Providing Health Insurance to IHSS Providers (Home Care Workers) in Los Angeles County

Report to the
California HealthCare Foundation
June 2000

Michael R. Cousineau, Dr.P.H.
Associate Professor of Clinical Public Administration
University of Southern California

Acknowledgments

Major assistance in the conception and design of this project was provided by Carol Regan, M.P.H., Health Policy Director for the Service Employees International Union (SEIU).

Subcontractors and partners in the implementation of this project included: Lucien Wulsin Jr., Insure the Uninsured Project; Barbara Caress, the Segal Company; Molly O'Rourk, Peter D. Hart Research Associates; Mark DiCamillo and Victoria Albright, Field Research Corporation.

The following individuals also provided assistance to this project: Alicia Kokkinis, University of Southern California (USC) School of Policy, Planning, and Development; Tyrone Freemen, Aram Adgaian, and Angela Keefe, SEIU Local 434B; Geoffrey Gibson, SEIU 1199 National Benefit Fund; JoAnne Towers, Information Services Division, Los Angeles County Department of Health Services; Phoebe Liebig, USC Department of Gerontology; Robert Myrtle and LaVonna Blair-Lewis, USC School of Policy, Planning, and Development; E. Richard Brown and Nadereh Pourat, University of California Los Angeles (UCLA) Center for Health Policy Research; Lillian Gelberg, UCLA, Department of Family Medicine; Allison Diamant, UCLA Division of General Internal Medicine; and Bryce Yokomizo and Kitty Cooper, Los Angeles County Department of Public Social Services. Special thanks to Christian Peralta and Xiaoguang Cai who provided technical assistance with the analysis and report.

The California HealthCare Foundation, a private philanthropy based in Oakland, California, was created in 1996 as a result of the conversion of Blue Cross of California, a nonprofit organization, to Wellpoint Health Networks, a forprofit company. The Foundation focuses on critical issues confronting a changing health care marketplace by supporting innovative research, developing model programs, and initiating meaningful policy recommendations in the areas of managed care, California's uninsured, California health policy, health care quality, and public health.

Table of Contents

Executive Summary

The California In-Home Supportive Services (IHSS) program provides personal care assistance to 230,000 elderly and disabled clients and employs more than 200,000 home care workers statewide—72,000 in Los Angeles County alone. The program is supported entirely with government funds, including more than $667 million in state general funds for the 1999 Fiscal Year.

The Los Angeles County IHSS Provider Health Insurance Project was created to gather and analyze data and investigate options for insuring home care workers in Los Angeles County. These workers are predominantly **women** (83 percent); **older** (more than half over age 45 and one in ten over 65); **racially and ethnically diverse** (39 percent Latina, 25 percent African American, 14 percent Armenian and Russian descent); and **poor or near poor** (80 percent live in a household with income below 200 percent of Federal Poverty Level).

Key Survey Findings

- Nearly half—45 percent—of Los Angeles home care workers are uninsured.
- A large number of IHSS workers live below the Federal Poverty Level.
- Home care workers without health insurance face significant financial and other barriers to health care.

- Many uninsured IHSS workers and their children may be eligible for Medi-Cal and other public health care programs.
- IHSS workers are more likely than other Los Angeles County adults to utilize county health care facilities.
- Many uninsured home care workers delay care and have chronic medical conditions that go untreated.
- Home care workers lack access to preventive care.

Actuarial Analysis and Cost Estimates

- The estimated age-adjusted monthly premium cost for comprehensive HMO coverage for Los Angeles home care workers would be about $149 per member per month. The estimated cost of the plan is $1,788 per year per enrolled worker in Los Angeles County.
- The resulting cost estimates are:
  - $129 million to insure the entire workforce;
  - $57 million for the uninsured only; and
  - $35 million for the uninsured not linked to Medi-Cal (primarily single adults or childless married couples).

Options for Providing Health Insurance for Home Care Workers

We provide several discrete approaches and options for providing health insurance to home care workers. In doing so, we recognize that there is considerable overlap of strategies and financing mechanisms among these otherwise diverse ideas.

State Program for Home Care Workers

A single state program for IHSS workers is simple, relatively easy to administer, and could cover all eligible workers in the Los Angeles County and possibly the state. The program is modeled after the San Francisco Healthy Worker program,[1] which is financed with multiple sources that are largely invisible to the worker.

Under this program, IHSS workers would be *presumptively eligible* for full benefits and there would be no means test (since so many of those who are uninsured are known to be below 200 percent of Federal

Poverty Level). Those currently on Medi-Cal would have a choice between their existing coverage and the new program. If the plan were restricted to uninsured home care workers not linked to Medi-Cal, the cost of the program would be estimated at $39.3 million, with $13.7 million annual state share and $7.4 million for the county share. Combined, these would generate an approximate federal match of $13.5 million.

Enrollees would pay a $3 per month premium, with subsidies declining for families above 200 percent of Federal Poverty Level. Health insurance costs would be included in the claim rate that is submitted to the federal government for program reimbursement.

Many different purchasing arrangements could be envisioned under the plan, including PacAdvantage, MRMIB programs (the Healthy Families network), CalPERS, or the existing Medi-Cal provider networks (including the managed care arrangements that are now in place).

County Health Plan

Under this approach, eligible IHSS workers in Los Angeles would enroll in a county health plan, either the county's HMO or another county-operated and contracted system. All IHSS workers' eligible children would be enrolled in Medi-Cal or Healthy Families. The county would extend individual coverage to uninsured workers who are not eligible for Medi-Cal; all others with private insurance, Medi-Cal, or Medicare would remain with that coverage. Outreach and enrollment into Medi-Cal, Healthy Families, and other health programs would remain an important component of the county-organized plan.

The full cost for enrolling uninsured people into the plan would be $18.5 million if the program were restricted to those who were not Medi-Cal eligible or linked. This would leverage federal reimbursement of 52 percent of the premium cost of a plan (an estimated $18 million).

The County IHSS Health Project

Under this *virtual enrollment* approach, the Los Angeles County Department of Health Services (DHS) would establish the *IHSS Health Project*. All uninsured home care workers would be offered a program that guarantees access to a broad set of services via an enrollment card. This card would entitle workers to use county and Private Public Partnership (PPP) providers without copayments, similar to the county's General

Relief Health Plan. Under this model, county DHS remains at risk for hospitalization and specialty care.

Because such a large percentage of IHSS workers are below 200 percent of the Federal Poverty Level, all uninsured IHSS workers would be presumptively eligible for the program. However, individuals would apply for Medi-Cal and self-declare their income only for the purposes of determining eligibility for other programs and for determining the amount of copayment.

All workers would receive full primary, dental, and specialty care services including prescription drugs. Services would be offered free or with a $5 copayment (based on income), prescription drugs free or $2 or $5 copay at higher incomes.

Because this is a project and not an enrollment program, actual costs would have to be determined based on utilization. The proposed program would be paid for using a combination of county and federal funds. Approximately half of the costs of ambulatory care services provided in health centers, clinics, and Public Private Partnership (PPP) sites are recoverable under the 1115 Waiver.

Outreach and Enrollment of Eligible Workers into Existing Programs

The final approach would incrementally increase coverage by enrolling eligible workers into existing programs, particularly Medi-Cal, Access for Infants and Mothers (AIM), and Healthy Families. Workers who have dependent children and have family incomes below 100 percent of Federal Poverty Level would be targeted for outreach and enrollment. Those not eligible would be informed of the county's health system and the PPP program.

There are 6,000 IHSS workers who are eligible for but not enrolled in Medi-Cal. Most are eligible under Section 1931(b) Medi-Cal for families transitioning off cash assistance. It covers families with incomes up to 100 percent of the Federal Poverty Level.

