

The State of IHSS Health Benefits in California: A Survey of Counties



RTZ Associates, Inc.

Tel: 510.986.6700

Fax: 510.986.6707

www.rtzassociates.com

**With Support from the California Health Care Foundation, based in
Oakland, Ca.**

The State of IHSS Health Benefits in California: A Survey of Counties

May 2005

METHODS

In March 2005, RTZ Associates, Inc. surveyed California counties to determine the extent, methods and costs of providing health benefits coverage to California's In-Home Supportive Services (IHSS) workers. This survey report describes the features and funding of innovative health benefits programs, the characteristics of the workforce affected by these programs, and the impacts of benefit programs on the State, county, workers and consumers they serve. This report is intended to assist legislators and state planners in understanding the actual costs and impacts of health benefits for these workers as they consider upcoming budget allocations.

IHSS HEALTH BENEFITS BACKGROUND

In Home Supportive Services (IHSS), a California public program begun in 1973, enables low-income elderly individuals and people with disabilities to live in their homes rather than institutions. Statewide, California's IHSS is a \$2+ billion per year program funding a workforce of more than 280,000 direct service providers. It is the nation's largest Medicaid-funded program for consumer-directed, long-term care.

Public Authorities (PAs) were formed to function as the employer of record for IHSS independent providers (IPs). These quasi-governmental agencies are directed by consumer-majority boards and function as IPs' employer of record for purposes of payroll and collective bargaining. PAs also operate countywide IP registries, provide worker training and manage worker health benefits programs across the State. Fifty counties in California have formed their own Public Authorities to oversee IHSS provider services. In two additional cases, three counties have combined to form one multi-county Public Authority. Two counties, Alpine and Tuolumne, do not have Public Authorities. In the following analyses, each multi-county Public Authority is treated as one county.

Prior to the formation of PAs, IHSS workers were paid minimum wage and had essentially no access to benefits. These conditions resulted in a workforce with high turnover and low recruitment, making it difficult for consumers to find and keep home care providers. The development of the PAs made it possible for communities to raise wages and offer benefit packages. In addition, recent legislation institutes federal financial participation in IHSS worker benefits programs, which dramatically reduces the costs of benefits to the worker, the county and the state.

The IHSS benefits program provides an innovative solution to the growing problem of underinsured and uninsured California residents. While the lack of access to adequate health care is a growing national problem, it has become particularly acute in California. With 20.6% of California's residents uninsured, the state has the sixth highest percentage of uninsured non-elderly (ages 0-64) in the nation and the largest number of uninsured residents (6.5 million) of the 50 states.

The IHSS Health Benefits program constitutes a cost-effective answer to this problem. Because IHSS health benefits is funded by Medicaid, the program attracts over \$75 million in federal health care dollars annually to the state. Additionally, in counties such as San Francisco, where the health care provider *is* the public health system, benefits programs provide much needed funding for the Public Health Department and the community health infrastructure. The survey confirms that the health care provider also serves as the public health system in seven counties. In the past, the IHSS worker, who received low pay and no benefits, often relied on county indigent care programs for health care services. Now, Medicaid funding for IHSS makes federal funds available to pay over 50% of the health benefit cost. This offsets indigent care costs with expanded county health revenues. In fact, 42% of Public Authorities responding to the survey reported that IHSS benefits have reduced indigent care costs.

The program also provides significant health care coverage to a traditionally low-income, female, underinsured workforce. Studies of the IHSS workforce in San Francisco and Alameda counties have shown that while many workers have second and even third jobs in addition to their IHSS work, these jobs do not provide health benefits. IHSS workers who work full-time, as well as workers who work multiple jobs, have incomes that render them ineligible for Medi-Cal. A small percentage of workers are eligible for

health benefits through a spouse's job, and some part-time IHSS workers are eligible for Medi-Cal, but many workers rely on county-provided care to the uninsured.

Consumer demand for this workforce has more than doubled in the past decade due to the growth of consumer-directed care and the recent population growth of elderly individuals and people with disabilities across the state and nation. This increased demand has revealed the pivotal role IHSS workers play in the state's long-term care network. The health and stability of this workforce is of crucial concern in a State that provides services to 280,000 low-income long term care consumers who require ongoing in-home direct support in order to remain safely in their communities.

