Analysis of the Potential Impacts of Statewide or Regional Collective Bargaining for In-Home Supportive Services Providers

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The California Department of Social Services contracted with the UC Berkeley Labor Center for this report. However, the analyses, interpretations, conclusions, and views expressed in this report are those of the authors and do not represent the California Department of Social Services.

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List of Abbreviations and Acronyms

ACS	American Community Survey
ARPA	American Rescue Plan Act
CCI	Coordinated Care Initiative
CDSS	California Department of Social Services
CMIPS	Case Management Information and Payroll System
CPI	Consumer Price Index
CY	Calendar Year
DHCS	Department of Health Care Services
DOF	Department of Finance
FLSA	Fair Labor Standards Act
FMAP	Federal Medical Assistance Percentage
FY	Fiscal Year
IHSS	In-Home Supportive Services
IP	Individual Provider
LTSS	Long-Term Supports and Services
MOE	Maintenance of Effort
MOU	Memorandum of Understanding
NLRA	National Labor Relations Act
SEIU	Service Employees International Union
UDW	United Domestic Workers
VLF	Vehicle License Fee

Executive Summary

This report investigates the potential impacts of shifting collective bargaining for California's In-Home Supportive Services (IHSS) providers from the county level to the state or regional level. IHSS is a crucial Medi-Cal entitlement program that delivers home care services to more than 700,000 disabled, aged, and blind Californians, primarily through the Individual Provider mode in which individuals hire their caregivers—often family members. Since 1999, IHSS providers have had the right to unionize and engage in collective bargaining with county-level IHSS Public Authorities acting as employers of record. These workers are currently represented by the Service Employees International Union (SEIU) and United Domestic Workers (UDW).

Recent legislation, AB 102 (2023), mandates an analysis of the implications of transitioning to statewide or regional bargaining, including fiscal implications and human impacts. The California Department of Social Services (CDSS) contracted with the UC Berkeley Center for Labor Research and Education (Labor Center) to conduct part of this analysis, encompassing the potential impact on workforce recruitment and retention, implications for the county–state Realignment structure, how wage increases would interact with statewide minimum wage adjustments, and possible funding sources to implement statewide or regional collective bargaining for IHSS providers.

To conduct this analysis, we reviewed and analyzed a wide array of data sources: current IHSS union contracts; CDSS administrative data on IHSS wages and benefits and program utilization; existing research on provider retention and health outcomes from wage improvements and provider training; and practices in six states with statewide collective bargaining of home care workers. Observations from nine CDSS stakeholder meetings held between April and September 2024, along with interviews with participants, were used to gather insights. Finally, we analyzed CDSS baseline program cost projections and estimates of the impact of wage increases and partnered with Blue Sky Consulting to assess how IHSS program growth aligns with 1991 Realignment revenues, the primary source of funding for county obligations to IHSS.

Key Findings, By Report Section

I. Introduction

This section describes the purpose of the study and provides background on the IHSS program, IHSS collective bargaining, and program financing.

II. IHSS Labor Market Analysis

This section provides an examination of the demographics and socioeconomic conditions of IHSS providers in California. We also summarize the variability in wages and benefits across different counties that have resulted from the current system of collective bargaining and consider the implications in the context of the statewide home care labor shortage.

IHSS providers are predominantly female and care for relatives. More broadly, home care workers are predominantly workers of color, and one half were born outside of the United States.

- Three in four IHSS providers are women, about one in four speak a language other than English, and seven out of ten care for a relative.
- According to Census data, California home care workers more broadly are predominantly female, about one in two are foreign-born, and nearly three out of four are workers of color, with significant representation by Hispanic, Asian American and Pacific Islander, and Black individuals.
- IHSS providers—and home care workers more broadly—who are employed year-round earn less than half as much as all workers in California. Census data show home care workers are more than twice as likely to experience poverty. They are also more likely to work part-time and have lower levels of formal education.

IHSS wages and benefits vary significantly among counties.

- IHSS provider wages range from $16.00 to $21.50 per hour, with an average wage of $18.13 (as of July 2024).
- MIT's Living Wage Calculator estimates a single adult employed full-time and year-round would need at least $27.32 per hour to cover basic living expenses such as housing, transportation, food, and health care in California. Comparing IHSS provider wages to county-level MIT Living Wage estimates shows that no county offers wages high enough for a single adult to be self-sufficient.

- Health benefits are offered to at least some workers in 28 out of 58 counties, and nearly 110,000 providers, or 16 percent of all IHSS providers, receive these benefits. Two thirds (67 percent) of IHSS providers enrolled in health benefits work in Los Angeles, San Francisco, or Santa Clara Counties.

- In addition to setting wages and benefits, county MOUs contain a variety of terms of employment related to union representation, recipient and provider rights, and provisions that relate to IHSS Public Authority and county responsibilities, such as registry administration.

III. Collective Bargaining in Other States

We examine collective bargaining practices in other states with Medicaid-funded consumer-directed home care programs. Our analysis highlights the different bargaining structures, wage rates, and benefits offered to home care workers in these programs, as well as the advantages of statewide bargaining for creating uniform standards and facilitating large-scale changes.

Other states with Medicaid-funded consumer-directed home care programs have statewide bargaining with varied structures.

- Connecticut, Illinois, Massachusetts, Minnesota, Oregon, and Washington have Medicaid-funded consumer-directed home care programs and union-represented Individual Providers.

- The programs in these six states are much smaller than IHSS, and several limit enrollment and access to services. They are generally administered by the state government and do not involve local government funding.

- In two of these states, unions bargain directly with one or two state agencies; in three states, unions bargain with councils and commissions. Washington has a unique model with a private vendor as the employer for Individual Providers and a rate-setting board that recommends the rate for that vendor.

- In five of these states, starting wages for Individual Providers will be higher than wages for the vast majority of California IHSS providers as of January 1, 2025. Other states' home care programs have varied health insurance benefits, along with other benefits like paid time off, retirement programs, and workers' compensation.

- Interviewees in these states reported that opportunities with statewide bargaining included having consistent standards statewide, enabling significant structural changes that are more easily implemented at the state level, and improved efficiency.

IV. Potential Impacts of State-Bargained Wage Increases on Provider Retention and Quality of Care

This section explores the potential human impacts of statewide bargaining, specified in AB 102 in terms of home care worker turnover and retention and recipients' access to services. We review existing research on the effect of wages and benefits on home care worker turnover and retention and examine how pay, benefits, and continuity of care influence the quality of care provided to service recipients.

There is a strong link between home care worker pay and benefits, turnover/retention rates, and quality of care. The impacts of statewide or regional collective bargaining on workforce turnover/retention and consumer access to care are contingent on bargaining outcomes.

- Research on IHSS providers in California and home care workers across the United States indicates that higher wages, particularly in relation to local low-wage benchmarks, are strongly correlated with reduced turnover and increased retention, especially among non-family caregivers. High-quality health benefits are also associated with increased retention.

- Existing research also shows that increased continuity of care through consistency of caregivers leads to improved health outcomes and greater satisfaction among service recipients.

- Based on the above research and the current ratio of non-relative providers, each $1 increase in IHSS provider compensation above baseline projections could decrease program-wide turnover by 2.0 percent across California as a whole.

- Analysis of IHSS payroll system data indicates that program-level annual turnover was 16.8 percent in 2023. The likelihood of leaving IHSS is more than twice as high among non-relative providers as among relative providers: 28.1 percent and 12.7 percent, respectively. Turnover increased significantly in 2022 and 2023, in contrast to 2017-2021 when turnover decreased slightly.

- The potential impact of regional or statewide collective bargaining on IHSS provider turnover and consumer access to care is contingent on the ability of unions and workers to negotiate wages and benefits higher than under the status quo, which is discussed in **Section V**.

- Other states with statewide bargaining tend to offer significantly higher wages for home care providers compared to county-bargained IHSS wages in California, but their programs are significantly smaller.

V. Potential Impact of Statewide Collective Bargaining on Program Cost

This section focuses on the cost implications of statewide or regional collective bargaining. We analyze CDSS projections on the fiscal impact of IHSS wage growth under a baseline scenario and with wage increases in $1 increments. We analyze the interaction between minimum wage adjustments and provider wages. We also project future service cost growth and assess how collective bargaining could reshape wage disparities across counties.

IHSS wages have seen significant growth recently. Future wage growth under potential statewide bargaining will depend on the state budget, union negotiation capabilities, and regional cost-of-living disparities.

- In all but two counties, IHSS wages are set as a supplement on top of the minimum wage. When the minimum wage was rising rapidly to $15, IHSS wage growth closely tracked minimum wage growth. Since 2022, the minimum wage has been adjusted annually by the Consumer Price Index, up to 3.5 percent a year. Between 2023 and 2024, IHSS wages grew much faster than the minimum wage.

- CDSS projects baseline IHSS service cost growth rate of 8.56 percent between FY 2027-28 and FY 2031-32. This estimate assumes 3.1 percent annual wage growth, inclusive of minimum wage adjustments, compared to the 7.7 percent average growth rate between 2018 and 2024.

- If statewide bargaining is implemented, each $1 across-the-state compensation increase is estimated by CDSS to cost $586 million (4.2 percent) more than the projected baseline in the first year (FY 2027-28), rising to $721 million in FY 2031-32.

- The impact of statewide bargaining on IHSS wage growth is not predetermined. Key determining factors of wage growth under statewide bargaining would include the state budget context, workers' capacity to negotiate higher wages through their unions, and the ability of the state and IHSS stakeholders to identify new revenue sources.

- Given existing research on the wage compression effects of unionization—especially under centralized collective bargaining—and IHSS unions' stated intentions to raise the wage floor for the lowest-paid providers in the state, intra-state and intra-regional wage disparities are likely to narrow under statewide or regional bargaining.

VI. Implications for MOE and Realignment

In this section, we focus on the potential impacts of statewide collective bargaining on the Maintenance of Effort (MOE) and 1991 Realignment.

Statewide collective bargaining would require changes to the MOE. At the same time, the potential cost implications of statewide collective bargaining for MOE and 1991 Realignment are overshadowed by the existing long-term challenge of funding a rapidly growing IHSS program.

- Statewide collective bargaining would necessitate a change in the MOE, which is currently predicated in statute on local collective bargaining. Though operationally unwieldy, regional collective bargaining under a multi-county coalition bargaining model could theoretically continue under the current MOE.
- County costs for IHSS have grown significantly faster than 1991 Realignment revenues, 6.5 percent vs. 4.6 percent between FY 2017-18 and FY 2024-25.
- Results of the 1991 Realignment projection model developed by Blue Sky Consulting using sales tax growth trends and baseline cost projections from CDSS indicate that County MOE will continue to grow faster than the rate of Realignment revenue growth under the status quo of county-level collective bargaining, even with modest real wage growth.

VII. Potential Sources of Funding for Statewide Bargaining

This section examines funding options to support increased costs from statewide or regional bargaining in the IHSS program. We consider sources like the state General Fund, federal Medicaid funding, and Realignment as possible contributors to cover increased expenses.

Several funding sources could be considered to cover any increased state or county costs incurred due to statewide or regional bargaining.

- It is unknown whether regional or statewide collective bargaining will likely lead to faster wage and benefit growth compared to the status quo and how counties' level of responsibility for the non-federal share of costs will change, if at all.
- The state IHSS share has historically been paid for out of the General Fund, and any increase due to bargaining would need to be considered by the governor and legislature in the context of the state budget.
- New state revenues could also be considered, but it is beyond the scope of this research study to detail those options.

- 1991 Realignment revenues are likely to grow at a slower rate than overall non-federal IHSS expenditures, regardless of whether bargaining is at the county, regional, or state level.
- If federal funding for Medicaid home- and community-based services increases permanently, as temporarily occurred in recent years due to federal COVID relief laws, those additional federal dollars could be used to support any increased spending due to statewide/regional bargaining or program growth.

I. Introduction

A. Purpose of Study

The purpose of this study is to investigate the potential impacts of consolidating collective bargaining for California's In-Home Supportive Services (IHSS) providers from the county level to the state or regional level.[1] A Medi-Cal program, IHSS currently provides home care services to more than 700,000 aged, disabled, and blind Californians.[2] The vast majority of IHSS home care workers are employed through a self-directed model, the Individual Provider (IP) model, in which individual recipients hire, supervise, and terminate their own caregivers, but these workers are paid with public funds, with payroll administered by the state on behalf of recipients. A supermajority of IHSS providers are recipients' family members.

Since 1999, IHSS providers across California have had the right to form a union and bargain collectively. AB 1682 (1999) required each county to establish a county-level public authority or other mechanism to serve as an employer of record for the purpose of collective bargaining over wages, benefits, and other scope specified by state law. The 58 county-level IHSS bargaining units are organized under the Service Employees International Union (SEIU) Local 2015 and United Domestic Workers (UDW), which is affiliated with the American Federation of State, County and Municipal Employees.

AB 102 (2023) provided funding to the California Department of Social Services (CDSS) to "analyze the costs and benefits of approaches that transition collective bargaining with In-Home Supportive Services providers from the current model to a statewide and/or regional model" and authorized the department to hire a consultant to conduct this analysis.[3] The scope of issues to be analyzed included the following:

- The potential impact on workforce recruitment and retention;
- Potential implications on the current county–state realignment structure;
- How any increases would interact with the statewide minimum wage increases; and
- What funding sources, including Realignment, would be available to implement statewide or regional collective bargaining.

To investigate these issues, we undertook the following activities. We reviewed current MOUs between IHSS provider unions and counties, analyzed Census data, and analyzed a variety of administrative data provided by CDSS related to provider pay, benefits, job tenure, and demographics, including data from the CDSS Case Management Information and Payrolling System (CMIPS). At the request of CDSS, we researched practices and policies in six other states that conduct statewide collective bargaining with home care IPs and reviewed research on the impact of wages and benefits on provider recruitment and retention and the impact of direct care worker turnover and training on recipient health outcomes. We also analyzed CDSS projections of estimated baseline program cost and the cost of each $1-per-hour increase in provider compensation. We contracted with Blue Sky Consulting to analyze the interaction between IHSS program growth and 1991 Realignment, which provides most of the funding counties use to meet their financial obligations to the program. Finally, we observed nine stakeholder meetings convened by CDSS to discuss IHSS collective bargaining in April-September 2024, and we interviewed stakeholder committee participants.

Organization of Report

The remainder of this report is organized as follows:

- The rest of this **Introduction** provides a brief background on key characteristics of the IHSS program: the program's purpose; its reliance on the Individual Provider mode of providing care; the establishment of county-level IHSS Public Authorities to facilitate collective bargaining with IPs; and a brief overview of program financing, including provisions that influence county-level wage negotiations.

- **Section II** examines the makeup of the IHSS workforce, analyzes the current distribution of IHSS provider wages and benefits, identifies key elements in the scope of bargaining under the status quo of county-level collective bargaining, and highlights the overarching home care labor shortage in the context of an aging population and the low wages and benefits offered to IHSS providers. (For the purposes of this report, "low wages" and "low-wage jobs" are defined according the Organization for Economic Cooperation and Development [OECD] threshold of two thirds of the median wage.)

- **Section III** presents our research on how state-level collective bargaining for home care IPs works in six other states, including the role of consumers and wage and benefit outcomes.

- **Section IV** explores the potential human impacts of wage increases bargained at the state level, highlighting research on the relationships among turnover/retention, wages/benefits, training, and access to quality care. It presents current data on IHSS provider

turnover, estimates the turnover impact of each $1-per-hour increase in provider compensation, and highlights past and current state-level initiatives to address provider recruitment and retention.

- **Section V** analyzes the potential cost impact of statewide or regional collective bargaining given enrollment trends, wage growth dynamics (including state minimum wage policy), and key factors at play in county, regional, and statewide bargaining. It also examines key results from CDSS cost projections for FY 2024-25 to FY 2031-32, including the baseline projection and estimated cost of each additional $1 in provider hourly compensation.