An outreach program could be established using Los Angeles County Department of Public Social Services eligibility workers, members of SEIU Local 434B, and SEIU's worker registry to identify and eventually enroll eligible IHSS workers into Medi-Cal. This program would cost $550,000, covering outreach and enrollment services only.

Conclusion

Of the coverage options outlined above, two are incremental steps that take advantage of existing financing structures, public programs, and delivery systems for low-income families and the uninsured. The two more comprehensive approaches, built on the foundation of existing public policy, may require additional legislation or federal waivers for implementation.

This study provides key data on home care workers' demographics, utilization patterns, and preferences. It also lays out viable options for extending needed coverage to this group of low-income, underserved individuals, with implications for national as well as state policy options for reducing the number of uninsured. Regardless of the approach or approaches taken, covering home care workers is consistent with other policy goals in California and Los Angeles County and could result in dramatic benefits for workers and their clients.

Project Design and Results

The California In-Home Supportive Services (IHSS) program provides personal care assistance to 230,000 individuals who are Medi-Cal-eligible aged, blind, or disabled and who are unable to remain in their home without assistance. There are 200,000 IHSS providers in California (referred to hereafter as home care workers); more than one-third (72,000) work in Los Angeles County alone, caring for 90,000 IHSS recipients.[2] The program is supported with federal, state, and local funds. State general fund cost for the IHSS program was $667 million for the 1999 Fiscal Year.[3] The California Department of Social Services administers the IHSS program, while counties are responsible for its day-to-day operation. The cost of the IHSS program in California is low, about $300 per client per month, and IHSS providers provide services that can prevent costly institutional care for the elderly and the disabled.[4]

In September 1997, the Los Angeles County Board of Supervisors established the Personal Assistance Services Council (PASC), a public authority. The PASC serves as an employer of record with whom IHSS providers can collectively bargain for better wages and benefits. Los Angeles County is one of six counties in California that have established public authorities for IHSS.[5] However, only the City and County of San Francisco currently offers health care benefits to IHSS providers.

In February 1999, following a ten-year organizing effort, Los Angeles County's home care workers voted to join the Service Employees International Union (SEIU), Local 434B. At the time, Los Angeles County's home care workers received minimum wage, unemployment insurance,

state disability insurance, and workers' compensation. In July 1999, Los Angeles County home care workers received a modest wage increase of $0.50/hr under the terms and conditions of their first union negotiated contract with the PASC. Their salary is now $6.25 an hour; however, they do not receive health insurance as a part of their job as home care workers.

The University of Southern California was awarded a grant by the California HealthCare Foundation to conduct a strategic planning project, the Los Angeles County IHSS Provider Health Insurance Project, in an effort to investigate options for insuring home care workers in Los Angeles County.

The project was initiated because of the perceived need for health care among this population, and because opportunities to expand access to health insurance exist through various financing programs.[6] We faced many challenges in gathering data, however, because of the various levels of government involved in financing and governing the IHSS program. In addition, there is a lack of connection between the program governance under the PASC, and the program financing, which is generally provided through the Department of Social Services.

The IHSS project included a planning phase, data gathering through focus groups and a telephone survey of home care workers, and analysis of new and existing data. Project staff also held discussions with health plans in order to develop pricing information and explore opportunities for coverage. This information contributed to the actuarial analysis of the workforce, the cost estimate, and the consideration of insurance options.

Data Sources and Methodology

Focus Groups

Peter Hart Research Associates conducted six focus groups at various locations throughout Los Angeles County in late September 1999. All groups included 10 to 12 participants whose geographic and demographic characteristics reflected the composition of the workforce. Respondents had either to be uninsured or to not have had health insurance at some time during the previous two years, or to have stated that it was "very" or "fairly" likely that they would not have health insurance sometime in the next year.

The focus group guide centered around four key topics:

- importance of health insurance;
- access to health care;
- priorities in a health insurance plan; and
- home care workers' willingness to work for health benefits.

Telephone Survey

In cooperation with Field Research Corporation, project staff designed a 15-minute telephone questionnaire based on the findings from the focus groups. The telephone survey gathered data on the demographic and employment characteristics of the workforce; their health needs and access to care; and utilization of health services, including the use of safety net providers. The survey was conducted in November and December 1999 and questions were provided in both English and Spanish.

Department of Health Services Utilization Data

Project staff wanted to ascertain home care workers' utilization of services at Los Angeles County Department of Health Services (DHS) health facilities. To do so, the project team requested that administrative patient utilization data from DHS clinics and hospitals be matched against a list of home care workers. IHSS Program payroll records for a five-month period, February to June 1999, were matched against the DHS patient utilization records for the most recent, complete fiscal year, FY 97-98, based on name and date of birth.

Actuarial Analysis

The Segal Company prepared an analysis based on the workforce census (age and gender) and the survey findings. Traditionally underwriters use one of two approaches: They are given a plan of benefits and a population and asked to establish a premium, or a contribution rate is negotiated and the underwriter is asked to describe an affordable plan design. For this study, the starting point was the need for coverage and the resulting costs were estimated by assuming particular programs and designs. In conducting the actuarial analysis, the actual age and gender characteristics of the population were adjusted to reflect expected use of health services. The morbidity weighting was based on a table developed from the experience of a large IPA model HMO. Another standard

based on Medicare experience was used to evaluate the population aged 65 and over.

Input from Health Plans

Project staff met with representatives from several health plans: ULLICO, PacifiCare, the Los Angeles County Department of Health Services and their Community Health Plan, Kaiser, and Blue Cross. The purpose of the meetings was to identify interest in developing and participating in a health plan for the home care worker population. Complete census and survey findings were provided to the plans and several meetings were held to discuss possible network design, plan design, and pricing. Plans understood the need for identifying funding sources for coverage. The possibility of partnering among plans and with the union was also discussed.

Key Findings from the Focus Groups and Telephone Survey

Workforce Characteristics

A descriptive profile of the home care workers in Los Angeles County based on the survey sample is provided in Appendix 1. Compared to all adults, home care workers in Los Angeles County are older, with more than half age 45 or above, compared to only 38 percent among the general adult population.[7] Nearly one in ten are age 65 or older.[8] Eighty-three percent are women. Most IHSS workers are minorities including 39 percent who are Latino, 25 percent African American, 10 percent Armenian, 4 percent Russian descent, and 7 percent Asian. About half of IHSS providers are foreign born and 31 percent are naturalized citizens. Home care workers reside throughout the county's eight service planning areas (SPAs).[9] Home care workers have an average household size of three persons. Forty-four percent are married and 38 percent are the parent or legal guardian of children aged 18 or younger. An overwhelming percentage of providers are poor or near poor: 80 percent live in a household with a combined family income at or below 200 percent of the Federal Poverty Level.[10]

Employment Characteristics

Employment characteristics are shown in Appendix 2. Two-thirds of providers are related to the IHSS recipient and 42 percent live in a household with at least one disabled individual. Seventy-nine percent of home care workers have been caring for someone in the IHSS Program for at least one year, and 40 percent have been providing care for three or more years.[11] IHSS providers were paid a median 64 hours in the month prior to their interview. Two-thirds work at least 25 percent time and 10 percent work full time or more (see Appendix 1). One in three providers (34 percent) maintains one or more jobs in addition to their IHSS position.

Exhibit 1. Estimated Number of Workers by Hours Worked Per Month

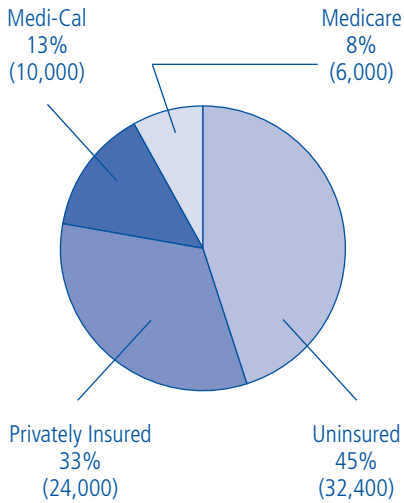
	Percent	Estimated Number
< 40 hours	28 percent	20,160
41-80 hours	37 percent	26,640
81-160 hours	26 percent	18,720
160+ hours	10 percent	7,200
Total	100 percent	72,000

Source: Los Angeles County IHSS Provider Health Survey 1999.