FUNDING MECHANISMS FOR IHSS

In 1992, California expanded its State Medicaid plan to include IHSS services as a Medicaid covered long term care service under the personal care service option. Under the Plan Federal financial participation was made available to pay for IHSS services. The service cost included wages and benefits by including the cost of insurance for the independent provider (IP) in the total cost of the service the IP provides to the IHSS beneficiary. The Federal Financial Participation rate in California is, on average, 51.5%, meaning the federal government pays more than half the benefits costs.

The 2000/01 California Budget Act expanded state funding for benefits, and created an ongoing state funding stream to provide additional incentives for counties to offer health benefits coverage to IHSS workers. Prior to the Budget Act, the state did not provide funding for IHSS benefits. The Act allocated funds to counties with PAs to cover the State's share of the cost of services, wages and benefits to IPs up to \$10.10/hour, with \$7.50/hour allocated to wages. The Budget Act initially allocated up to \$.60 per service hour to cover the State's share of the cost for benefits, and now allocates more per service hour. As long as wages are set or above \$7.50/hour, the remaining state participation can be allocated for either wages or benefits. Wage and benefit allocations for remaining state participation vary across counties.

Since the Federal government had previously made matching dollars available to support half the cost of IHSS up to two times the minimum wage, the addition of state financial participation reduced the county's share of cost to approximately 17%

WORKER DEMOGRAPHICS

According to adjusted California Management Information and Payrolling System (CMIPS) data, there were 317,709 homecare providers working in California in March 2005. Homecare workers are traditionally female. The March survey shows the percentage of female workers in each county ranging from 70% to 96%, confirming the continuation of this demographic pattern. The surveyed counties showing the highest percentage of female workers are Merced and Amador. The surveyed counties with the lowest percentages of female workers are San Francisco and Sonoma.

The study shows the age distribution across counties to be relatively steady. Across all counties, the majority of IHSS workers are between the ages of 30 and 55. The percentage of workers between the ages of 30 and 55 ranges from 42% in Napa to 79% in Merced. Those counties with the largest percentage of workers *over* the age of 55 are San Mateo (35%), El Dorado (33%), Placer (31%), Shasta (31%), Calaveras (30%) and Amador (30%).

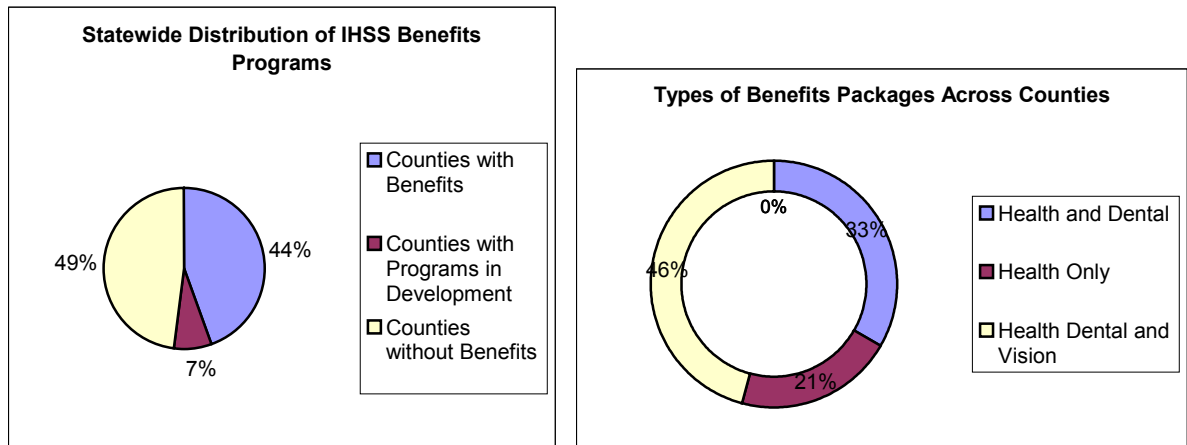
COVERAGE OVERVIEW

The IHSS health benefits system has been in operation since 1998. In this relatively short period of time, approximately half of California's PAs, working with local unions, have developed the IHSS benefit programs. Health benefits have been implemented through 24 single-county or multi-county Public Authorities. Four counties are currently developing benefits programs and 26 do not offer benefits programs. According to survey data, the majority of benefits packages across the state (11) include Health, Dental and Vision coverage. Health and dental packages (8) are the second most frequently offered benefit. Health-only packages (5) are the least common type of benefit offered.

