due to the PASC's commitment to continuous quality improvement through data-driven analyses. The PASC has commissioned a series of studies on the impacts of medical benefits on workforce recruitment and retention, and uses such analyses to improve operations and guide policy. One study found that during **the first year** of benefits program operation, worker turnover decreased and worker retention increased.⁷ A **two-year** longitudinal study confirmed these findings over a longer period of time.⁸ Finally, a study conducted in August 2005 revealed a higher worker retention rate for enrolled workers than eligible non-enrolled workers across a **three-year** study period.⁹

In 2005, the PASC commissioned a worker survey to assess satisfaction with the benefits plan and medical care, to analyze demographics and enrollment patterns, and to ascertain worker reasons for non-enrollment. The

⁷ Zawadski, R. & Radosevich, J. (2003). *The impact of medical benefits on retention of homecare workers: Preliminary analysis of the IHSS medical benefits program in Los Angeles County*. Prepared for the Personal Assistance Services Council of Los Angeles County.

⁸ Zawadski, R. (2005). *The impact of medical benefits on retention of homecare workers: A two-year study of the IHSS medical benefits program in Los Angeles County*. Prepared for the Personal Assistance Services Council of Los Angeles County.

⁹ Zawadski, R. (2005). *Expanding health benefit eligibility: Impacts on the IHSS workforce*. Prepared for the Personal Assistance Services Council of Los Angeles County.

survey indicated that a majority (53%) of eligible workers who declined enrollment were covered under other medical plans such as a spouse's plan or through Medicare or MediCal.¹⁰ This suggests that eligible workers tend to remain in their pre-existing benefits programs when applicable; this is important because, unlike the PASC benefit program, these other programs carry no local cost.

By conducting studies of enrollment, cost, and worker satisfaction, the PASC has been able to continuously enhance its benefits program to meet workers' priorities within existing funding limitations. Ongoing analyses have enabled the PASC to advocate to the Board of Supervisors for a successful reduction in worker eligibility requirements, thereby increasing the number of workers receiving benefits. Finally, Los Angeles' balancing of a very low worker premium (\$1) with relatively high and then moderate hour requirements (112 hours, then 80 hours, for two consecutive months) demonstrates how a variety of factors can be adjusted to influence worker enrollment rates.

SAN BERNARDINO COUNTY

Benefits Implementation History

The San Bernardino County IHSS Public Authority (SBPA) was created in January 2002. Once formed, the SEIU organized workers and was selected as the bargaining agent. A labor agreement was reached in Jan 2003 and was in effect until Jan 2004. That agreement called for an increased wage and \$500,000 in local funds allocated for health benefits; however, health benefits were not implemented during the term of that MOU. A successor MOU was approved in March 2004 for a one-year term ending March 31, 2005—this MOU called for no wage increase but reallocated the unspent \$500,000 for health benefits from the prior MOU. The SBPA then developed and implemented its benefit program. Information about benefits was distributed to workers in a series of town hall meetings in September 2004. Applications were sent to over 11,000 eligible workers and over 2500 applied. Medical benefit coverage began in December of the same year.

San Bernardino Benefits Overview

San Bernardino offers a comprehensive health benefit but no dental or vision benefit. Services are provided by Inland Empire Health Plan, a PPO. As in San Francisco, eligibility requirements were kept low, (25 authorized and paid hours per month for 2 consecutive months), and, as in Los Angeles the worker share of the premium was a very modest \$1. However, in implementing this benefit program, the San Bernardino Public Authority was limited to a spending cap imposed by the Board of Supervisors. Given this fiscal constraint and liberal eligibility criteria, the SBPA was immediately oversubscribed and implemented a benefits waiting list. In response to the over-subscription, the SBPA created a prioritization system for determining which eligible workers would receive benefits. As part of its effort to develop a more stable and skilled workforce, the SBPA opted to give priority to individuals who have a higher number of total hours worked.

¹⁰ Zawadski, R. (2005). *Impacts of medical benefits on service use and satisfaction: A survey of IHSS homecare workers in Los Angeles*. Prepared for the Personal Assistance Services Council of Los Angeles County.