Nearly half—45 percent—of Los Angeles home care workers are uninsured.

There are 32,000 uninsured IHSS providers, 45 percent of the nearly 72,000 home care workers in Los Angeles County. Thirty-three percent of home care workers have private health insurance, two-thirds of whom receive their benefits through a spouse's or family member's plan, and one-third through their other job or in the individual market. Public programs cover the remaining 21 percent.

Exhibit 2. Health Insurance Status of IHSS Providers, Los Angeles County, 1999



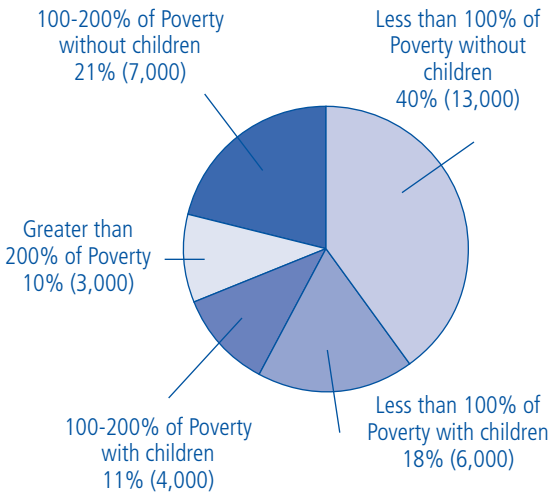
Note: May not equal 100% due to rounding.

Source: Los Angeles County IHSS Provider Health Survey 1999.

A large number of IHSS providers live below the Federal Poverty Level.

Nearly 80 percent of all IHSS providers live in households with incomes less than 200 percent of the Federal Poverty Level; 48 percent live below the Federal Poverty Level. Uninsured workers are worse off: 90 percent are living below or near the poverty level.[12] In contrast, 54 percent of uninsured working-age adults (18-64) in the county are poor or near poor.[13]

Exhibit 3. Distribution of Uninsured Home Care Workers by Poverty Status and Whether Respondent Has Dependent Children



Note: May not equal 100% due to rounding.

Source: Los Angeles County IHSS Provider Health Survey 1999.

Many uninsured IHSS providers and their children may be eligible for publicly financed health care programs including Medi-Cal.

Focus group participants generally were not aware of existing publicly financed health insurance options such as Medi-Cal, Healthy Families, or AIM, though many uninsured home care workers may be eligible for public programs. As shown in Exhibit 3, more than 18 percent of uninsured home care workers have children and are living below Federal Poverty Level, which may make most eligible for full Medi-Cal, while 11 percent live in households between 100 percent and 200 percent of Federal Poverty Level, potentially making them eligible for Medi-Cal with a share of cost.

Home care workers face significant financial and other barriers to health care.

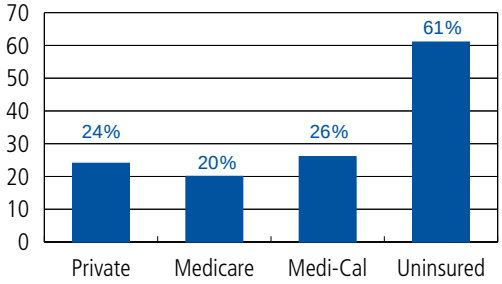
Focus group participants reported that not having health care is a top occupational and personal concern for them. Uninsured home care workers experience a variety of negative consequences and make many personal sacrifices because they lack coverage, including not seeking care when sick and assuming personal debt to pay for needed care. Workers reported that having health insurance would greatly improve several aspects of their daily life. Hospitalization coverage, which would involve the biggest expense to home care workers, is a priority for them in any benefit plan. One worker during a focus group indicated:

> *"In order to pay medical bills I have to borrow from Peter to pay Paul, where this month I'll pay this one, and next month I'll pay the other one."*

This statement was supported by survey findings (see Exhibit 4) that indicated that more than 40 percent of uninsured home care workers delayed or did not receive needed medical care because they could not afford it, five times greater than those with private coverage. An estimated 61 percent of those who are uninsured have some difficulty

paying for health care costs compared to 25 percent of privately insured home care workers. Nearly one-quarter of uninsured home care workers (23 percent) had not filled or postponed filling a needed prescription in the past year compared to 6 percent of privately insured home care workers. And uninsured IHSS providers are four times more likely to be without a regular provider than their privately insured counterparts (42 percent vs.12 percent).

Exhibit 4. Difficulty Paying Health Care Costs by Insurance Status, IHSS Providers, Los Angeles County, 1999



Source: Los Angeles County IHSS Provider Health Survey 1999.

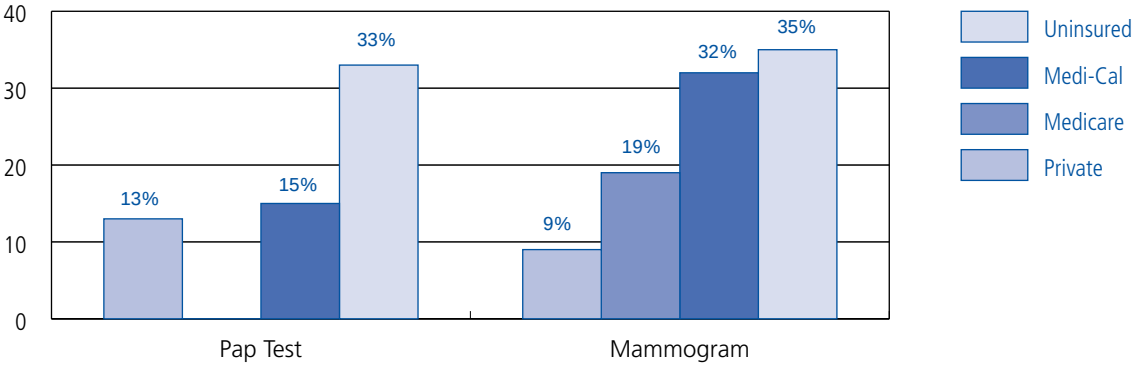
Many uninsured home care workers delay care and have chronic medical conditions that go untreated.

Many home care workers suffering from chronic medical conditions including diabetes, hypertension, and high blood cholesterol are not under the care of a physician. A third of uninsured home care workers with diabetes are not getting care compared to 13 percent of privately insured home care workers with diabetes. And five percent of uninsured home care workers have delayed or forgone needed surgery.

Home care workers lack access to preventive care.