Survey results show that 53,846 or 17% of these workers are covered by IHSS health benefits. Although less than half (44%) of California counties currently offer health benefits programs, those counties offering health benefits are primarily the larger counties with denser provider populations. Consequently, a full 92% of all IHSS workers in the state live in counties that offer health benefits coverage.

Those counties that have not developed benefits programs provided information about the development status of benefits as well as obstacles to benefits implementation. 55% of responding counties (6 out of 11) and 22% of all counties without benefits programs replied that they were currently in negotiations with the union regarding benefits programs. In some cases, negotiations had been put on hold. Two counties replied that no funding existed for health benefits and two counties have considered but postponed developing health benefits programs.

Figure 1: IHSS Benefits Distribution



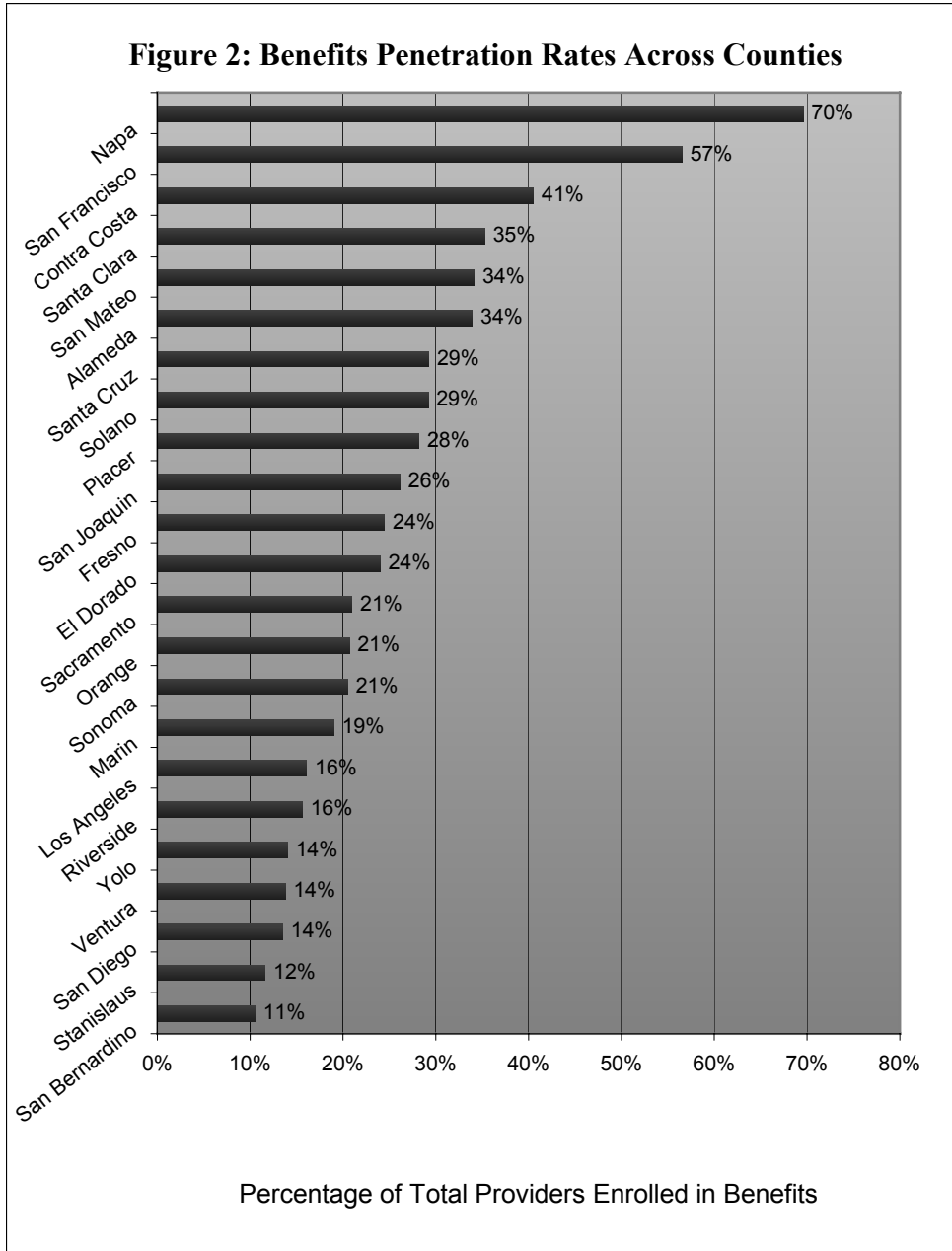
BENEFITS PENETRATION RATES