- **Section VI** examines the potential ramifications of statewide or regional collective bargaining for MOE and 1991 Realignment, highlighting historical trends in the relationship between IHSS MOE cost and Realignment revenues and projecting future outcomes based on CDSS cost projections and a number of alternative MOE rules.

- **Section VII** discusses potential funding sources for the implementation of statewide or regional collective bargaining, considering state general funds, 1991 Realignment, and federal funding.

B. IHSS Program Background

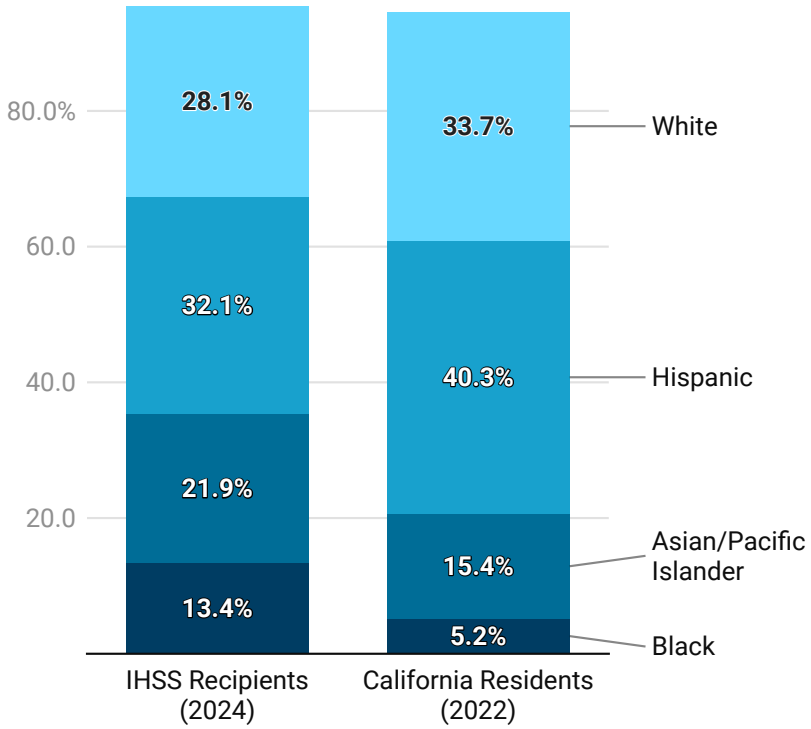
IHSS is an entitlement program that provides home care services to disabled, aged, and blind Californians who qualify for Medi-Cal. The vast majority of participants receive care through the Individual Provider (IP) mode: after county social workers determine eligibility and authorize IHSS services, individual recipients recruit, hire, and supervise their own home care workers, but the state issues these workers' paychecks, using state, federal, and county funds.[4,] As of 2024, 72 percent of IHSS providers were recipients' family members.[5]

Recipient profile. Close to one in three recipients are Hispanic (32.1 percent), more than one in four are White (28.1 percent), slightly more than one in five are Asian American/Pacific Islander (21.9 percent), and nearly one in seven are Black (13.4 percent).[6] Compared to the population at large, IHSS recipients are more likely to be Asian American/Pacific Islander or Black (**Figure 1.1**). Nearly one half of IHSS recipients speak a language other than English, most commonly Spanish, Armenian, Vietnamese, and Cantonese.[7] Two thirds (66 percent) are 65 years and older, and one in ten are under 18 (10.1 percent). Most recipients are women (57.6 percent).[8] More than one third of IHSS recipients are classified as "severely impaired," and about one half of all IHSS participants are enrolled in the IHSS Community First Choice Option (CFCO)

program for those who would otherwise need to be in a nursing home. The average number of monthly authorized hours is 117 across all IHSS recipients from all funding sources and 160 for those enrolled in CFCO as of June 2024.[9]

Importantly, the vast majority of IHSS recipients have low income and participate in Medi-Cal, which caps income at 138 percent of the Federal Poverty Level: $20,783 annually for a single person and $28,208 for couples in 2024.[10]

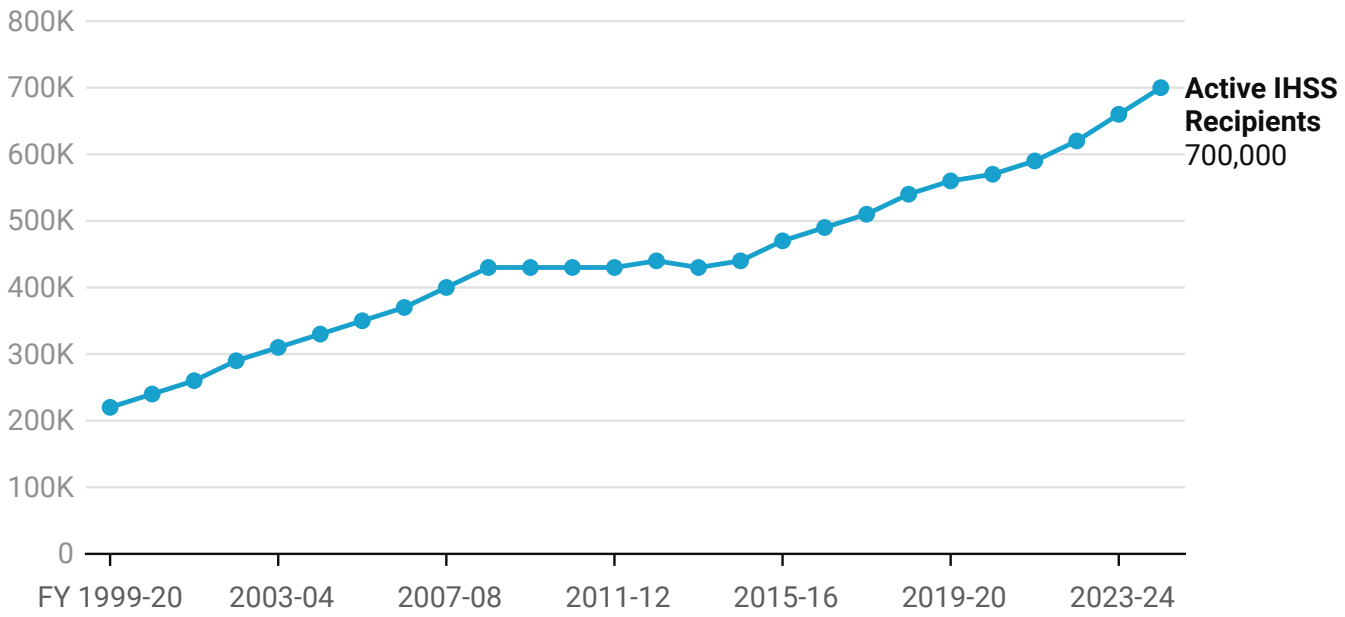
Figure 1.1. Race/Ethnicity of IHSS Recipients and California Residents



Note: CDSS, "In-Home Supportive Services Program Data," June 2024, and Public Policy Institute of California, "California's Population," January 2024.

Caseload growth. As an entitlement program for eligible residents, IHSS has grown rapidly since the late 1990s. As **Figure 1.2** shows, caseload (the number of active cases) doubled from about 220,000 in FY 1999-2000 to nearly 430,000 in FY 2008-09, then plateaued for the next five years. Then, between FY 2013-14 and the end of FY 2023-24, caseload grew to more than 700,000 active participants. CDSS estimates that the caseload will grow by 4.01 percent annually over the next eight years.[11]

Figure 1.2. IHSS Caseload, FY 1999-00 to FY 2024-25



Note: UC Berkeley Labor Center analysis of data from the California Legislative Analyst's Office 2017-18, 2019-20, 2021-22, 2024-25 IHSS Budget Reports, and the California Legislative Analyst's Office Department of Social Services 2020-21 Budget Report. Some data were extracted from original report figures using WebPlotDigitizer. FY 2024-25 caseload estimate is from DSS and includes IP mode only.

Self-directed home care model. California is unique in the extent of its reliance not just on home- and community-based services (HCBS) in publicly funded long-term care, but in its reliance on the consumer-directed model, rather than home care agencies, for providing these services. In the consumer-directed model, service recipients take on the key employer roles: home care workers are hired by individual recipients, rather than by a private or public agency. In California, once IHSS services are authorized by a county social worker, the recipient recruits and hires their own home care workers, supervises them, and can fire them at will. However, wages are set at the county level; the state administers IP payroll and uses federal, state, and county funds to pay providers; and individual recipients have no control over provider compensation.[12]

This system has key advantages. Consumer-directed home care enables many recipients to continue to live safely in their own homes while maintaining agency over their services and supporting consumer choice and autonomy. HCBS cost less than institutional care such as nursing homes. At the same time, this service model creates a complex employment relationship in which workers have historically had fewer legal rights and protections than

most workers in the private or public sector. For example, home care workers hired by private households have had limited rights due to the exclusion of domestic workers from the protection of key federal labor laws, including the Fair Labor Standards Act (FLSA).[13] It was not until 2016 that home care workers—including IHSS IPs—gained the right to overtime pay under new federal regulations related to the FLSA. In addition, IHSS IPs who are spouses or parents of recipients, who make up approximately 25 percent of all IHSS providers,[14] are ineligible to have Social Security (FICA) funds withheld from paychecks under federal policy and thus do not accumulate Social Security benefits for their work. IHSS IPs also had no legal right to collective bargaining until California legislation granted them limited collective bargaining rights in the 1990s.[15]

C. Brief History and Scope of IHSS Provider Collective Bargaining

As state policymakers weigh statewide or regional vs. county-level collective bargaining for IHSS, it is important to understand the unique nature of IHSS collective bargaining. The collective bargaining rights of IHSS IPs and other home care workers in consumer-directed, publicly funded home care programs are entirely defined by state law due to the nature of their employment: key employer roles—who hires and fires, who controls the work, and who controls pay—are not only fissured[16] across different entities, but across the public and private sectors.[17] Until the 1990s, these workers had no clear legal avenue to bargain collectively over wages and benefits. Individual recipients were considered their primary employer, but they had—and still have—no control over provider pay. Furthermore, domestic employees hired by private households were explicitly excluded from the NLRA when the law was enacted in 1937. Neither were IHSS providers recognized as public employees for the purposes of collective bargaining under state law. Current state law creates a limited employment relationship between IHSS providers and local government for the purposes of collective bargaining over a bounded set of workplace issues, with IHSS service recipients retaining key powers and county governments defining the parameters of negotiated pay and benefits.

Creation of IHSS Public Authorities as Employers of Record

In 1991, unions and IHSS workers won the passage of state legislation enabling counties to voluntarily establish public authorities to serve as the employer of record for the purpose of collective bargaining over wages, benefits, and other issues.[18] Alameda was the first county to do so, followed by San Francisco and six other counties. Collective bargaining rights were

established for all IHSS IPs in 1999, when California passed AB 1682, requiring all 58 counties to establish a public authority, nonprofit consortium, or other entity to serve as an employer of record by 2003 for the purpose of collective bargaining with providers.[19] Currently, 56 counties have an IHSS public authority or non-profit consortium that negotiates with the provider union in their county, while two counties choose to serve as employers of record and bargain directly with IHSS unions. Notably, AB 1682 (1999) codified the right of IHSS service recipients to hire and fire providers at will and excluded IPs from county employee status. This model has been replicated in several other states to establish collective bargaining in the context of consumer-directed, publicly funded home care but at the state level, rather than at the county level.

IHSS provider wages and benefits improved significantly after unionization. By 2008, 50 counties had negotiated wages above the newly increased state minimum wage of $8 an hour. Provider unions in some large urban counties negotiated wages significantly higher than the minimum. For example, IHSS workers earned the highest wages in the eight-county San Francisco Bay Area, with most counties offering $11.50 per hour. Santa Clara County paid a Bay Area (and statewide) high of $12.35.[20] Over the next decade, the number of counties paying above the state minimum fell in the context of accelerated growth in the minimum wage. In January 2018, when the state minimum wage was raised to $11 an hour, only 21 counties paid more to IHSS providers. After the 2017 Maintenance of Effort reform, which allowed counties to negotiate IHSS wage supplements that float above the minimum wage, provider pay resumed its growth in relation to the minimum wage. As of May 2024, 56 counties paid providers more than the minimum wage of $16.[21]

Coordinated Care Initiative

There was a notable previous attempt to consolidate IHSS collective bargaining as part of a broader initiative to restructure long-term services and supports (LTSS) called the Coordinated Care Initiative (CCI). Enacted in 2012, the CCI was a pilot project to support and provide coordinated care options to older Californians and people with disabilities across Medi-Cal and Medicare.[22] The CCI was implemented in seven demonstration counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.[23] The IHSS provisions of the CCI were repealed in 2017, but some other aspects of the initiative continued.

The CCI shifted the IHSS employer of record role from the seven demonstration counties to the state through the creation of the California IHSS Statewide Authority, which collectively bargained over provider wages, benefits, and terms of employment.[24] The five-member Statewide Authority was composed of two county representatives, as well as representatives from the California Department of Social Services, the California Department of Health Care

Services (DHCS), and the California Department of Finance (DOF).[25] The IHSS Statewide Authority also appointed and oversaw a 13-member Advisory Committee with 50 percent recipient membership, along with providers, advocates, and union representatives. The Advisory Committee was tasked with providing recommendations for improving the IHSS program to the Statewide Authority and CDSS. This IHSS statewide bargaining process did not result in any changes in provider wages and benefits for the participating counties because no agreement was reached.

D. Note on Program Financing

The IHSS program is supported by federal, state, and county funding, and cost-sharing rules have a significant effect on IP wage bargaining. Federal funding is determined by a Medicaid reimbursement formula, called the Federal Medical Assistance Percentage (FMAP), currently averaging 54.7 percent across IHSS programs. There is no federal participation in the IHSS Residual program for people who do not qualify for federally funded services. The state and county share of IHSS costs is set by state statute. In addition, counties bear administrative costs in excess of state funding.

Since FY 2012-13, the division of non-federal costs between the state and counties has been based on a Maintenance of Effort (MOE) model in which counties' IHSS costs increase by a fixed annual inflation rate determined by state legislation. In addition to the annual inflation factor, counties' MOE payments also include a share of locally negotiated wage and benefit increases in excess of wage thresholds set by the state. Under the 2019 MOE policy, each county's MOE obligation grows by 4 percent annually, plus 35 percent of the increment of locally negotiated wages and benefits above the state minimum wage, up to a limit specified by statute.

Two key provisions of the MOE that significantly affect the IHSS IP wages analyzed in this report are the wage supplement and the "10 percent option." Since FY 2017-18, counties have been incentivized to negotiate wage supplements of up to $1.10 on top of the state minimum wage, and the state would pay for 65 percent of this wage supplement. Provider wages thus maintain, rather than lose, their relative value when the minimum wage increases. In addition, counties already at or above the $1.10 limit can increase wages and benefits by up to 10 percent over a three-year period, and the state would also cover 65 percent of the cost of this increase. This option was last extended by the state legislature in 2021, when it allowed counties to exercise this option for two three-year periods after the state minimum wage reached $15. The few counties that go above and beyond this limit to provide higher wages and more generous health benefits pay 100 percent of the difference.

At the same time, the California Constitution limits the state from imposing unfunded mandates on local government. Thus, County MOE is funded in large part by 1991 Realignment revenues, which consists of a portion of the state sales tax and Vehicle License Fee (VLF) revenue dedicated to counties to pay for certain social service and health programs, including IHSS. Both the MOE and revenue allocation rules for 1991 Realignment have been incrementally adjusted over time due to MOE growth outpacing Realignment revenue growth. Further details on MOE growth and 1991 Realignment are provided in **Section VI**.