To make the full use of the allocated funds in the first MOU year of operations, the SBPA structured enrollments in order to use all funds within the remaining five months of the year. The 2005-2006 successor MOU did not expand the total funds available to the benefits program. Instead, the same amount of funding was allocated over a longer time period. The resulting decrease in available monthly funds will necessitate a drop in enrollment. Overall, the reduction of monthly funding will eliminate program growth and may necessitate moving enrollees to the waiting list.

Health Benefit Eligibility & Enrollment

As mentioned above, San Bernardino benefits eligibility is based on 25 authorized and paid hours per month for two consecutive months. Continued eligibility is based on 25 paid and authorized hours per month for two of the prior three months.

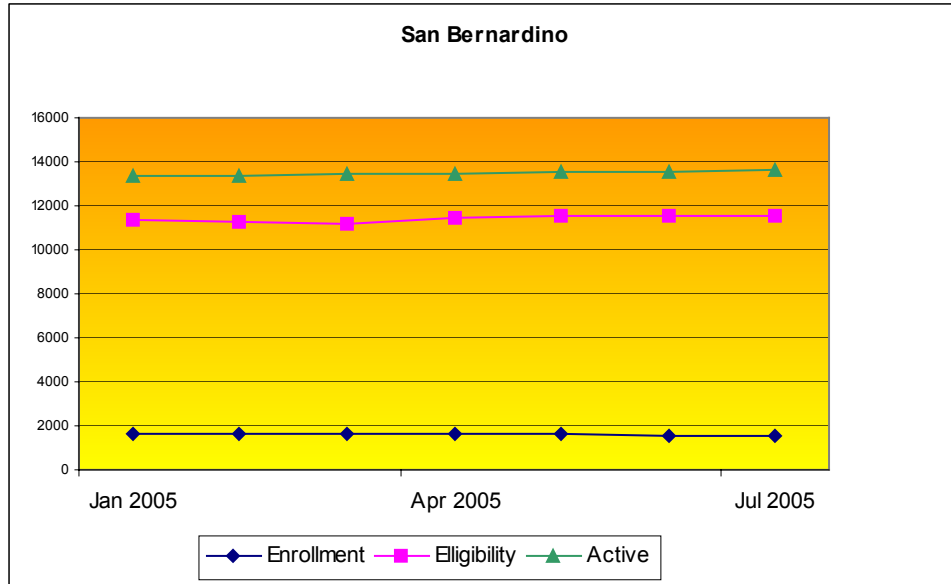
San Bernardino Enrollment* at a Glance

Eligible	11,569
Enrolled	1,516
Waitlisted	1,016

*Based on HomCarefds data for July 2005

The chart below shows the number of enrollees, eligible workers, and total active workers for the period of benefits operation, January to July 2005. Because San Bernardino’s program is relatively new, the chart shows less dramatic change than some of the older programs, such as San Francisco’s. In addition, the over-subscription for benefits combined with the enrollment cap has resulted in steady enrollment numbers and a sizeable waitlist. During the first month of operation, 1,620 providers were enrolled in the program. By July 2005, there were 1,518 enrollees. The total enrollment was reduced through attrition to stay within budget.