Preventive services can positively impact the health status of the individual through screening, early detection, diagnosis, and treatment of disease (see Exhibit 5). More than one-third (35 percent) of uninsured

Exhibit 5. Female IHSS Providers without Recommended Preventive Services* in the Past Two Years, by Insurance Status, Los Angeles County, 1999

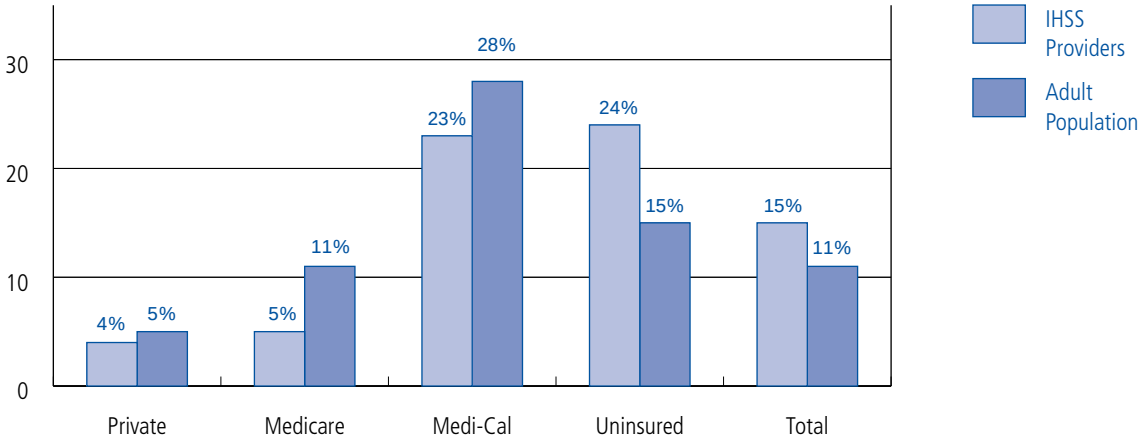


* Pap Test: Females aged 18-64; Mammogram: Females aged 50 and older. Los Angeles County, 1999.
Source: Los Angeles County Health Survey 1997 & Los Angeles County IHSS Provider Health Survey 1999.

female home care workers aged 50 and older had not received a mammogram in the previous two years, nearly 4 times greater than those with private health insurance (9 percent). One in three uninsured female IHSS providers (aged 18-64) had not had a Pap test in the past two years compared to 13 percent of privately insured home care workers. One uninsured focus group participant stated:

> *"I had to have a Pap smear because I had a problem—previous to that I did not have one for 10 years. I didn't go. I just didn't go."*

Exhibit 6. Department of Health Services (DHS) Use in Previous Year, by Insurance Status, IHSS Providers & Adult Population (aged 18 and older), Los Angeles County, 1997 & 1999



Source: Los Angeles County Health Survey 1997 & Los Angeles County IHSS Provider Health Survey 1999.

IHSS providers are more likely to utilize county health care facilities.

An estimated 15 percent of IHSS providers have received care from DHS in the past year, representing approximately 11,000 unique DHS patients (see Exhibit 6). Among uninsured home care workers and those covered by Medi-Cal, nearly a quarter had used a DHS facility sometime in the previous year. The rate of DHS use among home care workers is noticeably higher than the estimated 11 percent among the general adult population.[14] It is, however, similar to the findings of a study that matched county DHS users and the IHSS workforce (see below). Many focus group participants had experience with using county facilities and hospitals for treatment, and many described obstacles to using public facilities. Many expressed preferences for private providers although some described difficulties with private HMOs as well.

Additional Analyses and Funding Sources

DHS Administrative Data Match

Matching IHSS providers with DHS users in Fiscal Year 1997-98 identified 16,896 workers who used outpatient services and 933 inpatient users.[15] About 75 percent of the outpatient users and 60 percent of the inpatient users were uninsured. Altogether, these workers generated a total of 27,527 visits and 3,814 inpatient days (see Appendices 2a and 2b). Of the 27,527 outpatient visits in FY 97-98, half occurred at county hospital clinics and about a third at DHS comprehensive health centers or clinics and 15 percent at hospital emergency rooms. There were very few visits to county Public Private Partnership (PPP) sites or DHS public health clinics.[16] There were 3,814 county hospital inpatient days. More than half of these patient days (2,184 days) were for uninsured individuals. Total county expenditures estimated for IHSS providers in FY 97-98 were about $14.3 million, including an estimated nearly $9.6 million expenditures for the uninsured (see Appendix 2c).[17] DHS costs based on charges are more than $24 million.[18]

Actuarial Analysis and Cost Estimates

Estimated Premium. The estimated age-adjusted monthly premium cost for HMO coverage in Los Angeles would be about $149 per member per month (PMPM). The actuarial analysis concluded that the PMPM rate would be about $20 less if the pool excluded those over the age of 65. Because this is not a feasible approach under current federal law, the $149 figure is used throughout this analysis. The estimates are based upon the following generic plan design:

- Coverage for the home care worker only, no family coverage.
- No annual deductible and unlimited lifetime benefit.
- $5 copayment for doctor's visits (increasing copayments to $10 would decrease premiums slightly).
- No copayment for inpatient services and 20 percent copayment for hospital outpatient.
- $8 copayment for generic prescription drugs; $15 for brand name drugs.
- No out-of-network benefits.

Exhibit 7. Estimated Annual Cost of Insuring the Los Angeles County IHSS Workforce*

Workforce	Population	$149 PMPM
All Workers	72,000	$128,736,000
Uninsured	32,000	$57,216,000
Uninsured not linked to Medi-Cal**	22,000	$39,336,000

* Assumes all of those eligible in each of these categories will enroll. Cost sharing and other factors will discourage some from participating and reduce the total insurance cost.

** Those not categorically linked to Medi-Cal.

Source: Los Angeles County IHSS Provider Health Survey 1999.

Exhibit 7 shows annual total costs for insuring Los Angeles County home care workers based on $149 per member per month ($1,788 per year per enrolled worker). We estimate the cost of insuring the entire work force at $129 million, all uninsured at $57 million, and $39 million for the uninsured that are not linked to Medi-Cal, primarily single adults or childless married couples. It is important to note that plan design choices—including benefit packages, copayments, and eligibility rules—will have important implications for program outcomes. For example, different levels of benefits and cost-sharing will have very different results in terms of achieving enrollment objectives; relative attractiveness of existing options, such as public programs or coverage through a spouse; the risk profile of the population attracted to the new program; long term costs; and program sustainability.

Financing Sources

California spends more than $25 billion in public funds for health care services, primarily targeting low-income and other hard-to-reach populations. These funds support 20 separate programs at the local and state level, many of which leverage federal funds. To expand coverage for home care workers, public financing is required because in Los Angeles County, as in several others, the employer of record, PASC, is a public authority and a quasi-governmental agency. The share of the insurance costs that would usually come from the employer will likely depend instead on the allocation of new public funds or the reallocation of existing funds. Funding sources may include one or more of the following.

- *State general funds*. California devotes more than $8.8 billion that is leveraged to draw down more than $12 billion in federal funds for Medi-Cal. In addition, under realignment, the state allocates funds to counties for health-related services.[19] It combines funds from the state general fund and vehicle license fees. Currently, the state transfers funds to counties for health care services through the realignment program, Proposition 99, and other programs. Counties use these funds for primary care (outpatient ambulatory), hospital services, and public health. In some counties, some of these funds are used to support services in private clinics and health centers. In

others, funds are retained by the local government and used to provide care directly through county health service programs. There are no data to show the amount spent for each of these service areas.

- *County general funds (Net County Costs).* Throughout the state, counties spend $478 million of their own funds for indigent care and related services. It is not known what share of these funds go to support other services; however, in some cases, local dollars help to leverage other funds. In Los Angeles County, local funds are allocated and transferred to the state and then used to draw down additional federal dollars.
- *State and county tobacco settlement dollars.* The State of California is to receive $25 billion over the next 25 years, half of which is shared among the 58 counties and four cities. Los Angeles County's share is $3.3 billion. Although there are no restrictions placed on the use of these funds, Los Angeles County has pledged to use these funds for health care and public health; the state has not made that commitment.
- *Federal matching funds.* The federal government provides matching funds for several programs including the Children's Health Insurance Program (CHIP [Healthy Families]), Medicaid, the IHSS program, and the 1115 Medicaid Demonstration Project. Mechanisms for drawing down federal funds under these programs are in place but vary in how the formulas are used. Each is quite complicated and may involve inter-governmental transfers and formulas, some of which are outlined below. (See Appendix 4 for further discussion of the Los Angeles County 1115 Medicaid Demonstration Project.)
- *Federal matching funds in the IHSS rate structure.* Health insurance could be financed by including the premium cost in the reimbursement that is claimed by the state for IHSS salaries. This is the financing package that supports the San Francisco program.
- *Worker contributions.* Plan design may include some worker cost-sharing, including co-insurance and copayments. These cannot be expected to provide a major funding source, however, because of the low financial status of the home care workforce. Because these are low-income workers, co-insurance and copayments will reduce participation rates as well as utilization.
- *Charitable foundations.* Foundation support may be available for subsidies or evaluation of the health plan. Examples of foundations

supporting premium payments include the California HealthCare Foundation's support of the Riordan/California Kids program and Alliance Health Care Foundation's support of the Sharp Health System's program for uninsured low income workers in San Diego.