Endnotes

1 This report is submitted in fulfillment of Agreement #23-3093 between the California Department of Social Services and the Regents of the University of California/UC Berkeley Center for Labor Research and Education (Labor Center). The authors would like to acknowledge Matt Newman and James Paci of Blue Sky Consulting, who contributed subsections B and C of the 1991 Realignment analysis in **Section VI**, including research on 2019 MOE, 1991 Realignment, and MOE/Realignment projection modeling; and Sarah Thomason of Movement Economics, who contributed data analysis consulting, research services, and chart design and report production services to this project. The views and opinions presented in this report are solely those of the authors and do not necessarily reflect the views of the University of California.

2 "California Department of Social Services, In-Home Supportive Services (IHSS) Program Data" (California Department of Social Services, July 2024), https://www.cdss.ca.gov/Portals/9/IHSS/Data/IHSS_Program_Data-Jun2024.xlsx.

3 Budget Act of 2023, Section 2.00, Item 180-001-0001—For support of State Department of Social Services, Provision 17.

4 Two counties, San Francisco and Contra Costa, provide services to some of their IHSS recipients through private home care agencies. This is called "Contract Mode."

5 "In-Home Supportive Services (IHSS) Program Data."

6 Hans Johnson, Marisol Cuellar Mejia, and Eric McGhee, "California's Population" (Public Policy Institute of California, January 2024), https://www.ppic.org/publication/californias-population/; California Department of Social Services, "In-Home Supportive Services (IHSS) Program Data."

7 California Department of Social Services, "In-Home Supportive Services (IHSS) Program Data."

8 California Department of Social Services, "In-Home Supportive Services (IHSS) Program Data."

9 California Department of Social Services, "In-Home Supportive Services (IHSS) Program Data."

10 Department of Health Care Services, "Do You Qualify for Medi-Cal Benefits?," accessed September 13, 2024, https://www.dhcs.ca.gov/services/medi-cal/Pages/DoYouQualifyForMedi-Cal.aspx.

11 From IHSS cost projection model results shared by CDSS, September 2024.

12 A small share of IHSS recipients have incomes that exceed Medi-Cal eligibility thresholds and fall under Share of Cost requirements; these recipients are required to pay providers the share of wages not covered by IHSS.

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II. IHSS Labor Market Analysis: Current Wages, Benefits, and Terms of Employment

In this section, we provide an overview of the IHSS workforce; describe outcomes of the current county-level collective bargaining model in terms of the wages, benefits, and key contract provisions; and outline the challenge of ensuring an adequate home care workforce to meet growing care needs in an aging California. This information is important for two reasons. First, it provides key outcomes of the status quo of county-based collective bargaining. Second, AB 102 calls for an analysis of the potential human impacts of different models of collective bargaining on workers and recipients, specifically in terms of provider turnover/retention and recipient access to care. An overview of current IHSS IP compensation and California's future IHSS workforce needs provides critical background and context for the turnover and retention research that will be reviewed in **Section IV**.

We first review workforce demographics (based on provider characteristics and payroll data provided by CDSS) and Census data on home care workers more broadly. We then summarize the health and non-health benefits offered to IPs in each county, including discussing the level of enrollment and contribution amounts, based primarily on our analysis of the current Memorandums of Understanding (MOUs) that have been negotiated between the unions and employers of record in 57 counties.[1] We also highlight common examples of terms of employment reflected in the MOUs. Finally, we examine the challenge of meeting rising demand for home care in California, given demographic changes, low wages (defined as less than two thirds of the median wage), and the state's public policy goal of providing access to long-term services and supports (LTSS) that will enable seniors to age in place.

A. Characteristics of IHSS Providers

In this section, we provide insights into the characteristics of IHSS providers. Key findings reveal that IHSS providers are predominantly female and frequently care for family members. Looking more broadly at Census data, women of color and foreign-born workers are overrepresented among home care workers in California.

Our analysis examines the demographic profile of active IHSS providers in California using data from the Case Management, Information, and Payrolling System (CMIPS) as of July 2024. CMIPS provides detailed insights into the demographics of IHSS providers and their earnings, though it is limited in capturing certain characteristics.

To broaden the demographic analysis, we supplement our analysis of CMIPS data with findings from the U.S. Census Bureau's American Community Survey (ACS) for the period 2018-2022, focusing on home care workers classified as "Personal Care Aides" working in the following industries: "Home Health Care Services," "Private Households," "Employment Services," "Other Health Care Services," "Individual and Family Services," and "Administration of Human Resource Programs." This dual-source approach allows for a comparison between the demographics of IHSS providers and the larger population of home care workers, as well as California's workforce as a whole.[2]

The CMIPS data (**Table 2.1**) show that about three in four IHSS providers are female (74.3 percent). Around one quarter of IHSS providers speak or write in a language other than English (26.3 percent and 24.1 percent, respectively), and six out of ten are 45 years or older (63.2 percent), with a median age of 51. Most providers care for one individual (79.6 percent). Seven out of ten providers care for a family member (72.1 percent; **Figure 2.1**). Adult children and parents (of adult or minor children) are the most common relative caregivers (**Table 2.1**).[3] The share of providers made up of relatives of recipients has steadily increased between 2017 and 2024, from 67.7 percent to 72.1 percent of all providers who reported service hours during the reference period (**Figure 2.1**). The number of relative providers grew by 30 percent between 2017 and 2023, from 335,000 to 467,000, while the number of non-relative providers grew by 15 percent, from 191,000 to 220,000 (**Figure 2.2**).[4] Finally, the CMIPS data show that median annual earnings for IHSS providers employed year-round in 2023 was $23,006.

We are unable to examine the race or ethnicity of IHSS providers using CMIPS data, as only about one quarter have this data attached to their record. Therefore, we supplement the analysis of CMIPS data using data from the ACS and show that more broadly, home care workers in California are predominantly women of color. About four out of ten home care workers are Hispanic (39.9 percent), two out of ten are Asian American/Pacific Islander (21.0 percent), and one in ten is Black (10.8 percent). Compared to the workforce as a whole, Black and Asian American/Pacific Islander workers are overrepresented in home care jobs. ACS data show that almost one half (48.3 percent) of home care workers are foreign-born (**Table 2.2**). The median age of home care workers in California is 51 years. Home care workers, including IHSS providers, are older than the workforce overall, where the median worker is 40 years old.

The ACS data also reveal other key socioeconomic characteristics of home care workers in the state. Home care workers are more than twice as likely to be in poverty compared to the rest of California's workforce, are more likely to work part-time, and are less likely to have completed a bachelor's degree or higher. Median annual earnings for home care workers employed

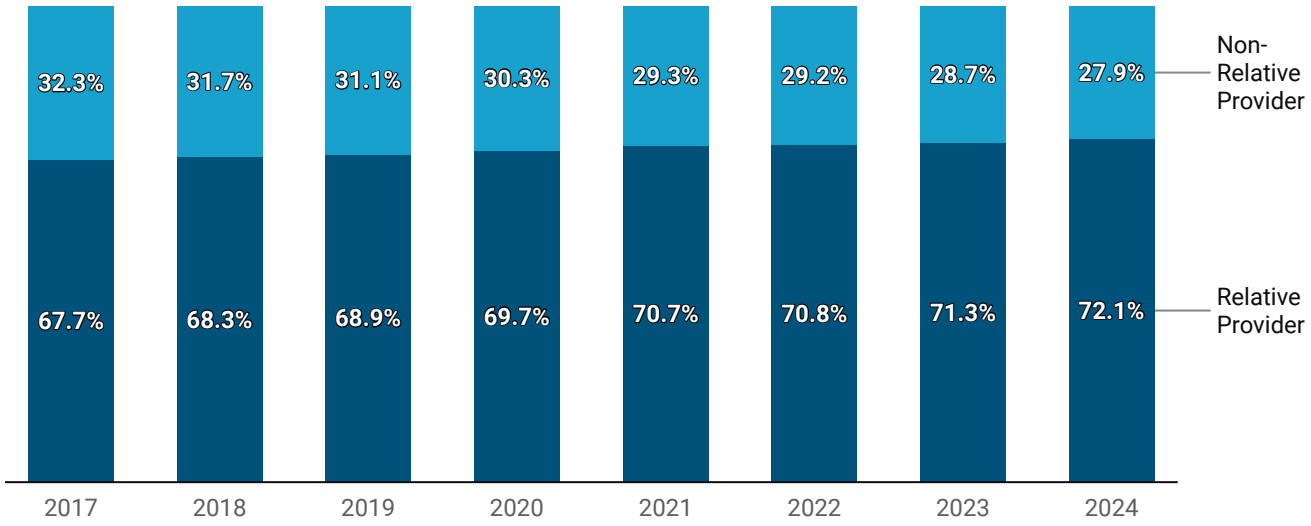
year-round was $23,951, compared to $57,484 for all workers in California. Comparing median annual earnings for IHSS providers from CMIPS data and home care workers in the ACS data show that home care workers earn less than half of what the median worker in California earns.

Table 2.1. Characteristics of IHSS Providers

Characteristic	Percentage
Gender	
Female	74.3%
Male	25.7%
Age (Median=51)	
18-24	4.1%
25-34	12.9%
35-44	19.8%
45-54	23.1%
55-64	24.4%
54-74	12.4%
75+	3.2%
Spoken Language	
English	70.6%
Spanish	12.8%
Other languages	13.6%
No data	3.1%
Written Language	
English	72.8%
Spanish	12.5%
Other languages	11.6%
No data	3.2%
Active Cases	
1	79.6%
2	16.9%
3 or more	3.5%
Relationship to Recipient	
Adult Child	37.6%
Parent	22.1%
Spouse / Domestic Partner	5.1%
Other Family	17.5%
Friend	6.9%
Other	36.4%
Median Annual Earnings (2023 dollars)	$23,006

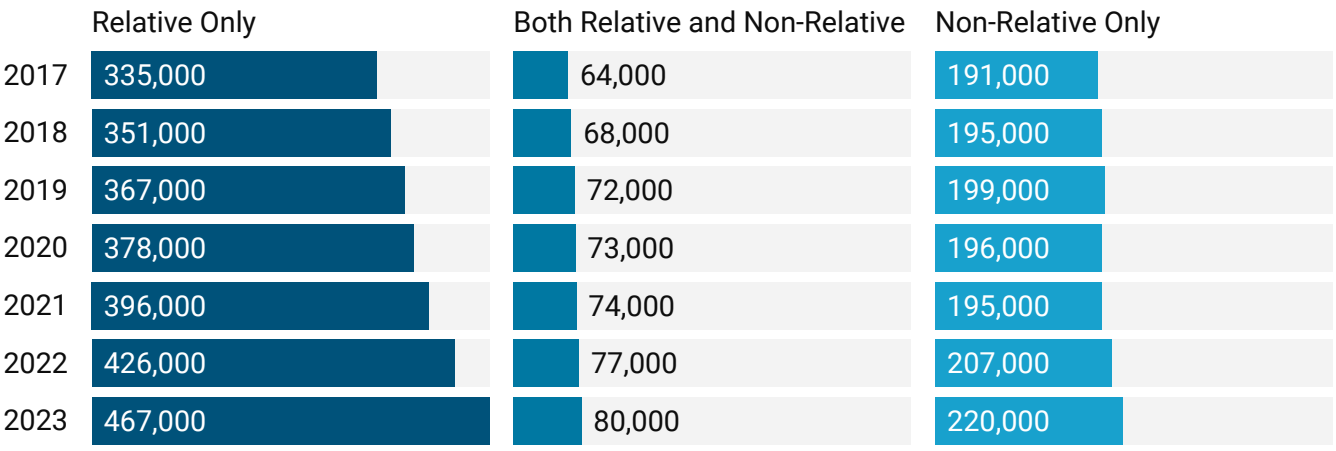
Note: UC Berkeley Labor Center analysis of CMIPS data from CDSS. Demographic characteristics represent a snapshot of active providers as of July 2024. Median annual earnings were calculated for providers employed year-round in 2023.

Figure 2.1. Share of Relative and Non-Relative IHSS Providers, 2017-2024



Note: UC Berkeley Labor Center analysis of CMIPS data from CDSS. Family providers in this chart include those who also work for non-family recipients. Data for 2024 is for the first half of the year.

Figure 2.2. Number of IHSS Providers, By Relationship to Recipient, 2017-2023



Note: UC Berkeley Labor Center analysis of CMIPS. Counts for each year include all providers who worked at any point during the year.

Table 2.2. Characteristics of California and U.S. Home Care Workers, 2018-2022

	California		United States	
	Home Care Workers	**All Workers**	**Home Care Workers**	**All Workers**
Gender				
Female	79.3%	45.8%	82.1%	47.5%
Male	20.7%	54.2%	17.9%	52.5%
Race/Ethnicity				
Hispanic	39.9%	38.5%	23.6%	17.8%
NH White	25.3%	35.8%	39.5%	60.4%
NH Asian American or Pacific Islander	21.0%	16.8%	9.9%	6.5%
NH Black	10.8%	5.1%	22.8%	11.6%
NH American Indian and Alaska Native	0.3%	0.2%	0.8%	0.4%
NH Multiracial/Other	2.7%	3.6%	3.3%	3.3%
Median Age	51	40	48	41
Age Group				
18-24	7.5%	11.7%	10.1%	12.4%
25-34	13.1%	24.9%	16.8%	23.0%
35-44	15.7%	22.5%	17.0%	21.6%
45-54	23.3%	20.2%	20.6%	20.3%
55-64	26.5%	15.5%	23.0%	16.9%
65-74	11.6%	4.4%	10.3%	5.0%
75+	2.3%	0.7%	2.2%	0.9%
Education				
Less Than High School	13.8%	7.1%	10.9%	4.9%
High School Diploma	43.1%	28.7%	47.9%	32.4%
Associate Degree/Some College	27.7%	24.3%	27.4%	24.6%
Bachelor's Degree	12.3%	24.9%	10.6%	23.8%
Graduate Degree	3.1%	15.0%	3.2%	14.4%
Nativity				
US Born	51.7%	66.2%	69.9%	81.7%
Foreign Born	48.3%	33.8%	30.1%	18.3%

continued

Table 2.2 continued

	California		United States	
	Home Care Workers	**All Workers**	**Home Care Workers**	**All Workers**
Language Spoken at Home				
English	41.0%	54.2%	63.9%	77.4%
Spanish	32.1%	29.0%	19.0%	13.6%
Filipino, Tagalog	7.2%	2.7%	2.8%	0.7%
Chinese	4.4%	3.6%	2.2%	1.2%
Vietnamese	2.9%	1.6%	1.1%	0.5%
Other Languages	12.4%	9.0%	10.7%	6.7%
Family Structure				
Married	43.7%	49.9%	38.8%	51.8%
Have Children at Home	50.2%	43.0%	46.9%	42.0%
Family Income Relative to Federal Poverty Level (FPL)				
<100% FPL	10.3%	4.8%	13.5%	5.3%
100-200% FPL	24.5%	10.8%	25.3%	11.1%
>200% FPL	65.2%	84.5%	61.2%	83.6%
Median Individual Annual Earnings (2023 Dollars)	$23,951	$57,484	$24,386	$53,184
Full-Time / Part-Time				
Full-Time (35+ Hours per Week)	50.5%	79.7%	54.5%	81.2%
Part-Time (Fewer than 35 Hours per Week)	49.5%	20.3%	45.5%	18.8%
Full-Year / Part-Year				
Full-Year (50-52 Weeks per Year)	87.0%	84.6%	82.0%	84.4%
Part-Year (Fewer than 50 Weeks per Year)	13.0%	15.4%	18.0%	15.6%
Health Insurance				
Covered by Employer-Sponsored Insurance (self or as dependent)	39.8%	69.8%	39.7%	72.4%
Covered by Publicly Funded Health Insurance (e.g., Medicaid)	50.5%	18.3%	43.5%	15.1%
Covered by Health Insurance From Any Source	91.2%	91.9%	85.7%	90.5%

Note: UC Berkeley Labor Center analysis of ACS 2018-2022 5-Year Sample. Sample includes employed workers (including self-employed) over the age of 18 with non-zero earnings who were not unpaid family members. Median individual annual earnings were calculated for workers employed year-round (50+ weeks) who were not self-employed and are in 2023 dollars.