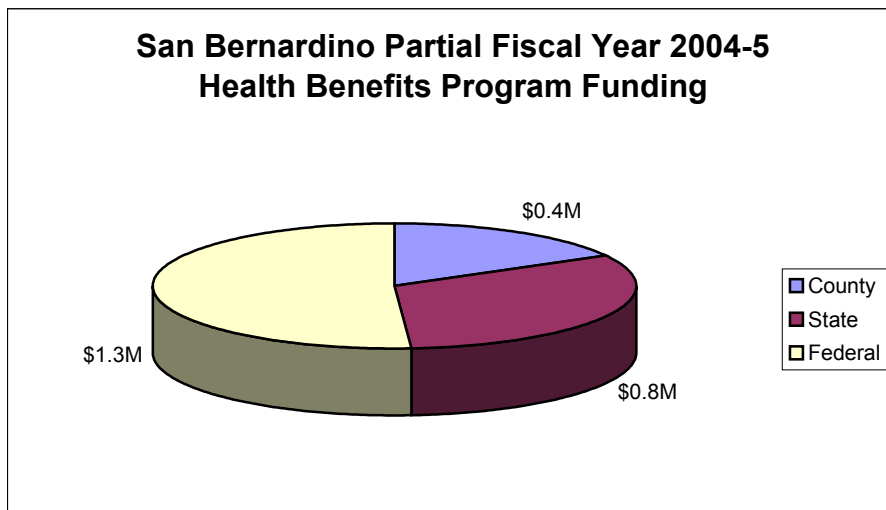
As of July 2005, 2532 workers applied for health benefits, representing 20% of all IHSS IP workers. Of these, 60% or 1516 providers were enrolled in benefits. This represents 13% of eligible IHSS IP workers in the county. This number represents 11% of all San Bernardino County IHSS independent providers, the lowest rate of coverage in the State. This relatively low enrollment reflects the SBPA’s benefits spending cap, not worker lack of interest. A waiting list has continued to grow since the inception of the program, and more than 1,000 applicants are currently waitlisted.



Cost

San Bernardino County faces a particular challenge in that it contains both urban and rural regions, and these regions have vastly different health plan costs. The total monthly premium therefore differs depending on whether the enrollee lives in a rural or urban area (\$526.17 and \$220.08, respectively). In either case, the worker share of the premium is \$1.

Total cost of health benefits for the partial FY 2004-05 was \$2,559,487. The federal share was \$1,311,737; the State share was \$811,102; and the county share was \$436,649. The current cost of benefits in San Bernardino County is \$.24 per paid hour of IHSS services.



Cost of Health Benefit per Hour of IHSS Work*

\$333,932	÷	1,365,967	=	\$.24
total cost		hours service		per hour

*For July 2005

Lessons Learned

Of the four Public Authorities highlighted in this report, San Bernardino’s is the newest and its health benefits program the youngest. With low eligibility requirements and extremely low worker premiums, San Bernardino’s program is also structured to cover as many providers as possible. However, the county’s limited spending cap has, in practice, significantly limited the number of providers who can be covered. Not surprisingly, the combination of high numbers of eligible providers and limited funding has generated a substantial waiting list. Significant additional local funding is needed to even maintain the current benefit program.

The SBPA, in conjunction with the union, has designed an interesting system to meet the challenge of limited funding combined with over-subscription. A priority system was developed based on the number of hours worked by each provider during the last two years (since July 2002), using the first date of hire as a tie-breaker. Providers are then assigned priority scores based on accumulated hours, creating a system that rewards providers with longer tenure and more accumulated hours.

The disparity in health coverage availability between rural and urban geographic areas has posed a major challenge to many California counties, forcing some to turn toward more limited benefits models, such as reimbursement coverage. San Bernardino has found an effective way to provide a comprehensive HMO benefit to serve both rural and urban worker populations in the county. Because the health plan premiums are higher in rural areas than in urban areas, the county has instituted a two-tier pricing structure. The tiered pricing structure has proved successful in that it has enabled the PA to serve eligible workers living in rural areas of the county. However, because the worker premium is the same for both rural and urban workers, the county absorbs the significantly higher cost of rural coverage.

San Bernardino is facing a significant reduction in benefits funding. The same level of funding used for a partial fiscal year will now be used over multiple years. Funding reductions, such as those San Bernardino faces, are unfortunate because the community loses federal and State funding, in addition to the ancillary benefits the program brings to the worker, the IHSS consumer and the county.

DISCUSSION

Health benefits represent a significant enhancement for California's IHSS workers in the form of much-needed medical coverage. In addition, IHSS health programs benefit consumers through increased workforce stability and represent an opportunity for counties to bring State and federal dollars into their communities. California has created incentives for counties to develop IHSS worker benefits programs, and the result is a great variety of programs designed to meet each county's particular needs, priorities, and challenges. California, its counties, and the entire nation have much to learn from these pioneering efforts.