The health benefits penetration rate represents the number of workers enrolled in health benefits compared to the total number of workers for that county. Penetration rates are a function of eligibility requirements determined by the Public Authority and the percentage of eligible providers enrolled in each county. A worker's eligibility for health benefits is determined by 1. the number of hours he/she works per month and 2. the number of consecutive months worked. Eligibility criteria vary widely across counties. Napa has relatively lenient eligibility criteria: a provider must work 25 paid hours per month for 1.5 months to be eligible for benefits. As a result, Napa shows a high penetration rate. In contrast, Stanislaus, San Diego, Yolo and Riverside counties all report eligibility criteria ranging between 75-80 minimum hours for 3-4 consecutive months. As a result, these counties show relatively low penetration rates.

Enrollment rates, shown in Figure 3, represent the percentage of workers eligible for health benefits who are enrolled in the program. Enrollment rates are a function of 1.

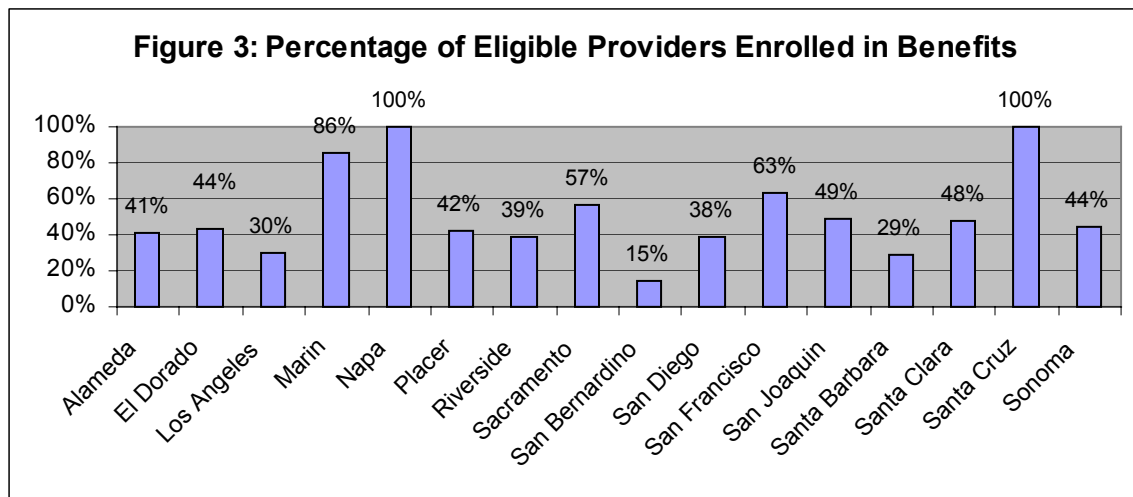
worker awareness of the IHSS benefit program 2.the worker’s share of the monthly premium, and 3. enrollment policies such as default enrollment and enrollment caps.