B. Analysis of Wages

In this section, we analyze IHSS provider wages and benefits, first describing the wage floor in terms of the critical role of state and local minimum wage policies, the extent of social insurance coverage for providers, and variation in wages negotiated at the county level under the current system of collective bargaining.

State Minimum Wage and Hours Laws

Through collective bargaining, workers negotiate wages, benefits, and workplace rights above the minimum standards provided by laws and regulations. Legal minimum standards are especially salient to collective bargaining in sectors with low wages and benefits or with uneven coverage of legal labor standards; both conditions apply to IHSS.

State minimum wage. The state minimum wage serves as the foundation for IHSS provider wages, given that provider pay in most counties is at or slightly above the minimum. Currently, most county-level IHSS collective bargaining agreements provide workers with a supplement that is a specified amount above the state minimum wage; as a result, IHSS provider wages increase along with the minimum wage. The amount of the locally negotiated wage increase that the state helps to fund is limited by statute, which sets a de facto cap on wage increases negotiated by most counties, given the steep marginal cost of negotiating increases beyond this limit. At the same time, the state significantly increased its minimum wage between 2017 and 2022. Consequently, the state minimum wage accounted for most of the growth in IHSS provider wages during this period, and this portion of wage growth was covered by state and federal funds.

Compensation for travel and overtime. Since 2016, IHSS providers have been eligible for overtime pay for hours worked in excess of 40 hours in a week, under a 2013 U.S. Department of Labor rule related to the Fair Labor Standards Act and analogous state legislation in California.[5] These regulations also require payment for travel time between multiple recipients.

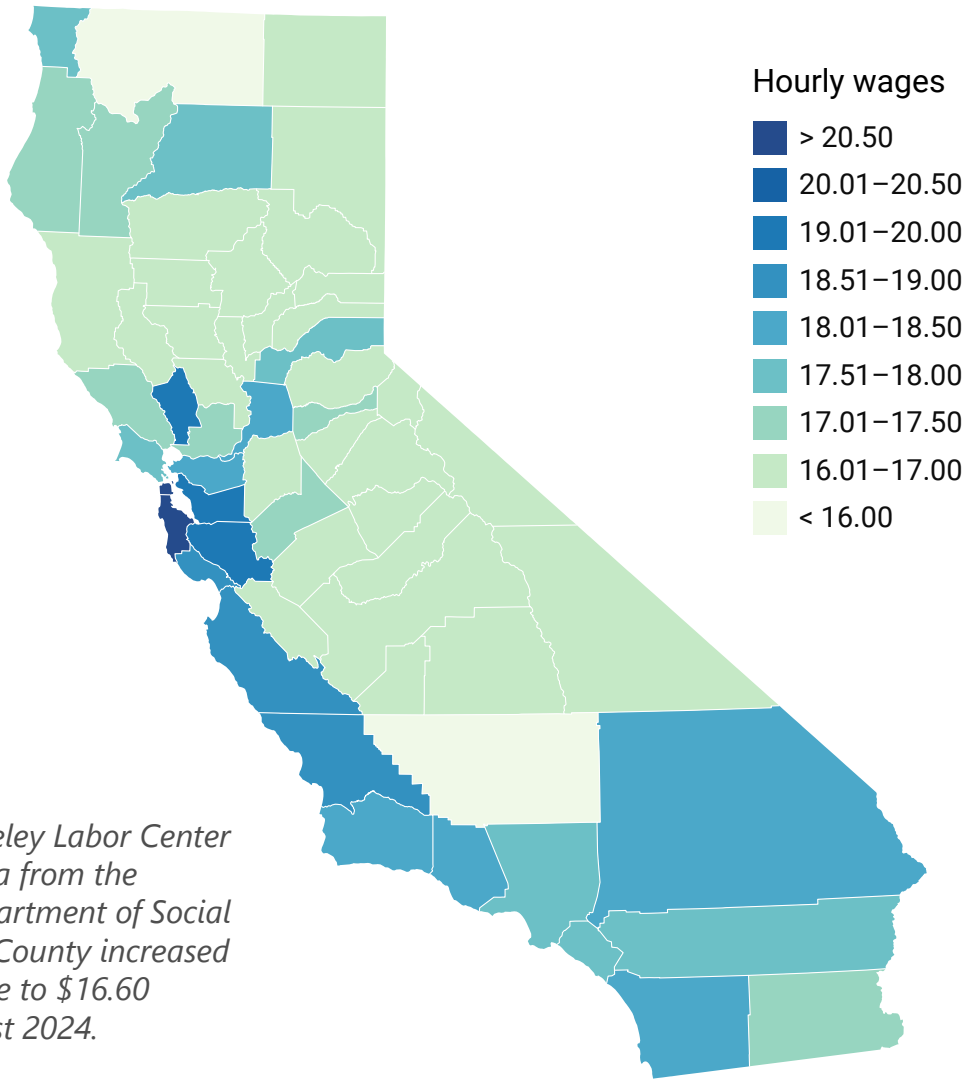
Current County Wages Compared to the Local Minimum Wage and Living Wage

This section explores the variation in IHSS provider wages across California counties and how these wages compare to local minimum wage rates and living cost estimates. This section also provides a detailed analysis of wage distribution.

IHSS provider wages and population sizes vary by county, so we calculated a weighted average wage based on each county's share of total paid provider hours. As of July 2024, the average weighted wage for IHSS providers was $18.13 per hour, with wages ranging from the state minimum of $16.00 to $21.50 **(Figure 2.3)**.

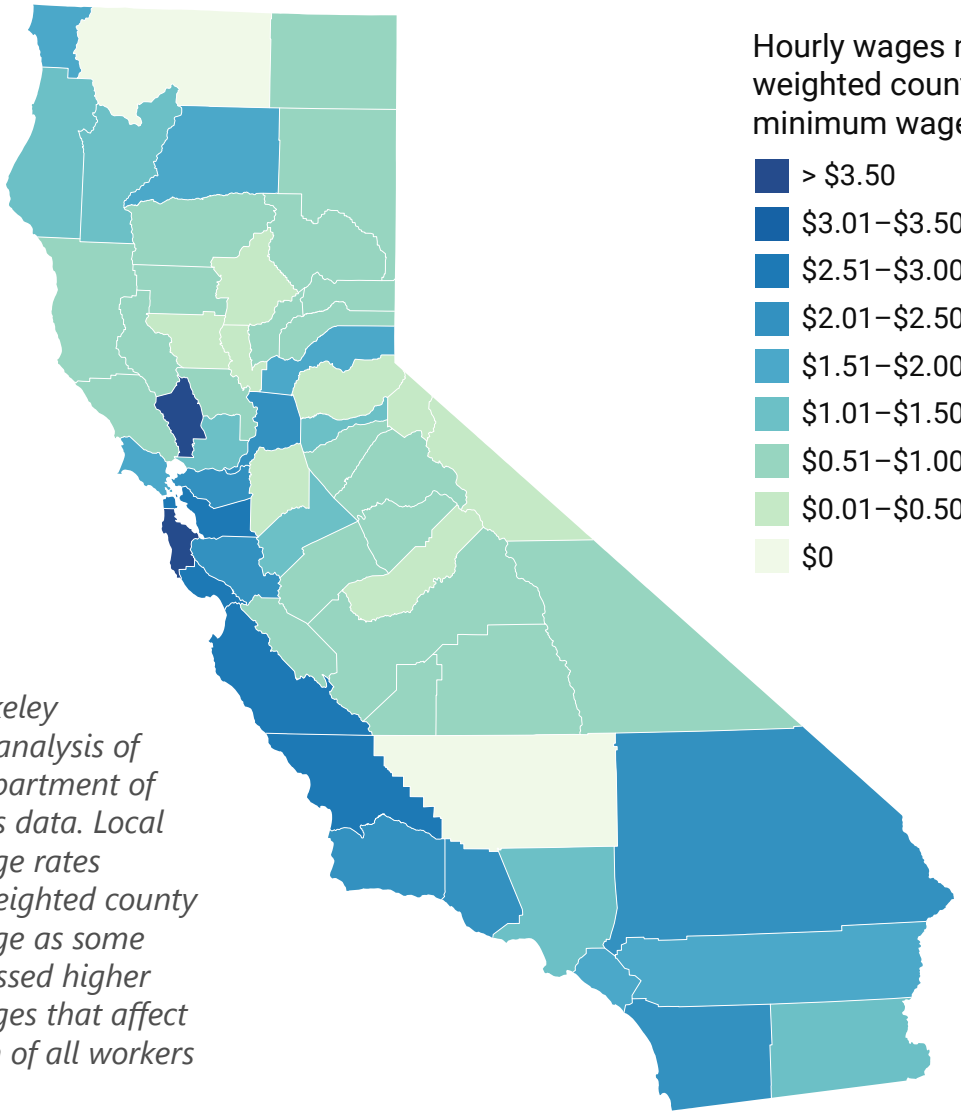
Over the past seven years, IHSS wages have risen alongside increases in the statewide minimum wage (see **Section V**). Though local minimum wage laws do not apply to IHSS workers, they strongly influence wage floors.[6] **Figure 2.4** highlights that IHSS providers earn between $0 and $4.00 above local minimum wage rates, with higher wages generally found in the Bay Area, coastal counties, and Southern California, which provide larger wage supplements to IHSS workers.

Figure 2.3. IHSS Provider Wage Rates, By County, July 2024



Note: UC Berkeley Labor Center analysis of data from the California Department of Social Services. Kern County increased its provider rate to $16.60 effective August 2024.

Figure 2.4. Difference Between IHSS Provider Wage and Local Minimum Wage Rate, By County, July 2024



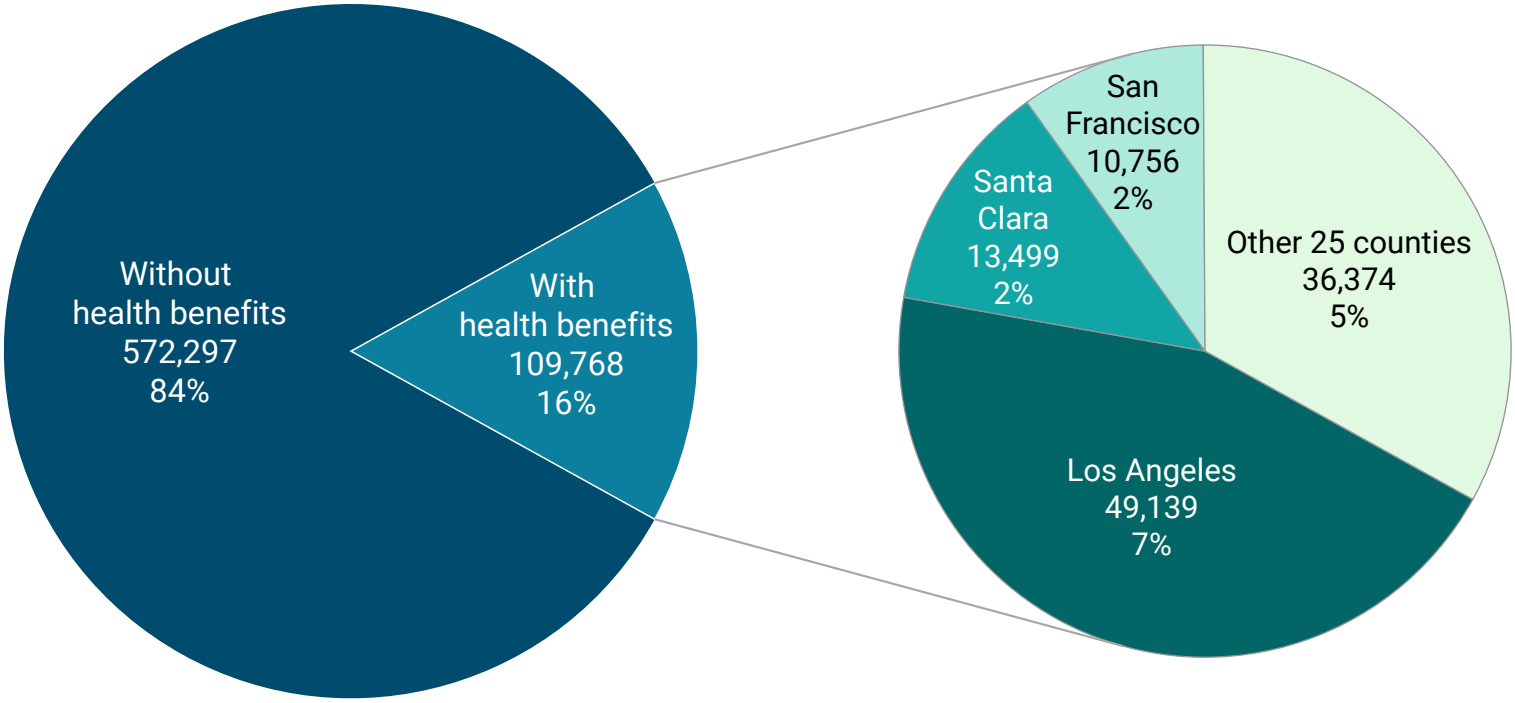
Note: UC Berkeley Labor Center analysis of California Department of Social Services data. Local minimum wage rates represent a weighted county minimum wage as some cities have passed higher minimum wages that affect only a portion of all workers in the county.

Based on the MIT Living Wage Calculator, which outlines the income needed to meet basic living expenses for different family sizes, no county currently provides wages sufficient to cover their county-specific costs for basic needs for even a single adult with no children. For California as a whole, the hourly wage needed to meet basic living expenses is $27.32 for a single adult with no children, $33.26 for two working adults with two children, and $47.96 for a single adult with one child.[7]

C. Health and Other Benefits

More than one half of California counties offer health benefits, dental, and/or vision to IHSS providers, with varying eligibility requirements, benefit levels, premium contribution requirements, and funding limitations. Health benefits are offered to at least some IHSS workers in 28 counties; nearly 110,000 providers, or 16 percent of all IHSS providers, receive these benefits. Two thirds (67 percent) of IHSS providers enrolled in health benefits work in Los Angeles, San Francisco, and Santa Clara Counties (**Figure 2.5**), all of which provide benefits through county-based health plans. In addition to counties offering health benefits, according to enrollment data, 34 counties offer dental benefits to some providers, and 32 counties offer vision benefits to some providers (**Table 2.3**).[8]

Figure 2.5. IHSS Providers Enrolled in Health Benefits, 2024



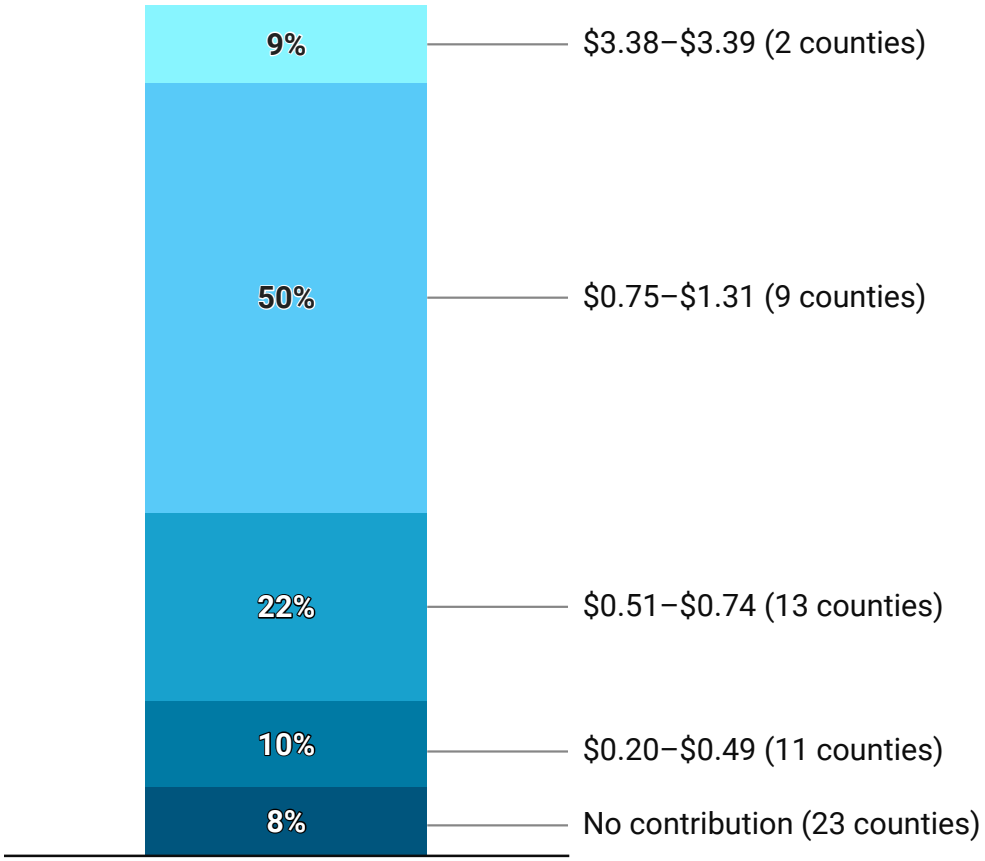
Note: UC Berkeley Labor Center analysis of California Department of Social Services data, August 2024.