Program Growth

Health benefits for homecare workers have come a long way in the past six years. When the San Francisco Public Authority launched its benefit program in March 1999, it initially provided health benefits to 974 workers. Today, more than 7,000 San Francisco IHSS workers receive HealthyWorkers benefits. Programs for IHSS worker benefits have caught on across California. According to a spring 2005 survey of counties, twenty-four California counties offer health benefits to more than 35,000 IP homecare workers and another 8 counties have benefit programs in development. More than 75% of all IHSS workers live in counties where a Public Authority offers health benefits to qualified individuals.

This steady growth of the IHSS benefit program reflects its success in addressing the needs of workers, consumers, and counties. The IHSS workforce has traditionally lacked adequate medical coverage, relying disproportionately on county indigent care and emergency services. A 2005 survey of workers enrolled in the LA PASC-SEIU medical plan showed that 80% of enrollees were previously uninsured. In the same survey, 51% of non-enrollees reported using the public health system at least once in the previous year. The advent of IHSS worker benefits has provided many workers with health insurance, enabling them to utilize preventive healthcare services such as routine screenings and checkups.

Improvements for IHSS workers are also improvements for consumers. High workforce turnover has traditionally made it difficult for individuals to find reliable, capable workers to meet their needs. California's effort to improve IHSS wages and benefits has begun to make homecare a more attractive employment option, with studies by the Los Angeles PASC demonstrating that benefits can enhance worker recruitment and retention. In San Francisco and Sacramento, increased wages and benefits have enabled the SFPA and SCPA to move beyond perennial worker shortages; today those counties have an adequate pool of available IP workers to meet consumers' needs. Neither county is currently taking new workers into its registry. In addition, 12% of San Francisco's IP workers live outside the county but choose to commute, most likely due to the attractive wages and benefit package offered. A more stable workforce and longer work tenure mean that homecare consumers have a more reliable and skilled workforce from which to draw.

Finally, the IHSS health benefits program is valuable to California counties. State and federal matching funds enable counties to better serve IHSS consumers. Studies of individual counties, such as Los Angeles, also show that IHSS benefits insures the previously uninsured, thereby decreasing the strain on local resources such as indigent care and emergency services. Every local dollar spent up to financial matching levels

draws nearly five dollars in State and federal funding. This fact alone can impel counties to find creative methods of maintaining or even enhancing program financing. One viable method may be to leverage State Realignment funding to reimburse local dollars spent on benefits. The availability of these funding streams means that the advantages of implementing these programs often outweigh the costs – making benefits an excellent value.

Program Variations

California’s IHSS policy provides incentives for offering health benefits to workers, but it leaves program design and implementation to counties. As a result, extensive program variations have emerged across the State. While IHSS program decentralization has presented a number of challenges, it also created a natural laboratory, enabling California counties to learn from each other and to provide models for other States and regions.

Eligibility Requirements vary from 25 hours of work (e.g., San Francisco and San Bernardino Counties) to 85 hours a month for three consecutive months in many counties (e.g., Sacramento and Marin Counties). Los Angeles County currently requires 80 authorized hours per month for two consecutive months. The counties highlighted in this report currently require the following work authorization and/or payment before workers are invited to enroll in their benefit programs:

Eligibility Requirements

<u>County</u>	<u>Eligibility Requirement</u>
San Francisco	2 months work; 25 hours for 1 of those months
Sacramento	85 hrs./mo. for 3 consecutive months
Los Angeles	80 Auth. hrs./mo. for 2 consecutive months
San Bernardino	25 hrs./mo. for 2 consecutive months

The variability of consumer-directed homecare work – due, for instance, to changes in consumer needs – makes eligibility determination a challenging aspect of program design. Decisions about eligibility have impacted the number of individuals who receive benefits. For instance, San Francisco, with the least restrictive eligibility requirements, has the highest percentage of workers receiving benefits. Los Angeles and Sacramento with 80 and 85-hour eligibility requirements, respectively, have a smaller percentage of eligible and therefore, enrolled, workers.