- *Subsidies or charitable contributions from plans.* Many health plans have built reserves that could be tapped for premiums. Several plans, including Blue Cross and Kaiser, provide limited subsidies for health programs for the uninsured.

Options for Providing Health Insurance for Home Care Workers

We provide several discrete approaches and options for providing health insurance to home care workers, recognizing that there is considerable overlap of strategies and financing mechanisms among these otherwise diverse ideas.

We based these options on the following assumptions:

- The plan will cover individual workers only and not dependents.
- The plan is comprehensive, covering primary care, dental, hospitalization, prescription drugs, and ancillary services (although discussions about carve-out of certain services are included in several instances).
- The plan will have a $5 or no copayment for those with net incomes up to 133 percent of Federal Poverty Level; copayments may be graduated upward at higher incomes.
- No copayment for inpatient care.
- No out-of-network benefits.
- No annual deductible and unlimited lifetime benefit.
- Co-insurance, $3 per month up to 200 percent of Federal Poverty Level, graduated upwards based on income.

In acknowledgement of the needs of this low-wage workforce, we base our analysis on a comprehensive package of benefits. However, we recognize that any plan design will require difficult tradeoffs among affordability, comprehensiveness, and potential program reach.

In analyzing these options, our criteria include:

- cost;
- the extent to which the option maximizes federal participation;
- effect on net costs to the county;
- ease of implementation;
- impact on the number of uninsured;
- acceptability to the IHSS workforce;
- choice of plan and provider;
- prospects for long-term sustainability;
- consistency with 1115 Waiver goals; and
- whether the option could serve as a model for providing health insurance to other low- income workers.

A summary of options and their performance with respect to these criteria are shown in Exhibit 10 on page 29.

Option 1: Creating a State Program for Home Care Workers

Approach

A single state program for IHSS providers is simple, relatively easy to administer, and could cover all eligible workers in the county and possibly the state. The program is modeled after the San Francisco Healthy Worker program. The approach would create a single program, linking workers to health care providers in each county. Although multiple financing mechanisms might underlie the program, these would remain largely invisible to the worker.

Eligibility

All IHSS providers in California would be *presumptively eligible* for full benefits for six months if they worked a minimum number of hours. There would be no means test since so many of those who are uninsured

are known to be below 200 percent of Federal Poverty Level. Those currently on Medi-Cal or those eligible for Medi-Cal would have a choice between their existing coverage and the new program.

Cost

Exhibit 8 shows the cost of the plan for all uninsured home care workers and for those who are not linked to Medi-Cal. For the latter group only, we estimate the cost of the plan at $39.3 million, the state's share at $15.2 million annually, and the county's share at $8.2 million. Combined, these would generate an approximate federal match of $15 million. If the program included only those who are eligible for Medi-Cal, federal participation would increase and county share decrease. These estimates are general; actual costs to the state and the county may vary depending on the actual financing structure and the participation rate among workers. For example, the federal matching funds under Medi-Cal vary somewhat from the federal participation rate under the IHSS rate structure. Offering a plan to all workers requires a high initial cost estimate; however, it is unlikely that all individuals will elect to voluntarily enroll in a plan, reducing the actual cost.

Exhibit 8. Estimated Share of Costs based on Rate Formula* at $149 Per Member Per Month

$149 PMPM	Total Cost	Worker Contribution**	State	County	Federal
All Uninsured	$57,216,000	$1,152,000	$22,229, 000	$11,970,000	$21,865,000
Uninsured not linked to Medi-Cal***	$39,336,000	$792,000	$15,282,696	$8,229,144	$15,032,160

* See endnote 20 for rate structure. ** Based on an average $3 per member per month co-insurance.
*** Those without children and below 200 percent of Federal Poverty Level.

Source: Segal Company Actuarial Analysis.

Financing

The financing is based on the San Francisco Healthy Worker project. The model assumes a near full subsidy for workers up to 200 percent of Federal Poverty Level that work at least quarter time (except for a $3 a month co-insurance). Subsidies decline for families above 200 percent of Federal Poverty Level.

If all workers were enrolled in the state program, the estimated 6,000 Los Angeles County workers who are categorically linked to Medi-Cal

would be enrolled to draw down federal Medicaid funds, which would offset the cost of the program, especially to the county. About 4,000 Los Angeles County home care workers are categorically linked to Medi-Cal, but have incomes above the threshold for Medi-Cal eligibility. Further offset for these estimated 4,000 IHSS providers may be available due to categorical eligibility and spend-down rules.

For those not linked to Medi-Cal, health insurance costs would be included in the claims that are submitted to the federal government for salary reimbursement.[20] Since the IHSS program is funded primarily with state and federal funds, along with a county contribution, establishing a state program would take advantage of the rate structure that currently finances the IHSS program. State tobacco funds would be used for the state portion and these, matched with federal funds, would then be used to purchase a plan in each county, creating a single program. While multiple financing arrangements are necessary, these would remain largely invisible to the IHSS provider.

Many different purchasing arrangements could be envisioned under the plan. For example, services could be purchased through PacAdvantage, MRMIB programs (The Healthy Families Network), CalPERS, or through existing Medi-Cal provider networks, including the managed care arrangements that are now in place. The state could also negotiate with individual plans or a partnership of plans. The state could also negotiate with L.A. Care or directly with the Los Angeles County Department of Health Services.

Advantages

This approach could provide workers considerable choice among health plans and provider groups. The approach could significantly reduce the number of uninsured adults and possibly children in Los Angeles County and the state. This financing system would use the existing rate reimbursement structure and would have a small effect, if any, on increasing the county's net costs and would maximize federal reimbursement. This is a relatively stable approach to health care coverage that can be sustained for longer periods of time. Workers themselves would appreciate the stability, choice, and broad coverage this approach offers. The program may cost less than Los Angeles County (or PASC) could negotiate on its own because of the larger pool that would be created at the state level. It would be particularly useful for smaller counties that could not purchase an affordable plan without combining their workforce with others.

Issues and Obstacles

Although the overall costs of the program are high relative to other approaches, the benefits are likely to be much greater by improving access to primary care, reducing hospitalization, and reducing the number of uninsured. However, the program could take a year or more to implement because of legislation or waivers that may be needed to integrate public finance opportunities, the lengthy rate negotiations, and the time needed to develop outreach and marketing plans. Also, the program may not be politically feasible in the near future given the state's interest in moving more incrementally to cover the uninsured. In addition, offering a plan for home care workers may attract people from existing private insurance, thereby increasing the public cost of the program. Individuals currently covered by Medi-Cal may also drop it unless the program supports a seamless system of delivery of care.

Option 2: County Health Plan

Approach

Under this approach, eligible IHSS providers in Los Angeles County would enroll in a county health plan, either the county's HMO or some similar safety-net oriented system involving the county's publicly operated system and the Public Private Partnership clinics. The program would primarily target adults without children. IHSS providers who currently have private insurance, Medi-Cal, or Medicare will remain with that coverage. Outreach and enrollment into Medi-Cal, Healthy Families, and other health programs would remain an important component of the county-organized plan. The county would extend individual coverage to uninsured workers who are not eligible for Medi-Cal. All IHSS providers' eligible children would be enrolled in Medi-Cal or Healthy Families (nearly 95 percent of whom are estimated to be eligible based on family income). Because workers would be enrolled into a plan, enrollment and benefit design would be subject to Knox-Keene regulations. This is in contrast to the option discussed next, in which people are not enrolled in a health plan but are eligible to receive services from the county health system.