Even though nearly one half of counties offer health benefits, fewer than two out of ten providers are enrolled. The share of providers enrolled is lower than the share of counties offering health benefits primarily due to eligibility requirements, wait lists, and providers having other sources of health coverage. In counties offering health benefits, hours requirements for

health benefits vary greatly: from 25 hours per month within two consecutive months in San Francisco to 80 hours per month within three months in multiple other counties.[9] Additionally, 13 counties have a provider waiting list for health benefits due to limited funding or limited slots for providers **(Table 2.3)**. Some IHSS providers may not enroll in benefits through their IHSS job because they have other coverage such as Medi-Cal, insurance through Covered California with federal premium subsidies, or coverage through a family member's job or their own second job. Approximately one half (50.5 percent) of California home care workers broadly reported having publicly funded health insurance in 2018-2022 **(Table 2.2)**.

In counties offering health benefits, the government contribution is funded by federal, state, and county dollars. Government contributions for health benefits vary from $0.20 to $0.49 per hour in 11 counties, to $3.38 to $3.39 per hour in two counties. The most common government contribution level is $0.75 to $1.31 per hour, which applies to 50 percent of IHSS providers working in nine counties **(Figure 2.6)**. Regardless of a provider's enrollment, these government contributions are made per paid hour towards a broader provider health benefits pool.

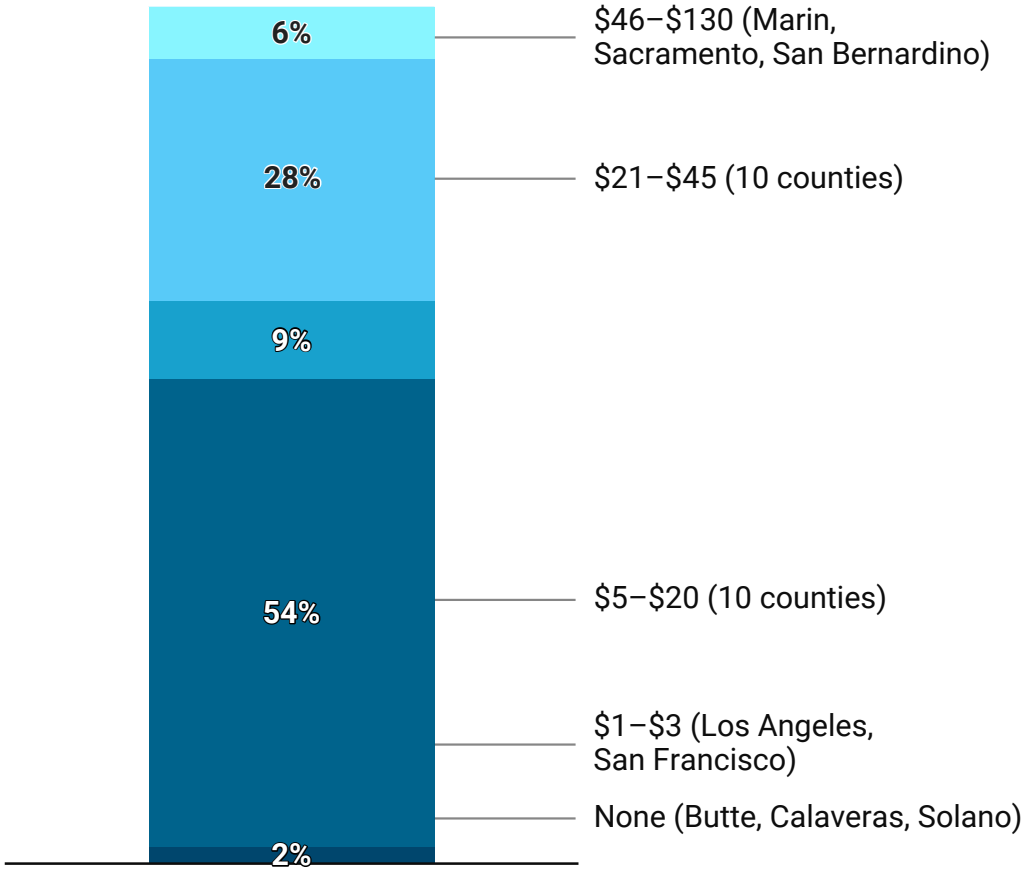
Figure 2.6. IHSS Providers, By Hourly Employer Contribution to Health, Dental, and Vision Benefits, 2024



Note: UC Berkeley Labor Center analysis of benefit data obtained from the California Department of Social Services. Percentages weighted by number of providers in each county.

Most counties require a provider premium contribution, which is made through payroll deduction. Provider contributions for health benefits vary from zero (in three counties) to $130 per month (in Marin County) **(Figure 2.7)**. Slightly more than one half (54 percent) of IHSS providers with health benefits contribute $1 to $3 per month and are located in Los Angeles and San Francisco Counties. County MOUs do not specify provider copays or deductibles, which vary by health plan.

Figure 2.7. IHSS Providers With Health Benefits, By Monthly Provider Contribution, 2024



Note: UC Berkeley Labor Center analysis of California Department of Social Services 2024 data, county MOUs, UDW insurance agency website, Health Care Employees/Employer Dental and Medical Trust website, Sacramento public authority website, and SEIU Local 2015 analysis (2024). Percentages weighted by number of providers enrolled in health benefits in each county.

Table 2.3. IHSS Provider Benefits, By County, 2024

County	Health Benefits	Dental Benefits	Vision Benefits	Providers on Waiting List (Health Benefits)	Hourly Employer Contributions to Health Benefits	Hourly Employer Contributions to Dental and Vision Benefits	Monthly Provider Contributions to Health Benefits
Alameda	5,550	5,550	5,550	—	$1.19	$0.00	$20.00-$45.00
Amador	22	22	22	—	$0.60	$0.00	$12.00
Butte	468	468	468	—	$0.60	$0.01	$0.00
Calaveras	47	47	47	—	$0.51	$0.01	$0.00
Contra Costa	2,271	2,271	2,271	—	$1.31	$0.40	$34.42
El Dorado	—	1,340	1,340	—	$0.20	$0.00	$0.00
Fresno	2,040	2,040	—	1,166	$0.85	$0.00	$18.00
Imperial	900	900	900	19	$0.43	$0.00	$20.00
Los Angeles	49,139	—	—	—	$0.92	$0.00	$1.00
Marin	156	171	154	13	$0.82	$0.00	$130.00
Monterey	714	—	—	16	$0.66	$0.00	$15.00
Napa	74	45	28	45	$0.40	$0.01	$40.00
Nevada	84	558	558	—	$0.60	$0.00	$5.00
Orange	4,353	4,353	4,353	74	$0.71	$0.03	$30.00
Placer	—	3,393	3,393	—	$0.20	$0.04	$0.00
Plumas	16	174	174	—	$0.60	$0.00	$5.00
Riverside	4,860	4,860	4,860	—	$0.71	$0.03	$30.00
Sacramento	3,108	3,108	3,108	1,732	$0.80	$0.00	$51.65
San Benito	—	702	700	—	$0.20	$0.00	$0.00
San Bernardino	2,945	—	—	296	$0.42	$0.01	$60.00
San Diego	4,151	4,547	4,151	252	$0.60	$0.03	$30.00
San Francisco	10,756	8,759	10,756	—	$3.38	$0.02	$3.00
San Joaquin	759	759	—	288	$0.70	$0.00	$25.00
San Luis Obispo	—	1,587	1,587	—	$0.20	$0.03	$0.00
San Mateo	1,243	1,320	1,320	28	$1.07	$0.01	$5.00
Santa Barbara	—	2,700	2,700	—	$0.20	$0.04	$0.00
Santa Clara	13,499	14,219	14,219	—	$3.39	$0.01	$25.00
Santa Cruz	330	330	330	—	$0.85	$0.00	$40.00

continued

Table 2.3 continued

County	Health Benefits	Dental Benefits	Vision Benefits	Providers on Waiting List (Health Benefits)	Hourly Employer Contributions to Health Benefits	Hourly Employer Contributions to Dental and Vision Benefits	Monthly Provider Contributions to Health Benefits
Sierra	6	23	23	—	$0.60	$0.00	$5.00
Solano	1,303	1,303	1,303	—	$0.55	$0.00	$0.00
Sonoma	682	709	682	64	$0.85	$0.13	$25.00
Stanislaus	—	4,953	4,953	—	$0.21	$0.00	$0.00
Sutter	—	765	765	—	$0.20	$0.00	$0.00
Yolo	218	218	218	109	$0.60	$0.00	$32.00
Yuba	74	74	74	—	$0.45	$0.00	$15.00
Statewide Total	**109,768**	**72,268**	**71,007**	**4,102**			

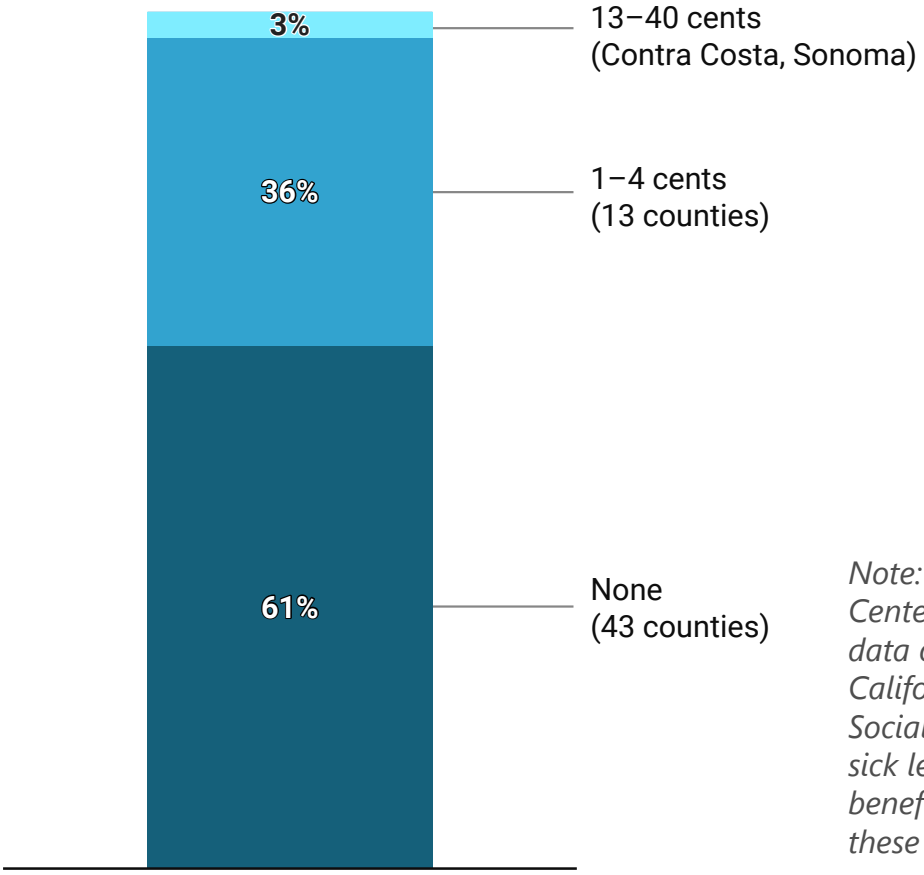
Note: UC Berkeley Labor Center analysis of DSS 2024 data, county MOUs, insurance agency website, health care trust website, public authority website, and SEIU Local 2015 analysis (2024).

IHSS providers in 48 counties are eligible for at least one non-health benefit such as personal protective equipment (PPE), life insurance, education and training, and transportation. IHSS Public Authorities in 15 counties make hourly contributions to non-health benefits for providers, with contributions ranging from $0.01 to $0.40 per hour **(Figure 2.8)**. IHSS Public Authorities in many other counties contribute a flat annual amount to their union trust to be used for various non-health benefits.

PPE is the most common non-health benefit, available in 42 counties. In these counties, the IHSS Public Authority and unions collaborate to distribute PPE to providers, and in some cases, the IHSS Public Authority reimburses providers who have already purchased PPE.

Many counties have a range of education and training benefits. In eight counties, the IHSS Public Authority allocates funding for and develops training plans for both providers and recipients. In three counties, incentive payments are offered to providers attending education or training programs. In Santa Clara County, the IHSS Public Authority provides a $500 tuition and textbook reimbursement, as well as reimbursement for pre-approved adult school classes for providers. In Mendocino County, the IHSS Public Authority provides the union with annual funding for health and safety training, such as CPR and basic first aid.

Figure 2.8. IHSS Providers, By MOU Hourly Contribution to Benefits Other Than Health, Dental, and Vision, 2024



Note: UC Berkeley Labor Center analysis of benefits data obtained from the California Department of Social Services. Statewide sick leave and workers comp benefits are not included in these hourly contributions.

Life insurance and pension benefits for IHSS providers are more limited across California counties. IHSS Public Authorities in seven counties offer life insurance programs for providers and, in some cases, their dependents. Contra Costa County is the only county to offer contributions to a union pension fund[10] on behalf of eligible providers who have worked 1,000 hours or more.

Six counties offer benefits to mitigate transportation costs: four counties (Monterey, San Benito, San Francisco, and Santa Clara) offer transit passes; and two counties (Marin and San Diego) offer transportation subsidies for providers who must travel outside of their home to provide services.