Penetration rates are calculated in Figure 2 for each IHSS benefit program. The rates vary widely across counties, between 7% in San Bernardino County and 70% in Napa County. **The Average Penetration Rate across the Counties Shown is 21%.**



ENROLLMENT RATES

Figure 3 below shows each program's enrollment rate, a major factor influencing penetration rates. A county with a longstanding benefits program, such as San Francisco, shows one of the highest enrollment rates in the state. As of February 2005, both Napa and Santa Cruz counties had a default enrollment policy, meaning the PA automatically enrolls all eligible workers, resulting in 100% enrollment rates. Santa Cruz County shifted from a default enrollment policy to application based enrollment in March 2005. San Bernardino County's enrollment is kept artificially low by an enrollment cap. **Forty-five percent of workers who are eligible statewide are enrolled in benefits programs.**



THE IMPACTS OF HEALTH BENEFITS

Counties with operational health benefits programs were asked their views on the impacts of health benefits programs on the workers and county health system. Public Authority leadership and staff provided the following responses: 1) 42% of responding PAs and 33% of PAs with operational benefits programs believed that offering benefits had reduced costs for indigent care in the county; 2) 32% of responding PAs and 25% of PAs with operational benefits programs believed that offering benefits reduced the strain on the public hospital system; 3) 63% of responding PAs and 50% of all PAs with operational benefits programs believed that IHSS workforce stability had been improved by offering health benefits coverage.

Indicators suggest that county and state collaborative efforts are beginning to improve worker recruitment and retention in the counties that have implemented health benefits and other workforce improvements. A 2002 study by Candace Howes has demonstrated that San Francisco's significant wage and benefits improvements have resulted in a larger IHSS workforce, longer worker-consumer matches, and decreased worker turnover. Improving wages and benefits, combined with the increase in consumer demand, increased the number of workers by 54% over the four-year study period. In addition, turnover rates of the workforce fell by 30%, and the turnover rate of matches between a consumer and provider fell by 20%. The proportion of consumers matched to a providers of their own ethnicity, which is a measure of the quality of match, rose 6%.¹

In addition, a 2003 study of the impacts of health benefits in Los Angeles county conducted by RTZ for the Personal Assistance Services Council of LA found that health benefits did increase retention: 77% of health benefits program enrollees were found to be active in month 12, as compared with only 56% of non-enrollees.² A two-year longitudinal study conducted in 2004 confirmed these findings over a longer period of time: 66% of health benefit program enrollees were found to be active in month 24, as compared with 52% of workers who were eligible, but not enrolled in benefits.³

IHSS HEALTH BENEFITS COSTS

The cost of the IHSS health benefits program is shared by the counties, the state and the federal government. For those counties at or below the matching rate, the Federal Financial Participation Rate is 51.5%, which currently totals \$75,044,680. At this time, the state pays two-thirds of the balance, or \$45,172,526 annually to support the program. Individual counties remain responsible for the outstanding \$25,500,620, or 17.5% of the total.