Eligibility

All uninsured home care workers not eligible for other programs would be presumptively eligible. There would be no means test, but workers would be screened for Medi-Cal and Healthy Families eligibility. All

enrolled workers would have a $3 monthly co-insurance with higher co-insurance for those above the 200 percent of Federal Poverty Level.

Benefit Design

Benefits would be comprehensive as described above. Services would be limited to DHS primary care sites, including private providers that have contracts with Los Angeles County. Hospitalization and specialty care would occur primarily at county hospitals or a limited number of contracted private sites. Services would be offered free or with $5 copay (based on income), prescription drugs free or $2 or $5 copay.

Cost

The same overall cost estimates were used for this program as were used in describing the state program. In restricting the program to only those not eligible for Medi-Cal, we estimate the cost to the county to be $18.5 million. Enrolling the workers in the county's health plan may benefit the county by leveraging federal reimbursement of 52 percent of the premium cost of a plan (an estimated $20 million). A variation of the plan, in which workers would be offered a choice of plans, may require the purchasing of some services in the private sector.

Financing

The health program would be financed under the county's proposed 1115 Medi-Cal Waiver extension proposal. Matching funds to the estimated premium costs could bring in $20 to $29 million in federal funds under the terms and conditions of the 1115 Waiver. A variation to the waiver approach would draw down federal funds using the IHSS rate structure similar to the San Francisco model. This would reduce the county share due to a higher state contribution.

Advantages

This project falls within the county's 1115 Medicaid Demonstration project and thus takes advantage of the existing infrastructure in Los Angeles County. It is consistent with waiver goals because enrolling individuals into a plan can emphasize primary care and reduce inappropriate ER and hospital care. Because overall the demonstration project is considered short term (5 years) with measurable objectives, the IHSS component could be designed with an evaluation plan to determine the extent to which it could become a model for other home care workers or other low wage workers in the state.

The model can provide a way for the county DHS to build self-sufficiency beyond the waiver period. It would be financed using the existing reimbursement structure and could moderately increase Net County Costs in the short run, and maximize federal participation and reduce unnecessary and inappropriate county health care expenditures in the long run.

Issues and Obstacles

The State of California and Los Angeles County are currently negotiating for a five-year extension of the waiver. Expanded coverage for home care workers is included in the extension application but as a minor objective. Tying the project to the waiver raises questions about the long-term viability of a program since the waiver must be renewed every five years and a long-term, countywide sustainability plan has not yet been developed. The plan as described limits choice to county DHS health care providers, which many workers may not want to use. Increasing choice, however, would increase net county expenditures.

Exhibit 9. Estimated Share of Costs Between the County and Federal Participation Under 1115 Waiver for Uninsured IHSS Providers Categorically Linked and Not Categorically Linked to Medi-Cal

$149 Per Member Per Month	Number of Workers	Full Cost	Worker Share*	County Share	Federal Match
All Uninsured Workers	32,000	$57,216,000	$1,152,000	$26,910,000	$29,153,000
Uninsured Workers Not Linked to Medi-Cal	22,000	$39,336,000	$792,000	$18,501,120	$20,042,880

* Based on an average $3 per member per month co-insurance.

Option 3: The County IHSS Health Project

Approach

Under this approach, Los Angeles County Department of Health Services would establish the *IHSS Provider Health Project*. All uninsured home care workers would be offered a program that guarantees access to a broad set of services via an enrollment card. This card would entitle workers to use county and PPP providers without copayments, similar to the format currently available under the county's General Relief Health Plan. The program would entitle enrolled workers to go to any provider in the county's own health system. Workers could also receive care at the county's Public Private Partnership ambulatory care

network and the county's Healthy Families program network, both of which include some private physicians. Under this model, county DHS remains at risk for hospitalization and specialty care.

Eligibility

Because such a large percentage of IHSS providers are below 200 percent of Federal Poverty Level, all uninsured IHSS providers would be presumptively eligible for the program. However, individuals would complete a Medi-Cal application to determine eligibility for the Medi-Cal program. There would be no additional means testing or verification of income in order to avoid the cost of screening a population that is already known to be low- or very low-income and to encourage as many people as possible to enroll. Subsidies for health services already are provided by Los Angeles County through its Ability to Pay (ATP) system and the Public Private Partnership (PPP) program.[21]

Benefit Design

All workers would be entitled to receive full scope primary dental and specialty care services including office visits, ancillaries, and prescription drugs. Services would be limited to county-operated or county-contracted sites as described above. Hospitalization and specialty care would occur at county hospitals, or, in some cases, contracted sites in areas with low capacity. Services would be offered free or with $5 copayment (based on income), prescription drugs free or $2 or $5 copay at higher incomes.

Cost

Because this is a project and not an enrollment program, the cost of the program would be related to use of services. It is difficult to determine actual costs because it is not known what percent of the workers would actually use services. Based on past utilization, however, it is estimated that Los Angeles County spends more than $14 million annually providing health care services to uninsured home care workers.[22] Very few IHSS providers have used Public Private Partnership (PPP) sites. Assuming the unit cost of service provision remains the same and that utilization increases, the first year cost of the program would also increase.

Financing

The proposed program would be paid for using a combination of Net County Costs and federal matching funds. Approximately half of the costs of ambulatory care services provided in health centers, clinics, and PPP sites are recoverable under the 1115 Waiver.

Advantages

This approach is possible because the infrastructure of providers, financing, and reimbursement already exists in Los Angeles County. It could be implemented quickly using models such as VIDA and the General Relief health program.[23] Another advantage of this approach is that many IHSS providers already use DHS facilities. The cost of the program as designed would be low and it could bring additional federal dollars into the county. It also promotes the county's 1115 Waiver goals by moving people into primary care and could be designed to emphasize preventive care and disease management.

Issues and Obstacles

The terms and conditions of the waiver currently restrict PPP eligibility to 133 percent of Federal Poverty Level. Expanding the limit to 200 percent is consistent with other programs such as AIM and the state's Expanded Access to Primary Care (EAPC) that have similar income eligibility criteria, although this would require HCFA approval. It is unclear whether or not this could become a model for other home care workers because of the absence of a strong and comprehensive public delivery system in many counties in California.

Another problem with this approach is that workers may not go to some clinics because of structural barriers, perceptions about quality of care, and long waits for appointments and services. Finally, the contracts with PPP sites limit the number of visits for which a clinic can be reimbursed. If an IHSS provider seeks care from a PPP clinic that has exceeded its contractual limit, the patient may be denied care or may face other obstacles.

Option 4: Outreach and Enrollment of Eligible Workers into Existing Programs

Finally, we describe an incremental approach to increasing coverage that would enroll eligible workers into existing programs, particularly Medi-Cal, Access for Infants and Mothers (AIM), and Healthy Families

(for uninsured children of IHSS providers). Under this model, workers who have dependent children and have family incomes below 100 percent of Federal Poverty Level would be targeted for outreach and enrollment. Those not eligible would be informed of the county's health system and the county's Public Private Partnership (PPP) program.

Approach

There are 6,000 IHSS providers who are eligible for Medi-Cal but not enrolled. Several options are available for enrolling people into the Medi-Cal program. First, those currently receiving cash assistance are automatically eligible for Medi-Cal. Few IHSS providers are receiving cash aid. Many are nevertheless linked under Section 1931(b), Medi-Cal for families not receiving cash assistance. This program provides a link to Medi-Cal for families who previously would have been eligible for AFDC-linked Medi-Cal. It covers families with incomes up to 100 percent of the Federal Poverty Level. Included in this group are those who may have been eligible under the Medi-Cal Medically Needy category (those with incomes between 74 percent and 100 percent of Federal Poverty Level).