IHSS providers have access to additional benefits under state law or CDSS policy. All IHSS providers have workers' compensation to cover medical bills or disability compensation if they experience a qualifying injury or illness that occurs due to employment.[11] Additionally,

IHSS providers can make contributions to CalSavers, a Roth Individual Retirement Account that belongs to the provider. Beginning January 1, 2024, those who opt in can have their contributions deducted from their paychecks.[12] As of August 2024, approximately 500 providers had enrolled in this option.[13]

As of July 2024, eligible IHSS providers accrue up to five days of sick leave per year under SB 616.[14] Sick leave accrual begins once providers have worked 100 hours after their start date, and providers can use their sick leave after providing IHSS services for an additional 200 hours or more than 60 calendar days from the date of sick leave accrual, whichever comes first.[15] According to CDSS projections, nearly 700,000 providers will accrue sick leave in FY 2024-25, and more than 369,000 providers will use the accrued sick leave. The current sick leave policy has been expanded since IHSS providers began to accrue paid sick leave on July 1, 2018, under SB 3 (2016),[16] beginning with one day accrued per year in 2018, growing to two days in 2020, and three days in 2023.

D. Terms of Employment

County MOUs contain a variety of terms of employment that relate to recipient and provider rights and policies and procedures with implications for IHSS Public Authorities and county responsibilities, such as registry administration, in addition to terms related to having a union. Some terms of employment specified in MOUs mirror requirements in existing law. Inclusion of terms in an MOU means that parties now have a contractual obligation to conform to them and have recourse to dispute resolution procedures in the context of the collective bargaining relationship, in addition to the right to pursue enforcement in court or through an enforcement agency where the law allows.[17] Additionally, the inclusion of certain legal requirements in MOUs can inform and provide clarity for providers and IHSS Public Authority staff about existing rights.

MOUs also specify certain recipient, provider, and management rights, as well as non-discrimination policies. Forty-seven county MOUs include provisions related to recipient rights required by law,[18] which affirm recipients' right to hire, train, terminate, and supervise providers, as well as protect recipient confidentiality. Additionally, nine county MOUs include articles on provider rights, which give providers the right to decline or terminate employment at any time for any reason and represent themselves in employee relations with the IHSS Public Authority. Forty counties include provisions on IHSS Public Authority/management rights, which state that the IHSS Public Authority determines methods and means for efficient operations, completes duties in emergencies, and has access to add or delete names from the registry.

Non-discrimination articles are also included in 52 MOUs, as state law requires bargaining in reference to non-discrimination statutes if either the employer or union initiates it. Most non-discrimination articles prohibit the IHSS Public Authority and union from discriminating against providers based on protected classes and union participation, reflecting existing state and federal laws. Some non-discrimination articles also encourage recipients to refrain from discrimination against providers. IHSS recipients employing fewer than 15 employees are exempt from federal employment discrimination laws, such as Title VII of the Civil Rights Act of 1964 and Americans with Disabilities Act. IHSS recipients employing fewer than 5 employees are likewise exempt from state employment discrimination laws, such as the California Fair Employment and Housing Act.

Some terms of employment have more direct implications for IHSS Public Authorities or county administrations. In 43 counties, MOUs have payment and payroll procedures that clarify timesheet and direct deposit procedures and require the IHSS Public Authority to assist providers with payroll issues. Under state law, all counties must administer a back-up provider system with a $2 hourly wage differential,[19] but in four counties, MOUs have articles that recognize back-up provider systems as necessary for paid sick leave and require that back-up providers be paid a higher wage. In 52 counties, MOUs include articles addressing the legal requirement[20] that IHSS Public Authorities maintain a registry of providers to aid recipients' search and selection of a provider. Some MOUs specify that the IHSS Public Authority has authority to list, suspend, or remove providers for reasons such as abuse, theft, and misrepresentation. Most MOUs have an appeal process for providers excluded or removed from the registry.

Other common MOU articles address union recognition, grievance procedures, IHSS Public Authority compensation for union activities, no strike, no lockout clauses, and more. Many MOUs include other terms of employment related to mutual respect, provider responsibility, and a two-weeks separation notice.

E. Home Care Labor Supply Challenges in California

The home care industry in California is facing significant supply and demand challenges as it continues to expand rapidly, driven by the aging population and a shift from expensive nursing home care to more affordable home-based care.[21] The number of individuals over age 65 in California is expected to increase 19 percent from 7 million in 2024 to 8.4 million by 2032. More importantly, the 65+ population is getting older. The number of individuals over 80 years old will increase by 50 percent by 2032. These older age groups are more likely to need care, leading to a surge in demand for home care services.[22] However, the industry is

already struggling to meet existing needs, with many individuals unable to access necessary care. Given these trends, the state faces a projected shortage of between 600,000 and 3 million direct care workers, reflecting significant uncertainty in how the workforce will expand to meet rising demand.[23] This shortfall could have serious implications for the quality, affordability, and accessibility of care services across the state.

Major obstacles to meeting this growing demand are the low wages and benefits of home care jobs. In 2023, the median wage for California home care workers was $16.12 per hour, significantly below the median wage for all workers in the state.[24] Studies find that home care workers make less than other entry-level and service jobs.[25] Two out of every three personal care workers are in low-wage jobs, with many living in poverty.[26] Compounding this issue, home care jobs offer few benefits, with only four in ten California home care workers receiving health insurance through their own job or a family member's job, compared to seven out of ten California workers overall who have employer-provided health insurance (**Table 2.2**). As discussed earlier in this section, only 16 percent of IHSS providers have health benefits through their IHSS jobs (**Figure 2.5**). As a result, a significant portion of home care workers must rely on public support programs to make ends meet, adding to the financial burden on the state.[27]

The consequences of low wages and poor job conditions extend beyond workers, affecting recipients and the public. With 28 percent of non-relative IHSS providers leaving their jobs annually, high turnover rates force many recipients to repeatedly search for and train new providers, which disrupts their care. This trend creates increasing strain on recipients who struggle to find adequate care and face the risk of negative health outcomes, such as missed meals, dehydration, or medication errors.[28]

The share of authorized IHSS cases with paid hours and the share of authorized hours being paid have both declined in recent years, which may be indicators of a worker shortage. Analysis by the California Legislative Analyst's Office (LAO) found that the percentage of authorized cases with claimed hours each month decreased slightly after the COVID-19 pandemic began, from 91 percent in January 2019 to 88 percent in December 2023. The LAO found a similar decline in the percentage of authorized hours claimed during the same time period, from about 96 percent to about 94 percent.[29] While multiple factors contribute to authorized hours not being used or fully used,[30] a shortage of workers is likely at least one significant contributing factor.

The growing demand for home care, coupled with challenges in worker retention and recruitment driven by low wages and benefits, has negative ramifications for the well-being of the elderly and individuals with disabilities, as well as the state budget. If the home care system is unable to meet demand, more individuals may need to turn to nursing homes for care, which is far costlier. There is a broad consensus among researchers, stakeholders, and policy experts that this crisis will require improving wages and job conditions for home care workers to ensure that both the workforce and recipients receive the support they need.[31]

Endnotes

1 No MOU has been negotiated in Siskiyou County.

2 The Case Management, Information, and Payrolling System (CMIPS) includes administrative data on the entire IHSS provider workforce but is limited in capturing certain characteristics such as race and ethnicity. The U.S. Census Bureau's American Community Survey (ACS) enables an analysis of race and ethnicity, among other characteristics, but like other nationally representative surveys undercounts home care workers including IHSS providers. Research suggests that undercounting may be attributed to lower survey participation rates by immigrant workers and workers employed outside a traditional employer–employee arrangement, as well as survey construction that asks workers about their primary job as opposed to all jobs, see Asha Banerjee et al., "Domestic Workers Chartbook 2022" (Economic Policy Institute, 2022), https://www.epi.org/publication/domestic-workers-chartbook-2022/; and Candace Howes, "Raising Wages for Home Care Workers: Paths and Impediments," Fair Labor Standards Act (FLSA) Working Paper Series (Department of Labor | Institute for Research on Labor and Employment, February 25, 2014), https://www.dol.gov/sites/dolgov/files/OASP/legacy/files/FLSAPaperSeries.pdf. We estimate that about 71 percent of all Home Health and Personal Care Aides employed in California are IHSS. For a similar estimate, see California Legislative Analyst's Office, "California's Low-Wage Workers and Minimum Wage," March 11, 2024, https://lao.ca.gov/Publications/Report/4878/4. We also estimate that the ACS captures about 54 percent of the total Home Health and Personal Care Aides population reported by the Bureau of Labor Statistics Occupational Employment and Wage Statistics (OEWS) program. While this estimate represents a significant undercount, the ACS provides useful data on the demographics of home care workers, the majority of whom in California work for the IHSS program.

3 The table shows the share of providers with different types of relationships to recipients. Providers may work for multiple recipients and thus have multiple types of relationships. The table calculates the share by taking the number of all active providers of each relationship type (including providers with multiple relationships) divided by the number of unique (unduplicated) active providers. Thus, the sum of percentages in the table will exceed 100 percent. In **Figure 2.1**, we report that 72.1 percent of providers are relative caregivers in the first six months of CY 2024. This estimate was calculated as active relative providers divided by of all active providers. A small percentage of relative providers also care for non-relative recipients.

4 Data for 2024 are excluded from this analysis because using partial year data would have skewed the provider count downwards.

5 California Department of Social Services, "All County Welfare Directors Letter 16-01 Reinstatement of Implementation of Provisions of Senate Bills 855 and 783 (Chapters 29 and 685, Statutes of 2014) Relating to the IHSS and Waiver Personal Care Services Programs," January 7, 2016, https://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2016/16-01.pdf.

6 San Francisco and Marin County cover IHSS workers in their living wage policies, which set floors higher than the minimum wage. "Minimum Compensation Ordinance," San Francisco Labor and Employment Code § 111.2, accessed September 22, 2024, https://codelibrary.amlegal.com/codes/san_francisco/latest/sf_laboremployment/0-0-0-2213; "Living Wage," Title 2-Administration and Personnel Marin County Municipal Code § Chapter 2.50 Living Wage, accessed September 22, 2024, https://library.municode.com/ca/marin_county/codes/municipal_code?nodeId=TIT2ADPE_CH2.50LIWA.

7 Massachusetts Institute of Technology, "Living Wage Calculator," February 14, 2024, https://livingwage.mit.edu/.

8 No enrollment is reported in **Table 2.3** for two counties with dental coverage: Los Angeles County, where a union dental benefit is offered, and San Bernardino County. Additionally, San Bernardino and San Joaquin counties offer vision benefits, but no enrollment was reported.

9 Recipients were approved for an average of 117 monthly hours in July 2024, suggesting that many IHSS providers likely meet even the most stringent hours requirements. "In-Home Supportive Services (IHSS) Program Data" (California Department of Social Services, July 2024), https://www.cdss.ca.gov/Portals/9/IHSS/Data/IHSS_Program_Data-Jun2024.xlsx.

10 SEIU Benefit Funds, "SEIU National Industry Pension Fund," accessed September 20, 2024, https://www.seiufunds.org/funds/nipf.

11 California Department of Social Services, "In-Home Supportive Services - Guide to Workers' Compensation Benefits for Individual Providers," January 2004, https://www.cdss.ca.gov/cdssweb/entres/forms/english/pub203.pdf.

12 "IHSS Provider Resources," accessed October 26, 2024, https://www.cdss.ca.gov/inforesources/cdss-programs/ihss/ihss-provider-resources.

13 IHSS CalSavers enrollment data obtained from the California Department of Social Services, August 2024.

14 "SB 616 - Sick Days: Paid Sick Days Accrual and Use" (2023), 616, https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB616.

15 California Department of Social Services, "Sick Leave," accessed September 4, 2024, https://www.cdss.ca.gov/inforesources/ihss-providers/resources/sick-leave.

16 "SB 3 - Minimum Wage: In-Home Supportive Services: Paid Sick Days" (2016), 3, https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB3.

17 Under California law, public sector contracts cannot supplant workers' right to civil rights enforcement through the courts or enforcement agencies. The authors appreciate the assistance of Felix de la Torre, General Counsel at the California Public Employment Relations Board, for clarifying these issues. However, any inaccuracies are solely the responsibility of the authors.

18 Welf. & Inst. Code § 12301.6(c).

19 Welf. & Inst. Code § 12300.6.

20 Welf. & Inst. Code § 12301.6(e).

21 Many of the issues highlighted in this section were previously raised in a UC Berkeley Labor Center 2017 report: Sarah Thomason and Annette Bernhardt, "California's Homecare Crisis: Raising Wages Is Key to the Solution" (UC Berkeley Labor Center, 2017), https://laborcenter.berkeley.edu/pdf/2017/Californias-Homecare-Crisis.pdf.

22 "P-1: State Population Projections (2020-2060)" (Department of Finance, Demographic Research Unit, 2024), https://dof.ca.gov/forecasting/demographics/projections/.

23 Lauren Hunt, Jarmin Yeh, and Margaret Fix, "California's Direct Care Workforce: Who They Are, the Work They Do, and Why It Matters," CHCF Issue Brief (California Health Care Foundation, 2023), https://www.chcf.org/wp-content/uploads/2022/12/CaliforniaDirectCareWorkforce.pdf.

24 "California - May 2023 OEWS State Occupational Employment and Wage Estimates," Bureau of Labor Statistics, accessed September 26, 2024, https://www.bls.gov/oes/current/oes_ca.htm.

25 O. Khavjou, G. Suarez, D. Tyler, M. Squillace, J. Dey, and I. Oliveira, "Wage of Direct Care Workers Lower Than Other Entry-Level Jobs in Most States" (Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, August 2023), https://aspe.hhs.gov/sites/default/files/documents/7a611d901c615e5611ea095b1dcf8d08/wages-dcw-lower-ib.pdf; Ruth Milkman, "Stratification Among In-Home Care Workers in the United States," *Critical Sociology* 49, no. 1 (2023):11–22, doi: 10.1177/08969205221123034.

26 "Low-Wage Work in California Data Explorer 2024 - UC Berkeley Labor Center," accessed September 26, 2024, https://laborcenter.berkeley.edu/low-wage-work-in-california-data-explorer-2024/#s-6.data

27 Kezia Scales and Lina Stepick, "Understanding the Direct Care Workforce," PHI, 2024, https://www.phinational.org/policy-research/key-facts-faq/.

28 Meghan Jenkins Morales and Stephanie A Robert, "Examining Consequences Related to Unmet Care Needs Across the Long-Term Care Continuum," *The Journals of Gerontology: Series B 77*, no. Supplement_1 (May 1, 2022): S63–73, https://doi.org/10.1093/geronb/gbab210.

29 California Legislative Analyst's Office, "The 2024-25 Budget: In-Home Supportive Services," accessed August 26, 2024, https://lao.ca.gov/Publications/Report/4868.

30 One example of another reason hours could remain unused is if a recipient were hospitalized during a particular month.

31 One of the five goals of the California Master Plan on Aging (MPA) is to provide "Caregiving that Works," including a strategy of "Good Caregiving Jobs Creation": "The caregiving workforce can be grown through caregiver training and professional development opportunities, along with livable wages, job placement support, and improved job quality. Higher wages will help paid caregivers work toward financial security, alleviate economic disparities, and better reflect the true value of their work." In addition, the MPA LTSS Stakeholder Recommendations Final Report emphasizes low wages and benefits as a key contributor to the care labor crisis. "Master Plan for Aging," accessed August 23, 2024, https://mpa.aging.ca.gov/Goals/4/; Master Plan for Aging LTSS Stakeholder Committee, "Master Plan for Aging Long Term Services and Supports Subcommittee Stakeholder Report," May 2020, https://cdn-west-prod-chhs-01.dsh.ca.gov/chhs/uploads/2020/05/MPA-LTSS-Subcommittee-Report_FINAL-May-2020.pdf.

III. Home Care IP Collective in Other States

In this section, we summarize our research on statewide home care bargaining in other states. We highlight key population differences between California and other states and identify relevant home care Individual Provider programs in other states. We also examine roles in bargaining structures in other states, including recipients' roles in bargaining. Lastly, we compare wages and benefits in other states and summarize interviewee feedback on opportunities, limitations, and job quality standards achieved through statewide bargaining.