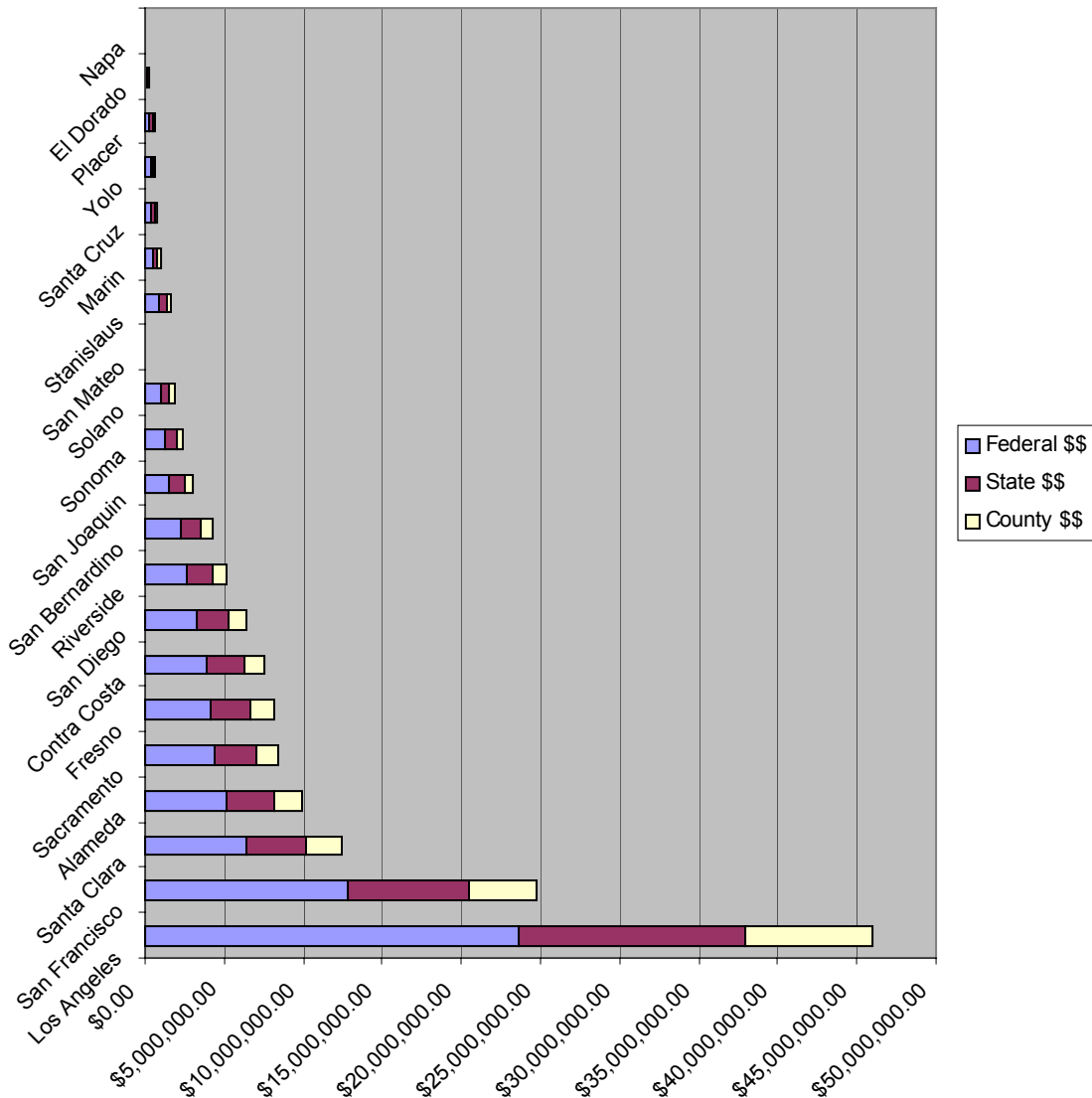
¹ Howes, C. (2002). *The impact of a large wage increase on the workforce stability of IHSS Home Care Workers in San Francisco County*. The University of California Institute for Labor and the Economy and the University of California, Berkeley Center for Labor Education and Research.

² Zawadski, R. & Radosevich, J. (2004). *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 Los Angeles County Personal Assistance Services Council.

³ Zawadski, R. (2005). *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 Los Angeles County Personal Assistance Services Council.

Annual program costs to each county have been calculated using the number of enrolled workers in health and dental benefits and the county share of the two premiums per worker per month. Annualized county costs for premiums range from \$136,800 in Napa County to \$45,972,632 in Los Angeles County. Los Angeles costs do not include dental benefits because LA workers pay the full cost of benefits for a union dental plan. The total costs across the 21 counties shown are \$147,392,826.