Because these individuals are already linked, an outreach program could be established using Los Angeles County Department of Public Social Services (DPSS) staff (eligibility workers), members of the SEIU Local 434B, and SEIU's worker registry to identify and eventually enroll eligible IHSS providers into Medi-Cal. The outreach and enrollment could be conducted during the process of enlisting an IHSS provider. DPSS workers assigned to the client would be responsible for screening individuals and making appropriate referrals to DPSS eligibility workers for enrollment.

Cost

This approach would cost $550,000, covering outreach and enrollment services only. California currently has allocated $3.9 million to 1931(b) outreach efforts. These funds are to be used by Los Angeles County DHS and DPSS, as well as private contractors, to conduct outreach and enrollment into the Medi-Cal and Healthy Families programs. Through the registry/outreach campaign, these individuals could be enrolled in L.A. Care or voluntarily into the county's Community Health Plan, bringing in additional federal and state match for their care.

Advantages

This is an important approach and could be the first of several incremental steps to full coverage. It takes advantage of existing finance opportunities, maximizes participation in existing programs, is low or no cost to the state and Los Angeles County, and could be implemented quickly. No special waivers or legislation would be needed to implement this approach.

Issues and Obstacles

The approach would have a small effect on reducing the number of uninsured because current eligibility requirements under Medi-Cal exclude so many home care workers. There are other restrictions that keep even linked individuals out of Medi-Cal. For example, an assets test may keep people out of the program who own homes or other items that place them above the threshold for eligibility for the Medi-Cal program. The outreach plan would also have to consider the restrictions now in place that prohibit plans from marketing their plans. And since the county, through its HMO (Community Health Plan), is participating in the Medi-Cal managed care program, it could not limit choice for those who are targeted by the outreach for Medi-Cal enrollment.

Exhibit 10. Summary of Options

	State Plan	County Health Plan	County DHS Operated Program	Medi-Cal/HF Outreach
Cost Range	Moderate	Low	Low	Low
Maximizes federal participation	Yes	Yes	No	No
Effect on Net County Cost	Low to moderate	Moderate	Low	None
Can be implemented quickly	Low	Moderate	High	High
Reduce the number of uninsured	High	High	Low	Moderate
Acceptance and participation by workforce	High	Depends on type of plan chosen	Low, people will continue to face barriers	Low
Choice	High	Depends on type of plan chosen	Low to moderate (depends on 1115 outcome)	Low for uninsured (many remain uninsured)
Long-term sustainability	High	Moderate	Moderate	Moderate
Will help to achieve 1115 Waiver goals	Little direct effect	High	Moderate	Low
Model for other low income workers	Yes	Only in some communities	Only in some communities	Yes

Conclusion

IHSS providers and their families should be covered by a health plan that provides access to a full range of comprehensive health care benefits. This would promote more appropriate use of health care services, reduce unnecessary hospitalization, improve clinical outcomes, and promote the use of preventive health care. Insurance would also enhance the stability of this cost-effective alternative to institutional care by reducing the high rate of turnover among home care workers, in turn improving care to IHSS clients. The costs of insuring IHSS providers, while substantial, must be weighed against the benefits of coverage to the health of workers themselves and the benefits to society afforded by a more stable IHSS workforce.

Because financing for IHSS providers comes from the public sector, with multiple levels of government involved and questions of overlapping jurisdiction, a public policy solution is necessary to insure this overwhelmingly low-income population.

There are several viable and attractive approaches to offering coverage. Two of these are incremental steps or pilot programs that take advantage of existing financing structures, public programs, and delivery systems for low income families and the uninsured. More comprehensive approaches, built on the foundation of existing public policy but potentially requiring additional legislation and/or federal waivers to implement, are also described. All of these represent opportunities for leveraging state and local investments in health coverage to draw down significant support from the federal government. They may also move home care workers into a more organized form of health care delivery

that emphasizes ambulatory care over hospital-based care. Contributions from philanthropy and the insurance industry could also play a role in lowering premiums and facilitating program evaluation. And although we outline discrete approaches, covering home care workers may require blending ideas, introducing different components in phases, and otherwise patching together financing from various sources.

This study provides important data on home care workers' demographics, utilization patterns, and preferences. It also lays out viable options for extending needed coverage to this group of low-income, underserved individuals. The study has implications for national as well as state policy options for reducing the number of uninsured. Regardless of the approach or approaches taken, covering home care workers is consistent with other policy goals in California and Los Angeles County and could result in dramatic benefits for workers and their clients.

Appendices

Appendix 1a. Demographic Characteristics of Survey Sample, Los Angeles County In-Home Supportive Services Providers, 1999

Characteristics	Number of Respondents	Percentage of Respondents
Gender		
Female	1,026	83%
Male	218	17%
Total	1,244	100%
Age		
15-17	4	< 1%
18-29	153	12%
30-39	275	22%
40-49	346	28%
50-59	263	21%
60-64	90	7%
65 and above	112	9%
Total	1,243	100%
Race/Ethnicity		
Hispanic/Latino	475	39%
Black/African American	313	25%
White/Caucasian	329	27%
Armenian	*123*	*10%*
Russian	*48*	*4%*
White, Other Ethnicity	*158*	*13%*
Asian/Pacific Islander	82	7%
American Indian/Other Race	31	3%
Total	1,230	100%

Characteristics	Number of Respondents	Percentage of Respondents
Citizenship Status		
U.S. Born	608	49%
Naturalized	386	31%
Non-Citizen	244	19%
Total	1,238	100%
Marital Status		
Single, Never married	376	30%
Married/Cohabiting	572	46%
Widowed/Separated/Divorced	292	24%
Total	1,240	100%
Parent/Guardian of Children*		
Yes	767	62%
No	475	38%
Total	1,242	100%
Family Income Relative to Federal Poverty Level (FPL)		
Less than 100 percent FPL	493	48%
100-200 percent FPL	317	31%
Greater than 200 percent FPL	210	21%
Total	1,020	100%

* Children aged 18 and younger.

Note: May not add to 100 percent due to rounding. Persons with unknown values were eliminated from the analysis.

Source: Los Angeles County IHSS Provider Health Survey, 1999.

Appendix 1b. Employment Characteristics of Survey Sample, Los Angeles County In-Home Supportive Services Providers, 1999

Characteristics	Number of Respondents	Percentage
Relation to IHSS Recipient		
Relative	835	67%
Non-Relative	408	33%
Total	1,243	100%
Duration of IHSS employment		
2 years or less	699	60%
3-5 years	241	21%
6-8 years	94	8%
9 or more years	122	11%
Total	1,156	100%
Hours worked per month in IHSS program		
Up to quarter time (≤ 40 hrs.)	306	28%
Quarter to half time (41-80 hrs.)	408	37%
Half to full time (81-160 hrs.)	290	26%
More than full time (> 160 hrs.)	108	8%
Total	1,112	99%

Characteristics	Number of Respondents	Percentage
Additional Employment		
Additional job(s)	420	34%
No additional job(s)	823	66%
Total	1,243	100%
Hours worked per month in IHSS program (for those with additional employment)		
Up to quarter time (≤ 40 hrs.)	124	33%
Quarter to half time (41-80 hrs.)	148	39%
Half to full time (81-160 hrs.)	89	24%
More than full time (> 160 hrs.)	17	4%
Total	378	100%

Note: May not add to 100 percent due to rounding. Persons with unknown values were eliminated from the analysis.

Source: Los Angeles County IHSS Provider Health Survey, 1999.