A. Background

At least six other states with Medicaid-funded consumer-directed home care programs have statewide collective bargaining and union-represented IPs: Connecticut, Illinois, Massachusetts, Minnesota, Oregon, and Washington. We did not find any states with regional bargaining models. We conducted research to understand the roles of state agencies and other employers of record, unions, and recipients in the statewide bargaining processes; the benefits and challenges of their bargaining structures; the topics bargained; and the job quality standards achieved in these six states. Our research methodology included reviewing collective bargaining agreements, government websites, news articles, and relevant statutes and legislation. Research also included conducting key informant interviews with union representatives[1] in all six states and with government representatives[2] in Connecticut, Massachusetts, Minnesota, Oregon, and Washington. We focused on consumer-directed models in each state, although many of the examined programs include both IP and other models.

While Connecticut, Illinois, Massachusetts, Minnesota, Oregon, and Washington serve as useful examples of how statewide bargaining can be structured, they have a number of key differences with California. First, several home care programs in other states have enrollment caps, while the California IHSS program does not.[3] Additionally, the IHSS program is orders of magnitude larger than the home care programs in the six other states. California's IHSS program serves more than 700,000 recipients, while home care programs in the other researched states serve between 8,800 to 47,000 recipients each (**Table 3.1**).[4] This difference is not only a reflection of California's much larger population, but also of the fact that among all 50 states, California has the highest prevalence of consumer-directed care per 1,000 adults with disabilities (**Table 3.2**).

Table 3.1. Individual Provider Home Care Programs in Other States and Total Number of Recipients

State	Programs With Individual Providers	Total Recipients With Individual Providers (2024 unless otherwise noted)
Connecticut	Community First Choice and various home and community-based service waivers administered by the Departments of Social Services (DSS) and Developmental Services (DDS).	8,800 (in 2021)
Illinois	Home Services Program, Developmental Disabilities Program	32,000
Oregon	Home and community-based services programs for mental health, aging, persons with disabilities, and individuals with developmental disabilities	27,000 total recipients, majority with IPs
Massachusetts	Personal Care Attendant Program	Over 40,000
Minnesota	Personal Care Assistance Choice, Consumer-Directed Community Support Waiver, Consumer Support Grant, Community First Services and Supports	20,000
Washington	Medicaid Personal Care Program, Community First Choice Program, 1915(c) Waiver Programs, Program for All-Inclusive Care for the Elderly	47,000

Note: Data from interviews with union and government representatives (2024), public data, and news articles. Many programs listed have additional non-Individual Provider models.

Table 3.2. Prevalence of Consumer-Directed Care in Researched States, 2023

State	Number of Self-Directing Participants Per 1,000 Adults With Disabilities	Rank Among 50 States
California	168	1
Minnesota	64	2
Massachusetts	61	4
Washington	61	5
Oregon	47	10
Illinois	29	14
Connecticut	16	25

Note: Data from AARP, "Self-Directed Program Enrollment | Long-Term Services and Supports 2023 State Scorecard," May 28, 2024, https://ltsschoices.aarp.org/scorecard-report/2023/dimensions-and-indicators/self-directed-program-enrollment.

Another key difference is that California's IHSS program is administered by counties and funded with a mix of federal, state, and county dollars. In contrast, the home care programs in the six other states solely rely on federal and state funding and have a limited local role in program administration, which includes determining recipient eligibility, conducting recipient assessment, and/or providing case management services. Some home care programs in Connecticut,[5] Minnesota,[6] Oregon,[7] and Washington[8] have certain local administrative roles performed by state employees in local offices, staff of Area Agencies on Aging, county staff, or others, depending on the state and program.[9] Home care programs in Illinois and Massachusetts have no local administrative role.

Bargaining Structures in Other States

While the six states in our analysis all have statewide collective bargaining systems, the specific structures vary significantly, including who sits on the employer side of the bargaining table and which entity serves as the employer of record for bargaining purposes. Unless otherwise noted, the union side of the bargaining table solely includes union members and staff.

The union bargains directly with one or more state agencies in two states. First, SEIU Healthcare Illinois bargains with the Departments of Central Management Services and Human Services.[10] In some bargaining sessions, the governor's staff also sit at the bargaining table.[11] Second, SEIU Healthcare Minnesota & Iowa bargains with Minnesota Management and Budget.[12] The Department of Human Services also sits on the employer side of the table. The union bargaining team generally has between 12 and 14 members, including two to three bargaining team members who are clients or responsible parties.[13]

Three states have home care workforce councils or commissions made up of recipient and state representatives that act as the employer of record for bargaining purposes and are involved in all topics of bargaining. These councils and commissions are also typically involved in developing registries, overseeing recruitment and retention initiatives, and developing training programs to support the workforce. These councils and commissions provide a structure for incorporating recipient voices into the bargaining process, though the ways in which recipients participate varies among these three states.

In Connecticut, SEIU 1199NE bargains with the Office of Labor Relations, which represents the Personal Care Attendant Workforce Council.[14] The council includes nine representatives of consumer organizations (seven of which are filled) and four representatives from four state agencies. Additionally, a subcommittee of council members, including two representatives of consumer organizations, sits on the employer side of the bargaining table.[15] The council lies within the executive branch of government and is administered by the Connecticut Department of Social Services.[16]

In Oregon, SEIU Local 503 bargains with the Department of Administrative Services, which represents the Oregon Home Care Commission. The commission includes five "consumer-employers" (four of which were filled as of September 2024) and four representatives from four state agencies.[17] In addition to the Department of Administrative Services, the employer side of the table usually includes labor relations staff, the director of the Oregon Home Care Commission, and representatives of the three Medicaid home care programs in the state. In addition, recipients sometimes testify on the union side of the bargaining table.[18] The commission is a semi-independent state agency in the Oregon Department of Human Services.[19]

In Massachusetts, 1199SEIU United Healthcare Workers East bargains with the Personal Care Attendant Workforce Council. The council includes ten "consumer representatives" and two representatives from two state agencies.[20] Typically, the Executive Director of the council, the Chair of the council, two to three "consumer representatives" from the council, and MassHealth (Medicaid/CHIP) representatives sit on the employer side of the bargaining table.[21] The council is part of the Executive Office of Health and Human Services (EOHHS), but is not subject to control from the EOHHS under statute.[22]

Washington has a unique model in which SEIU 775 bargains with Consumer Direct Care Network, a private vendor contracted by the Washington Department of Social and Health Services to serve as the employer for IPs.[23] Under this "agency with choice" model, recipients retain the power to recruit, supervise, and terminate their providers. Providers are legally private-sector employees with collective bargaining rights under the NLRA. Prior to bargaining, a vendor rate is set by a Consumer Directed Employer Rate Setting Board during publicly held meetings. The Rate Setting Board has five voting members, including two state representatives,[24] one employer representative, one union representative, a fifth member chosen by the preceding four members, and up to nine advisory members, including one representative from the State Council on Aging and two representatives of organizations representing people with disabilities.[25]

In California and most of the other states researched, the state legislature and governor play an important role in home care bargaining, even if not formally at the bargaining table, given that they play a key role in determining program budgets.[26] In Washington, however, the Consumer Directed Employer Rate Setting Board, which meets publicly, plays a formal role in recommending a vendor rate to the Governor's Office, which then assesses the financial viability of the proposed rate. Once the Governor's Office assesses financial viability and adds the board's recommendation to the proposed budget, the legislature makes the appropriation decision.[27]

B. Topics of Bargaining and Standards Achieved in Other States

In the other states examined, statewide bargaining applies to all topics of bargaining: wages; benefits; and terms of employment.

Starting wages in the other states researched were generally higher than those of IHSS providers in California. By January 1, 2025, starting home care wages in five out of the six other states researched (Connecticut, Oregon, Massachusetts, Minnesota, Washington) will be higher than wages for the vast majority of California IHSS providers (**Table 3.3**).[28] Starting wages in these five states range from $18.25 to $21.50. In California, wages are scheduled to be less than $19.50 on January 1, 2025, for the approximately 86 percent of IHSS providers who work outside of Alameda, Napa, San Francisco, San Mateo, and Santa Clara Counties.[29] The higher wages in other states primarily reflect differences in bargained wage levels, given that all but one of these states have minimum wages that are lower than California's minimum wage.

In four of these states, many providers have the opportunity to earn more than these starting wages due to hourly wage differentials based on experience, client characteristics, and level of need, training, or certification completion. For example, five states offer hourly wages above the starting wage if providers meet certain thresholds for longevity or cumulative hours worked, with a maximum ranging from an additional $2.40 to $4.00 per hour, depending on the state.

Table 3.3. Individual Provider Wages in Other States Compared to State Minimum Wage and Estimated Living Wage

	Individual Provider Wages		Points of Comparison	
State	**Starting Hourly Wage as of 1/2025**	**Differential Hourly Wages**	**State Min. Hourly Wage (2025)**	**Est. Hourly Living Wage (1 adult, 0 children, 2024)**
California	$16.50–$22.50 depending on county	None	$16.50	$27.32
Connecticut	$21.50	None	$16.42	$24.13
Illinois	$18.25	• Up to $4 based on longevity	$15.00	$22.86

continued

Table 3.3 continued

	Individual Provider Wages		Points of Comparison	
State	**Starting Hourly Wage as of 1/2025**	**Differential Hourly Wages**	**State Min. Hourly Wage (2025)**	**Est. Hourly Living Wage (1 adult, 0 children, 2024)**
Massachusetts	$19.50	• Up to $2.40 (effective April 1, 2025) depending on step based on cumulative hours worked • Additional $3.25 (effective January 2026) for providers working with consumers with more complex needs	$15.00	$27.89
Minnesota	$20.00	• Up to $2.50 depending on step based on cumulative hours worked • 7.5% enhanced rate for providers caring for clients who require care for more than 10 hours per day	$10.85	$21.45
Oregon	$20.00	• Additional $1 for every 2,000 hours worked, up to 8,000+ hours • $3 premium for caring for patients who are quadriplegic or require 24-hour care • Professional Development Certification (PDC) Differential: $0.75 CPR/First Aid Differential: $0.25	$14.70	$24.30
Washington	$21.44	• Up to $3.90 depending on step based on cumulative hours worked • Additional $0.25 for providers with valid Home Care Aide certification or who complete advanced training • Additional $0.75 for Advanced Home Care Aide Specialists and Advanced Behavioral Home Care Aide Specialists	$16.67	$25.60

Note: Data from UC Berkeley Labor Center analysis of current collective bargaining agreements in each state (2023-2024), interviews with union and government representatives (2024). 2025 minimum wages for Connecticut and Washington are UC Berkeley Labor Center projections based on the CPI-W. Connecticut offers a lump-sum longevity bonus.

California and three other states that were researched offer stipends, incentive payments, or bonuses for training, longevity, or providers meeting other criteria. These monies are separate from the hourly differential wages offered in some states. Connecticut provides longevity bonuses of $400 to $800 per consumer-employer based on the average number of hours per week worked for each, as well as stipends for the completion of voluntary skills enhancement training.[30] Massachusetts provides a $1,000 stipend for completing a professional development program.[31] Minnesota provides a one-time $1,000 retention stipend after six months of work, a $500 training stipend, and a $200 electronic visit verification stipend.[32] California temporarily provided one-time stipend incentive payments of $500 to $2,000 for completing Career Pathways training courses and providing care to IHSS recipients with complex needs.[33]

Other states' home care programs offer a range of benefits to providers, including health benefits, paid time off, retirement programs, and workers' compensation. Four states offer health benefits or health insurance premium assistance programs that build on the Affordable Care Act. Six states offer paid time off (PTO) and/or sick leave. Two states have retirement programs for providers: Washington requires employer contributions to a defined contribution retirement plan;[34] and Oregon automatically enrolls new providers into the OregonSaves Roth Individual Retirement Account program with automatic payroll deductions of 5 percent of income.[35] Collective bargaining led to the creation of additional structures in most states, such as training programs and administration systems (**Table 3.4).** In California, state law requires providers to be offered paid sick leave and workers' compensation, and under state policy, IHSS workers can opt-in to the CalSavers retirement program with direct deductions from their paychecks (see **Section II**).

Some states have created processes for addressing instances of discrimination against providers through bargaining or legislation. The Oregon collective bargaining agreement states: "The OHCC Care Provider Guide includes how a worker can file a discrimination claim with the OHCC Executive Director. The guide also provides links to the U.S. Equal Employment Opportunity Commission and BOLI websites should a worker prefer to file a claim directly with the Agency."[36] In Washington, recently passed legislation protects providers from discrimination and retaliation. Senate Bill 6205, passed in 2020, requires employers to establish policy and processes to prevent discrimination and abusive conduct, including tracking and training processes, as well as the creation of a workplace safety committee and stakeholder workgroup to make policy recommendations.[37] In California, recipients and providers can report or file discrimination complaints through their county offices or IHSS Public Authorities and through the CDSS Civil Rights Division.[38]

Table 3.4. Key Benefits and Structures Created by Statewide Bargaining in Other States

State	Health Benefits	Other Benefits	New Structures
Connecticut	Providers receive health insurance premium assistance equal to 7% of annual pay	PTO, added paid holidays, holiday pay, workers' compensation	New payroll agent system
Illinois	State contributes $1.04/paid hour to Union Health Benefit Fund (2018)	PTO, sick time, or holiday pay	Expanded paid training programs
Oregon	ODHS contributes $1.02/paid hour worked by all providers covered by the collective bargaining agreement to the Oregon Homecare Workers Benefit Trust to provide optical, dental, employee assistance program, paid time off, and related benefits	PTO, sick time, or holiday pay, retirement program	• Trust for training, health benefits, and PTO • Limitation for provider hours worked raised from 40-50 hours to 60 hours per week • Training requirement
Massachusetts	• No current health benefits • Providers receive assistance finding outside health care through PCA Healthcare Navigator	PTO, sick time, or holiday pay	• Statewide paid training program administered by Labor Management Fund • Established racial justice committee
Minnesota	No current health benefits	PTO, holiday pay	
Washington	• State contributes $5.22/paid hour to the SEIU Healthcare NW Health Benefits Trust Fund • Workers eligible if they work 80 hours/month and pay $25 monthly premium (2021) • At-home caregivers who work at least 120 hours a month have access to medical and dental coverage for dependent children for $100 a month	PTO, sick time, or holiday pay, retirement program workers' compensation	SEIU Healthcare NW Training Partnership

Note: Data from UC Berkeley Labor Center analysis of current collective bargaining agreements in each state (2023-2024), interviews with union and government representatives (2024). List is not comprehensive.

C. Reported Opportunities and Limitations With Statewide Bargaining

Across the six other states, most interviewees expressed that their home care worker and bargaining structures are hard to compare to California's due to size disparities and the fact that no other state has experience with a county-by-county bargaining system.

Most other states shared that having consistent wages, benefits, terms of employment, and training and orientation systems across their workforce allowed for clarity for providers and recipients, as well as reduced administrative costs. Some interviewees stated that their statewide bargaining systems are conducive to providers maintaining the same wages and benefits when moving from county to county, serving recipients in multiple counties, and allowing benefits to accumulate across hours worked for multiple recipients, such as paid time off in Massachusetts and health care and retirement in other states.[39] Several interviewees also expressed that some large benefit programs were more easily implemented on a statewide level, such as a health benefits plan in one state leveraging its large scale when negotiating with health insurers and health care premium assistance programs in two states being implemented in coordination with state insurance marketplaces.