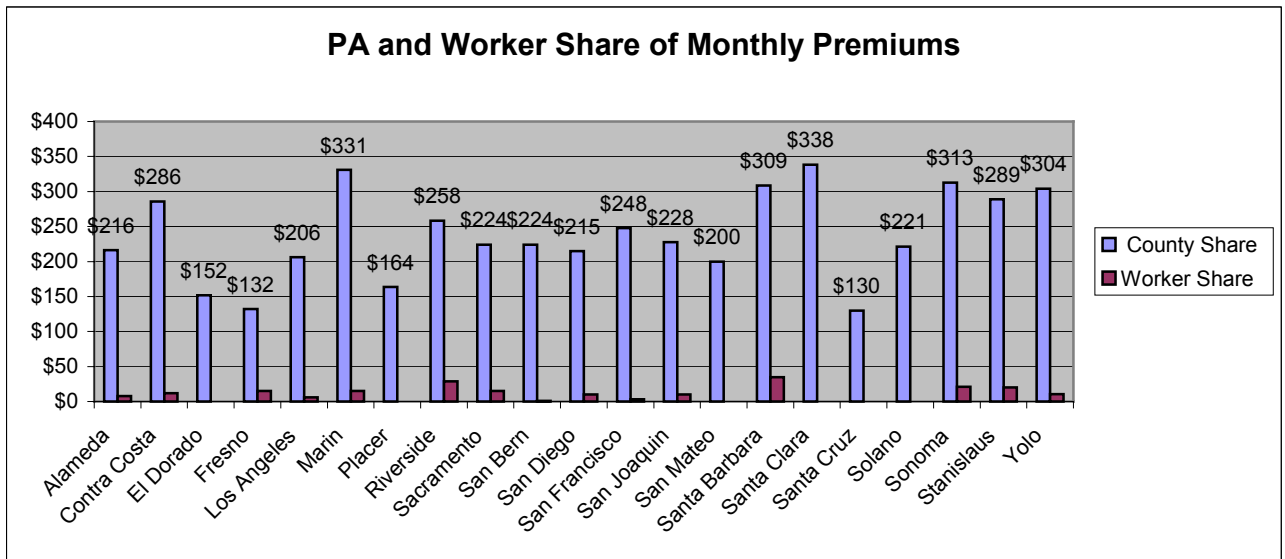
Figure 3: Total Cost of IHSS Benefits



*Dollar values of federal, State and county costs are listed on page 11.

COSTS PER WORKER

Many counties experience high annualized costs because they cover large numbers of workers. However, many counties with large coverage numbers are able to keep costs relatively low per worker. For example, Los Angeles, San Francisco, Alameda and Sacramento have some of the largest aggregate annual costs but fall in the mid- to low- range of costs per worker.



IMPACTS OF STATE FINANCIAL WITHDRAWAL

The state is now considering withdrawing its financial support of IHSS health benefits. A recent report to the Assembly Budget Committee calculated the actual savings and costs to the state if financial support is withdrawn from IHSS benefits. The report estimates that (1) additional Medi-Cal costs could easily offset 55% of the savings to the state realized through funding cuts; (2) the number of IHSS workers enrolled in CALWORKS could increase by approximately 55%; and (3) the number of IHSS workers eligible for food stamps could nearly triple.³

The table below shows financial contributions for benefits on the federal, State and county level. It also shows each county’s projected financial share if the State

³ Howes, C. (2005). *Proposed cuts in State match to IHSS wage and benefit costs: The impact on worker income, health insurance coverage, and Medi-Cal, CALWORKS and food stamp eligibility*. Report to the State Senate Budget and Fiscal Review Committee.

withdraws financial funding. If the state withdraws participation, over \$45 million in coverage costs will be absorbed by counties, leaving each county to pay nearly three times its current contribution. Because counties are ill-equipped to handle this added fiscal responsibility, state withdrawal will likely result in the elimination of or drastic reductions in health care for this at-risk population. According to survey questions answered by Public Authority leadership and staff, if state funding is cut: 47% of responding PAs and 38% of all PAs with operational benefits programs anticipate *discontinuing benefits*, 37% of responding PAs and 29% of all PAs with operational benefits programs anticipate *decreasing the type and scope of benefits offered* and 26% of responding PAs and 21% of all PAs with programs anticipate *a decrease in the number of workers covered* by the IHSS benefits program.

Figure 5: IHSS Health Benefits Costs: County Shares With and Without State Funding