Appendix 2a. Estimated Number of Patients and Outpatient Services Among IHSS Providers in the County DHS System, by Site of Services, FY 97-98

	Hospital Outpatient		Hospital ER		*Clinic Outpatient		Total Ambulatory Care	
Payer Source	Patients	Visits	Patients	Visits	Patients	Visits	Patients	Visits
Medi-Cal	1,382	2,805	510	560	343	541	2,235	3,906
Medicare and Private	718	1,417	334	370	925	1,710	1,977	3,497
Uninsured	6,039	10,549	2,855	3,255	3,790	6,320	12,684	20,124
Total	8,139	14,771	3,699	4,185	5,037	8,571	16,896	27,527

* Includes comprehensive health centers, clinics and public health sites. Does not include PPP sites.

Source: Medically Indigent Care Reporting System (MICRS), Los Angeles County DHS, 1999.

Appendix 2b. Outpatient and Inpatient Services and Estimated Costs* Among IHSS Providers, FY 97-98

	Inpatient			Outpatient		
Payer Source	Patients	Days	Costs	Patients	Visits	Costs
Medi-Cal	294	1,271	$1,888,706	2,235	3,906	$1,355,771
Medicare and Private	86	359	$533,474	1,977	3,497	$984,611
Uninsured	553	2,184	$3,245,424	12,684	20,124	$6,324,412
Total	933	3,814	$5,667,604	16,896	27,527	$8,664,794

* Los Angeles County DHS Inpatient costs are estimated at $1,486 per day. This represents a weighted average of the 1997-98 Inpatient costs per day at all DHS hospitals. Outpatient costs were estimated by averaging the costs of hospital outpatient visits across all four hospitals ($373 per visit) and averaging the costs of outpatient visits across all comprehensive health centers in four areas of the County ($186 per visit). Outpatient costs estimates were obtained from the Los Angeles County DHS Fiscal Management for FY 1997-98.

Source: Medically Indigent Care Reporting System (MICRS), Los Angeles County DHS, 1999.

Appendix 2c. Estimated Costs* of Providing Care to IHSS Providers in the County DHS System, FY 97-98

	Inpatient	Outpatient			Total
Payer Source		Hospital	Emergency Room	**Clinic Outpatient	
Medi-Cal	$1,888,706	$1,046,265	$208,880	$100,626	$3,244,477
Medicare and Private	$533,474	$528,541	$138,010	$318,060	$1,518,085
Uninsured	$3,245,424	$3,934,777	$1,214,115	$1,175,520	$9,569,836
Total	$5,667,604	$5,509,583	$1,561,005	$1,594,206	$14,332,398

* Los Angeles County DHS Inpatient costs are estimated at $1,486 per day. This represents a weighted average of the 1997-98 Inpatient costs per day at all DHS hospitals. Outpatient costs were estimated by averaging the costs of hospital outpatient visits across all four hospitals ($373 per visit) and averaging the costs of outpatient visits across all comprehensive health centers in four areas of the County ($186 per visit). Outpatient costs estimates were obtained from Los Angeles County DHS Fiscal Management for FY 1997-98.

** Refers to DHS clinics and comprehensive health centers.

Source: Medically Indigent Care Reporting System (MICRS), Los Angeles County DHS, 1999.

Appendix 3. Estimated Number of Workers by Insurance Status and Hours Worked

Payer Source	≤ 40 hours/ month		41-80 hours/ month		81-160 hours/ month		160+ hours/ month		Total	
Medi-Cal	14%	2,822	13%	3,463	14%	2,621	15%	1,080	14%	10,080
Medicare	10%	2,016	6%	1,598	10%	1,872	7%	504	8%	5,760
Private	37%	7,459	37%	9,857	25%	4,680	29%	2,088	33%	23,760
Uninsured	39%	7,862	44%	11,722	51%	9,547	49%	3,528	45%	32,400
Total	28%	20,160	37%	26,640	26%	18,720	10%	7,200	100%	72,000

Source: Los Angeles County IHSS Provider Health Survey, 1999.

Appendix 4. The Los Angeles County Medicaid Demonstration (Waiver) Project

The 1115 Medicaid Demonstration project (Waiver) provides federal participation for indigent care services in Los Angeles County. A proposal is currently under review for an extension of the existing waiver for an additional five years. The waiver does not enroll individuals into a health plan but rather claims matching funds to help Los Angeles County restructure its health care system away from inpatient and towards one that emphasizes outpatient services. The system is financed with local county dollars matched with federal funds that primarily support ambulatory care services including the Public Private Partnership program.

Notes

1. The San Francisco Healthy Worker Program is the health insurance program for home care workers in the City and County of San Francisco.
2. State of California, Department of Social Services. In-Home Supportive Services Management Statistics Summary. December 11, 1999.
3. Ibid. This does not include federal matching funds.
4. RTZ Associates, "Bold Action for a Challenging Problem, Immediate Steps and Long Term Solutions for Improving Services for Impaired Adults in Los Angeles County," Final Report. Los Angeles In-Home Supportive Services Study, November 1996.
5. As of June 1999, the other five counties with established public authorities were San Francisco, San Mateo, Alameda, Contra Costa, and Santa Clara.
6. Benjamin, A.E. "A Historical Perspective on Home Care Policy," *Milbank Memorial Fund Quarterly*, 71(1): 1993. Hayashi, R., J.W. Gibson, and R.A. Weatherley. "Working Conditions in Home Care: A Survey of Washington State's Home Care Workers." *Home Health Care Services Quarterly*. 14(4):37-48. 1994.
7. U.S. Bureau of the Census, Population Estimates Program, Population Division. Population Estimates for Counties by Age Group: July 1, 1998.
8. Ibid.
9. Service Planning Areas (SPAs) are eight regions of the county with an average population of 1.2 million people. They were established by the Children's Planning Council and approved by the Board of Supervisors as geographic areas for purposes of planning in 1993.
10. For a family of four, the 1998 Federal Poverty Level was an average of $16,660 a year and 200 percent of the level was $33,320.
11. The hours paid to IHSS providers are dictated by the needs of their client, the IHSS recipient. Annual home visits by Department of Public Social Services workers determine the number of hours of assistance needed per month.
12. Poor persons are defined as at or below the Federal Poverty Level of $16,660 for a family of four in 1998. Near-poor persons have incomes of 101 to 200 percent of the Federal Poverty Level.
13. Los Angeles County Health Survey, 1997.
14. Ibid.

15. Medically Indigent Care Reporting System (MICRS), Los Angeles County DHS, 1999.
16. The PPP program is a county DHS program to expand access to primary care using private clinics and physicians offices. The county contracts with these clinics at a specific rate of $62 per service rendered.
17. Source: Los Angeles County DHS MICRS, 1999.
18. These are estimated costs for serving uninsured patients who are IHSS workers. These may represent both net county expenditures as well as leveraged federal funds under the 1115 Medicaid Demonstration Project.
19. Assembly Budget Committee, "Governor's 2000-01 Budget Proposal for Health," 2000.
20. A shared formula similar to that used for paying IHSS salaries could be applied to cover health benefits. This is structured to provide about a 52 percent federal share of the Medi-Cal program. Of the remaining 48 percent, which is the state share, 65 percent of the IHSS program is paid with state dollars and 35 percent local county funds. This covers about 74 percent of the IHSS workforce. The other 26 percent are workers paid with state-only funds. For these individuals, 65 percent of the program cost is paid for by the state and 35 percent with local funds.
21. The County's existing Ability to Pay (ATP) system provides subsidized care to individuals seeking services at the Los Angeles County Department of Health Services facilities. The amount of the subsidy depends on family income and the full cost of the service. ATP applicants are required to complete a Medi-Cal application (and Healthy Families for children) to determine Medi-Cal eligibility. In addition, DHS contracts with private providers for serving uninsured individuals with net incomes below 133 percent poverty. DHS requires PPP providers to screen for Medi-Cal and Healthy Families eligibility.
22. Los Angeles County Department of Health Services, Information Services Division, MICRS, 1999.
23. VIDA is a strategy for improving access to care by linking people with providers in the San Fernando Valley of Los Angeles County.