Benefits Penetration

County	Eligible Workers		Enrolled Workers		
	Number*	Percent of Workforce	Number*	Percent of Eligibles	Percent of Workforce
San Francisco	11,996	91.6%	7,197	59.9%	54.9%
Sacramento	5,836	40.9%	3,093	52.9%	21.7%
Los Angeles	64,880	54.8%	19,293	29.7%	16.3%
San Bernardino	11,569	85%	1,516	13.1%	11.1%

*Based on HomCarefds data, July 2005

Counties must also decide **who will provide healthcare services to IHSS benefit enrollees**. Some Public Authorities contract with a county health system, and others contract with a private HMO or PPO to provide services. For instance, San Francisco opted to utilize its well-established county health system, whereas Sacramento was the first county to contract with a private insurer, Kaiser Permanente, for provision of services to IHSS workers. One major advantage of utilizing an existing public health system is the potential infusion of State and federal matching funds into that system, while using a private insurer gives the advantage of providing a generally highly-regarded benefit package.

Workers' share of the monthly benefit premium also varies from county to county. Each county must include a worker premium in order for its IHSS benefit program to continue under the Medicaid plan; however, the dollar amount of that premium is decided by each county. Premium variation is largely a function of how each county and Public Authority reconciles its fiscal realities with its commitment to cover as many workers as possible with the most comprehensive, quality benefit. In counties whose major concern is to cover as many workers as possible, the worker monthly premium is a token \$1 or \$3. In counties with smaller budgets, the worker share of monthly premium is as high as \$29. While one might expect a higher worker share to seem prohibitive to low-income workers, many workers enroll in these programs. Some even purchase benefits at full price through COBRA after their IHSS employment ends. These choices demonstrate the high value workers place on health benefits.

Healthcare Providers and Premiums

County	Healthcare Provider	Total Monthly Premium	Worker Share
San Francisco	County Health System	\$250.80	\$3
Sacramento	Kaiser/Pacific Dental HMOs*	\$308.29	\$15
Los Angeles	County Health System	\$206.27	\$1
San Bernardino	Inland Empire PPO	\$220.08 or \$526.17	\$1

*Sacramento County offers a bundled health and dental program. Therefore, monthly premiums and healthcare providers are listed for both health and dental coverage.

Public Authorities' program design may also vary in terms of the **range of healthcare services provided** to enrollees. Eleven California counties' IHSS worker benefits programs include health, dental and vision coverage. Eight counties provide health and dental, and five provide health benefits only. San Francisco's HealthyWorkers program and Sacramento's Kaiser coverage offer extensive coverage plans, including vision and pharmacy services, with minimal co-pays. However, some private plans offered through Public Authorities offer a much narrower range of services with considerably higher co-pays for the worker.

Finally, counties vary in their **general approaches to fiscal decision-making**. While counties such as San Francisco and Los Angeles have flexible budgets for IHSS benefits, others such as Sacramento and San Bernardino have set fixed program budgets, and therefore enrollment caps. As a result of eligibility expansions and marketing, the rate of coverage continues to expand significantly in San Francisco and Los Angeles. The rate of coverage is expanding modestly in Sacramento, and will most likely decrease in San Bernardino. In the latter instance, it was decided that a small wage increase for the entire IHSS provider population was preferable to the provision of health benefits for a segment of the population.

FY 2004-2005 Program Cost, by Payor

	County	State	Federal	Total
San Francisco	\$4,191,661	\$5,913,702	\$10,623,587	\$20,728,951
Sacramento	\$1,931,750	\$3,587,535	\$5,519,286	\$11,038,571
Los Angeles	\$7,515,541	\$13,960,580	\$22,577,460	\$44,053,580
San Bernardino	\$436,649	\$811,102	\$1,311,737	\$2,559,487

July 2005 Program Cost Per Hour of IHSS Services Provided

	Monthly Cost	Hours of Service	Hourly Cost
San Francisco	\$1,805,858	1,223,282	\$1.47
Sacramento	\$953,541	1,577,072	\$.60
Los Angeles	\$3,998,860	11,855,975	\$.34
San Bernardino	\$333,932	1,365,967	\$.24

Factors Driving Program Variation

At least three major factors influence the foregoing variations in benefits programs: stakeholder roles and relationships, fiscal considerations, and policy philosophies.