County	Total Cost	Federal Share	State Share	County Share	County Share w/o State funding
Los Angeles	\$45,972,632.52	\$23,675,905.75	\$14,251,516.08	\$8,045,210.69	\$22,296,726.77
San Francisco	\$24,791,050.08	\$12,767,390.79	\$7,685,225.52	\$4,338,433.76	\$12,023,659.29
Santa Clara	\$12,403,440.24	\$6,387,771.72	\$3,845,066.47	\$2,170,602.04	\$6,015,668.52
Alameda	\$9,970,588.80	\$5,134,853.23	\$3,090,882.53	\$1,744,853.04	\$4,835,735.57
Sacramento	\$8,473,626.00	\$4,363,917.39	\$2,626,824.06	\$1,482,884.55	\$4,109,708.61
Fresno	\$8,139,097.20	\$4,191,635.06	\$2,523,120.13	\$1,424,342.01	\$3,947,462.14
Contra Costa	\$7,562,241.36	\$3,894,554.30	\$2,344,294.82	\$1,323,392.24	\$3,667,687.06
San Diego	\$6,450,000.00	\$3,321,750.00	\$1,999,500.00	\$1,128,750.00	\$3,128,250.00
Riverside	\$5,148,435.60	\$2,651,444.33	\$1,596,015.04	\$900,976.23	\$2,496,991.27
San Bernardino	\$4,331,174.40	\$2,230,554.82	\$1,342,664.06	\$757,955.52	\$2,100,619.58
San Joaquin	\$3,033,097.20	\$1,562,045.06	\$940,260.13	\$530,792.01	\$1,471,052.14
Sonoma	\$2,371,488.48	\$1,221,316.57	\$735,161.43	\$415,010.48	\$1,150,171.91
Solano	\$1,881,629.28	\$969,039.08	\$583,305.08	\$329,285.12	\$912,590.20
San Mateo	\$186,796.16	\$96,200.02	\$57,906.81	\$32,689.33	\$90,596.14
Stanislaus	\$1,622,911.68	\$835,799.52	\$503,102.62	\$284,009.54	\$787,112.16
Marin	\$989,161.44	\$509,418.14	\$306,640.05	\$173,103.25	\$479,743.30
Santa Cruz	\$797,160.00	\$410,537.40	\$247,119.60	\$139,503.00	\$386,622.60
Yolo	\$638,400.00	\$328,776.00	\$197,904.00	\$111,720.00	\$309,624.00
Placer	\$582,892.20	\$300,189.48	\$180,696.58	\$102,006.14	\$282,702.72
El Dorado	\$235,203.12	\$121,129.61	\$72,912.97	\$41,160.55	\$114,073.51
Napa	\$136,800.00	\$70,452.00	\$42,408.00	\$23,940.00	\$66,348.00
TOTAL	\$145,717,825.76	\$75,044,680.27	\$45,172,525.99	\$25,500,619.51	\$70,673,145.49

CONCLUSION

The IHSS Health Benefits program provides valuable services to a traditionally underinsured and low-income population, with the bulk of costs covered by federal monies. A withdrawal in State funding from the IHSS benefits program in order to realize a short-term savings will generate a substantial increase in benefits costs to the counties, resulting in the termination of IHSS benefits programs across the state. With health benefits reduced or eliminated entirely for this workforce, more Californians will turn to public health programs for their medical needs, impacting an already overextended system.

The withdrawal of State funding from IHSS health benefits programs will result in higher costs to the State for three main reasons: 1. For every IHSS worker who turns to Medicaid, the State will lose the 17.5% IHSS financial contribution from the county. As a result, the State will be responsible for 49% of Medicaid coverage costs as compared to 31.5% of IHSS coverage costs. 2. In addition, indigent care costs, paid for by the county and State without any federal financial participation, will rise. 3. Finally, studies of the impacts of benefits on the IHSS workforce suggest that the elimination of benefits will cause a decrease in IHSS worker recruitment and retention. A decrease in the number, quality and continuity of the IHSS workforce will have serious consequences for the consumers who depend daily on home care providers for their health and well-being. Consumers unable to find home-based care will be forced to enter institutionalized care. A 2003 study on long term care in San Francisco found that institutional care costs were three and a half times higher per consumer than home- and community-based care costs.⁴

Although discontinuing state funding for IHSS benefits appear to realize a savings annually for the state, hidden costs more than offset that savings, and potentially negatively impact the health and stability of a much-needed workforce in California. Public policymakers must consider the actual costs to the state and the impact on workforce health and workforce stability before making any final funding decisions.

⁴ Zawadski, R. & Hernandez, M. (2003). *An analysis of Medicaid and IHSS services for the long term care Medicaid population in San Francisco*. Department of Aging and Adult Services, City and County of San Francisco.