Stakeholders. The groups who are at the table during program development and implementation determine the philosophy and direction of a benefit program. The four key stakeholders in most California counties' program planning processes are: the Public Authority, the labor union, the county Departments of Health and Human

Services, and the county health plan (if one exists). The Public Authority convenes the stakeholders and is the employer of record for IHSS employers, typically taking the lead in implementing and coordinating the health benefits program. The labor union represents workers' interests in contract negotiations. The union often initiates discussions about the level of benefits and advocates for workers. The county government, through its representative human service agencies and through its funding oversight, plays a strong role in shaping the philosophy and focus of the benefits program. As discussed earlier, the existence of a local public health system may increase stakeholder buy-in, because State and federal matching funds have the added function of enhancing county infrastructure. Stakeholder perspectives on fiscal and philosophical issues are important in shaping the eventual program in each county.

Fiscal Considerations. The flexibility of a county's benefits budget is a major determining factor in shaping its IHSS worker benefit program. For instance, the counties of San Francisco and Los Angeles adjust their budgets to accommodate increased enrollments and wider healthcare coverage. In contrast, Public Authorities in Sacramento and San Bernardino, whose revenues are much smaller than either SF or LA, must limit local budgets for benefits. One way to limit local benefit spending is to institute enrollment caps. The counties of Sacramento and San Bernardino have negotiated their enrollment caps in two very different, innovative ways. Sacramento has been successful in restricting eligibility requirements to coincide with enrollment limitations. Conversely, the SBPA has kept benefits eligibility requirements lower, and therefore has a waiting list for benefits. In order to manage the waiting list, the SBPA has developed a seniority-based priority scoring system.

Another fiscally relevant program choice is whether benefits are provided through the county health system or through a private HMO. Providing benefits through the county infuses the local health infrastructure with funding. However, many counties' public health systems, already overburdened, do not have the capacity to provide sufficient services in a timely manner. In either case, the fiscal impact of State and federal matching funds is significant, and if benefits *can* be provided through the county, those funds provide much needed support for local health infrastructure.

Policy Philosophy and Focus. Program design outcomes may be as much a function of stakeholder philosophies as of fiscal considerations. Factors such as commitment to public health and attitudes about resource allocation are critical. Every county and region faces difficult fiscal choices, but stakeholders' priorities vary across localities. All model counties in this study have demonstrated significant commitment to providing benefits, and have met their particular fiscal and structural challenges with creative solutions. San Francisco designed California's first – and one of its most far-reaching – benefits programs for IHSS workers, and accomplished this before State funding became available. Sacramento is a model of rapid benefits development and successful partnership with a highly-regarded, private HMO. Los Angeles serves more workers than any other county in the State, and has continually employed surveys and outcomes research to guide policy decisions, such as eligibility expansions and service improvements. San Bernardino has found an

innovative solution to the rural/urban split in health coverage, and has created a successful priority system to distribute available resources based on workforce longevity.

CONCLUSION

California has dramatically transformed the nature of its IHSS program, improving working conditions for caregivers, access to in-home services for consumers, and funding options for counties. Data is beginning to demonstrate the positive impact health benefits programs have on worker recruitment and retention – which is critical if California is to fulfill its commitment to providing community-based (versus institutional) services for individuals who are elderly and/or disabled. As the entire nation struggles to meet this goal, California provides a model for maximizing in-home supportive services. Now, six years into California’s bold policy initiative, many counties have implemented benefits programs for their IHSS workers. California counties have much to learn from each other, and the entire nation has much to learn from the resulting experiences and findings.