One union interviewee shared that having one big bargaining table means more opportunities for advocates to get involved.[40] While California does not have the ability to implement statewide changes through bargaining, it has made state-level changes through legislation and CDSS policy changes. Some key informants reported that having one bargaining table is more efficient for those directly involved. An interviewee in Minnesota expressed that one statewide bargaining system also presents administrative advantages as well as opportunities for greater accessibility to statewide online trainings and orientations.[41]

In Connecticut and Oregon, health benefits dovetail with existing statewide programs. Connecticut provides annual health care premium stipends to certain eligible PCAs to make premiums and out-of-pocket costs more affordable for those with coverage through Access Health CT, Connecticut's health care marketplace.[42] In Oregon, the Carewell SEIU 503 Healthcare Cost Assistance benefits provide premium and out-of-pocket assistance to providers who are enrolled in Oregon's health care marketplace (or Medicare).[43] In both states, this assistance supplements Affordable Care Act subsidies for those with marketplace coverage.

States with councils or commissions involved in the bargaining or advisory process expressed that these structures provide a place for recipient voices and enable a more unified state agency voice.

In Washington, interviewees explained that their unique vendor model benefits providers, as they are covered by state and federal laws, such as statewide minimum wage, health and safety protections, the NLRA, and the Family and Medical Leave Act. Washington interviewees also added that their Rate Setting Board structure has given greater opportunity for recipient input and for having a more transparent public policy process.

Some interviewees expressed that their current statewide bargaining structure faces some limitations because the ultimate decision makers (i.e., the governor and legislature) are not at the bargaining table. One interviewee said that one barrier is a lack of designated Human Resources staff for the home care workforce, leaving the council/commission to fill that role. Another stated that there is wide county-by-county variation in the assessment of approved hours of care and that this limitation cannot be addressed in bargaining by statute.[44]

Other states have successfully implemented statewide bargaining models with a range of structures. Though these states' bargaining models vary in terms of who sits on the employer side of the bargaining table, the role recipients play, and other structural details, all of the states researched have addressed a wide range of topics through statewide bargaining and improved job quality standards for IPs.

Endnotes

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IV. Potential Impacts of State-Bargained Wage Increases on Provider Retention and Quality of Care

In this section, we address the potential human impacts of statewide or regional collective bargaining—specifically, access to care, turnover/retention, and quality of care. We review existing research on the relationships among wages/benefits, retention/turnover, training, and quality of care. Our analysis includes research on changes in IHSS turnover/retention in the 1990s and 2000s as the result of wage and benefit increases bargained at the county level. We use these findings to estimate the potential benefits of the hypothetical state-bargained $1-per-hour compensation increase that will be analyzed in cost terms in **Section V**. We then present findings on IHSS provider turnover from 2017 to 2024 based on our analysis of CMIPS provider data. Finally, we highlight provider retention and training programs in California's IHSS as well as in states that have statewide collective bargaining with home care IPs.

IHSS provider recruitment and retention are particularly important at this juncture, given the magnitude of projected demand for IHSS providers (discussed in **Section II**). Other demographic changes, such as the declining working-age population and increased numbers of older adults without living family members, will add to the challenges. The ratio of working-age adults (age 19 to 64) to older adults (age 65+) is projected to fall over the next decade from 3.8 in 2024 to 3.0 in 2034.[1] This demographic shift will mean fewer working-age adults available to provide services for a greater number of adults needing care. Research has also found that the percentage of older adults who lack living close kin is expected to grow in the coming years,[2] indicating that the share of workers with care needs who have access to relative providers will continue to decline. This increases the risk that a growing share of people who need care will have difficulty finding providers at all. The share of non-relative providers in IHSS dropped from 32 percent in 2017 to 28 percent in 2024 (see **Figure 2.1** in **Section II**), with the number of non-relative providers increasing half as fast as relative providers during this period (see **Figure 2.2** in **Section II**), indicating potential disparity in access to the program depending on the availability of kin care.

A. Existing Research on the Impact of Wages on Direct Care Worker Retention and Quality of Care

A large body of existing research on turnover among direct care workers, including home care workers, points to a clear relationship between compensation and turnover/retention. Home care worker turnover is also sensitive to wage levels vis-à-vis other low-wage jobs. Turnover has direct bearing on consumer access to quality care because continuity of caregiving is associated with improved consumer outcomes, both in terms of satisfaction and objective health indicators.

Evidence on the Impact of Wages and Benefits on Home Care Provider Turnover and Retention

Studies of direct care workers have identified low compensation and poor job quality as key contributors to turnover. In addition, caregiving has the potential for burnout due to significant physical, mental, and emotional strain: workers are vulnerable to injury from assisting recipients with physical tasks and may face the challenges of caring for recipients with significant cognitive or mental health issues.[3] Since the COVID-19 pandemic, which began in March 2020 and continued through 2022, compensation growth in occupations with comparable entry-level requirements (e.g., fast food workers and janitors) has outpaced compensation growth in the direct care sector.[4]

In California, significant wage gains in the early years of IHSS collective bargaining led to lower turnover, especially among non-relative caregivers. In addition, there is some evidence that while IHSS relative caregiver turnover is not as sensitive to wage levels, the enrollment of recipients and their relative caregivers in the program may be influenced by wages.

San Francisco has the longest history of collective bargaining with IHSS providers, and Howes has closely studied the impact of wage and benefit gains on provider retention in the county over time. The first union contracts boosted IP wages from 83 percent of the 10th percentile wage in the surrounding metro area in 1997 to 123 percent in 2002. During the same period, the annual retention rate increased from 78 percent to 85 percent for all IPs and from 39 percent to 74 percent for new IPs.[5,6] Looking at the 2001-2009 period using CMIPS data from CDSS, Howes found that each 10 percent increase in wages relative to the 10th percentile area wage was associated with 4 percent higher annual retention, after controlling for provider demographics, provider relationship to recipient, and recipient functional impairment.[7] However, despite nominal wage growth, the relative wage actually fell from 126 percent to

113 percent during this period, due in part to local living wage and health care policies that significantly raised the wage floor.[8, 9] Thus, overall provider retention declined from about 82 percent in the early 2000s to 77 percent by November 2007, even after being offset by an increase in the share of relative caregivers, who have lower turnover than non-relative caregivers.[10]

A study of first-time IHSS recipients across California by the UCSF Health Workforce Research Center on Long-Term Care found that non-relative caregiver retention was strongly correlated with pay rates after controlling for demographic and local economic factors.[11] They also found that relative caregivers were more than twice as likely as non-relative caregivers to remain in their position after 12 months and that relative caregiver retention was not affected by local unemployment rates or area wages. The lowest-paid non-relative caregivers ($6 per hour) had an annual turnover rate of 27.4 percent, compared to 15.1 percent among the highest-paid non-relative caregivers ($12 per hour), after controlling for key recipient, provider, and local labor market characteristics.[12]

Health insurance provision is another critical factor in turnover and retention among home care workers. Howes found that San Francisco's health insurance benefit—relatively generous compared to other low-wage jobs—contributed to an increase in the likelihood of IPs being employed for at least one year.[13] Howes's 2014 study comparing San Francisco to eight other California counties suggested that high-quality health insurance provision, as opposed to limited health benefits or health plans with capped enrollment, had a positive impact on IHSS provider retention.[14] Drawing on a 2007 survey of home health aides across the United States, Stone and colleagues found that workers employed through agencies who were offered health insurance were 55 percent less likely to express a desire to leave their job.[15] A separate longitudinal study on home care worker turnover in Maine found that those lacking health insurance were twice as likely to leave their jobs.[16] According to a survey of former home care workers in Washington State, those who left their jobs to work in other sectors were more likely to receive health insurance for dependents and paid sick leave in their new positions.[17]

Studies from other states and the nation as a whole have produced similar findings on the relationship between home care provider compensation and turnover/retention. Morris found higher wages, more hours, and travel cost reimbursement to be significantly associated with reduced turnover among home care workers in Maine.[18] A 10 percent wage increase was associated with a 15.4 percent decrease in the probability of a home care worker leaving their job within two years. Morris also found that home care workers with employer-sponsored health insurance were 21 percent less likely to leave their jobs after controlling for full-time/part-time status. Similarly, workers with full-time hours were 21 percent less likely to leave. Baughman and Smith examined retention among U.S. direct care workers in private homes and non-nursing residential facilities during 1996-2000 and 2001-2003, finding that each 10 percent wage increase was associated with a 1.5 percent increase in provider employment

duration. Notably, higher state minimum wages were associated with lower retention for this workforce,[19] consistent with Howes's finding that home care worker retention is significantly associated with provider wage levels in relation to the wage floor.[20]

Evidence on the Impact of Retention on Quality of Care

Studies have found a consistent link between turnover and quality of care. High levels of turnover limit opportunities for home health aides to develop stable relationships with consumers and understand their needs.[21] Russell found that patients who consistently receive care from the same home health aide across multiple visits show significant improvement in various Activities of Daily Living compared to those who experience low continuity in their aide services.[22] Consumers with lower levels of caregiver continuity in their providers are significantly more likely to experience falls and depressive symptoms.[23]

In a 2022 national study of skilled nursing facilities throughout the United States, Ruffini likewise found that minimum wage increases reduced separations and increased the number of stable hires, with beneficial outcomes for patient safety and health.[24] Each 10 percent increase in the minimum wage reduced turnover among low-wage nursing home staff by 3 percent, restraint use by 3.2 percent, pressure ulcers by 1.7 percent, quality of care violations by 2.2 percent, and nursing home patient deaths by 3.1 percent. Synthesizing these findings with other nursing home staffing studies,[25] Ruffini noted that the effect of a 10 percent increase on the minimum wage had similar effects as increasing nursing assistant care by one hour per resident.[26]

Existing Research on the Impact of Training

Studies of home care workers have cited the lack of training, career ladders, and support factors driving home care workers' intentions to leave their jobs.[27] In one study of job satisfaction in Washington State, the top explanations for workers' decision to switch careers included better opportunities for advancement elsewhere.[28] Accordingly, Washington passed several laws creating opportunities for home care providers to advance in their careers through training and certification programs leading to higher pay.[29] In states like Tennessee, workers training to become home health care aides have the opportunity to receive college credits.[30]

Yet, several review studies have found mixed results from low-touch job training programs, suggesting that these opportunities must be high quality and evidence-based to have substantial effects on worker satisfaction.[31] A meta-analysis examining how home care worker training on cancer and dementia care impacts consumers found that training program quality varied widely and that high-quality programs involving deeper provider engagement resulted in improved health outcomes for service recipients.[32]

Potential Effects of Statewide Bargaining on IHSS Provider Retention

The studies discussed above show that wage and benefit improvements lead to improved home care worker retention, which in turn is linked to improved quality of care. Studies of the early years of IHSS unionization show dramatic reduction in turnover due to collectively bargained wage increases. There is also some evidence that improved wages, while not having a statistically significant effect on IHSS relative provider turnover, have increased access to care for recipients who have access to kin care.

However, the impact of changing IHSS collective bargaining from the county level to the state level is contingent on whether the latter leads to greater wage and benefit improvements than would happen under the status quo. As we will discuss in **Section V**, this is not a foregone conclusion. It is worth noting that other states with statewide bargaining tend to offer significantly higher wages for home care providers compared to county-bargained IHSS wages in California, as discussed in **Section III**. However, this comparison is limited by the fact the other states' consumer-directed home care programs are much smaller in scope than IHSS. Given existing research on centralized bargaining and the stated intentions of IHSS provider unions (see **Section V**), statewide bargaining could lead to less wage and benefit inequality between counties, with the greatest gains for providers in the lowest-paid counties.

Without knowing what the state-bargained wages and benefits will be, we cannot predict the outcome of statewide bargaining on IHSS workforce retention and quality of care. However, given that AB 102 includes an analysis of the cost of each $1 increase in IHSS provider compensation, we are able to estimate the potential benefits as follows. A $1 increase in 2027, net of employer FICA taxes, would translate to a modest 5 percent increase in IHSS wages relative to the CDSS projected statewide minimum wage of $17.50.[33] We estimate that this would initially decrease overall annual provider retention rates among IHSS IPs by 2 percent, based on Howes's findings and the fact that the current statewide relative provider ratio is roughly similar to the relative provider ratio in Howes's study of San Francisco.[34] Alternatively, two-year retention rates among non-relative caregivers could increase by 9 percent, based on Morris's findings.[35] However, if the $1 premium was not subsequently increased to keep up with minimum wage adjustments, the retention effect would diminish over time.

B. Recent Trends in IHSS Provider Turnover

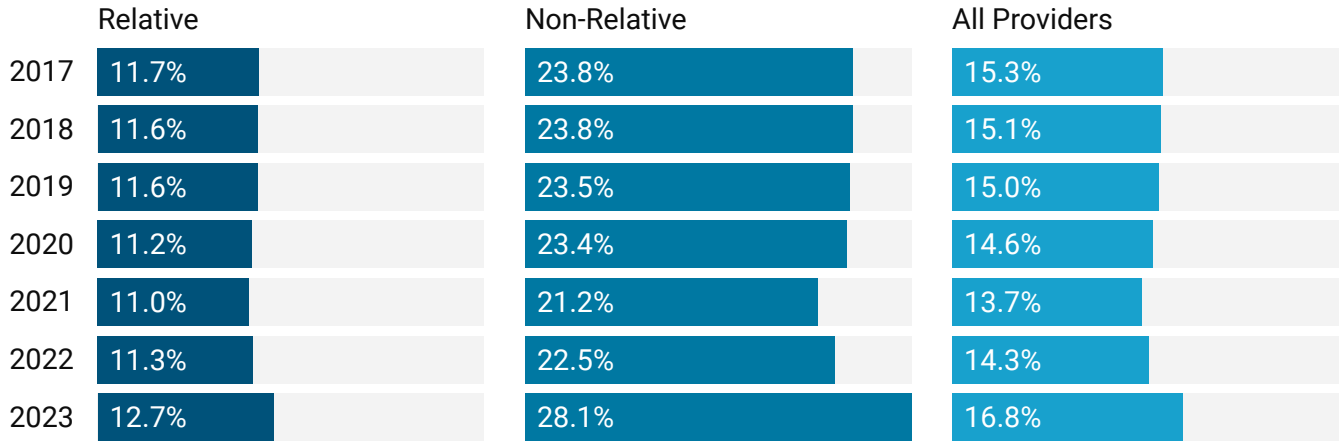
We obtained IHSS payroll warrant and provider management data files from CMIPS, spanning January 2017 to June 2024. After cleaning the dataset, we calculated the number of providers who left IHSS each calendar year based on the last pay period in which they reported service hours. We also computed the average monthly provider headcount for each calendar year. The systemwide turnover rate is the number of leavers divided by the average monthly headcount each year. Turnover was calculated separately for relative caregivers and non-relative caregivers as well as for all providers.

The resulting turnover rates for calendar years 2017 through 2023 are shown in **Figure 4.1**. Non-relative providers are twice as likely to leave IHSS in a given year compared to relative providers. Turnover rates for both groups inched down slowly between 2017 and 2020, from 11.7 percent to 11.2 percent for relative providers and from 23.8 percent to 23.4 percent for non-relative providers. While turnover across California dropped sharply in 2020 and then rebounded in 2021, turnover among IHSS providers turnover dipped in 2021 to 11.0 percent among relative providers and 21.2 percent among non-relative providers. Subsequently, in 2023 relative and non-relative provider exit rates rose significantly to 12.7 percent and 28.1 percent, respectively.

The small decline in turnover between 2017 and 2020 could be the result of the wage supplement and the 10 percent option discussed in **Section I.D**, which allowed the IHSS Public Authorities and unions to negotiate wages that grew consistently on top of minimum wage increases. The average real wage among IHSS providers in relation to the state minimum wage increased slowly between 2017 and 2021 and then held steady in 2022 and 2023, though declining due to high inflation (see **Figure 5.4** in **Section V**). The dramatic increase in turnover among non-relative caregivers in 2023 could be tied to slower real wage growth during that period and to post-pandemic burnout that has affected the health care industry as a whole. Turnover may drop slightly in response to wage gains in 2024.[36] At the same time, the COVID-19 pandemic created unprecedented disruptions in the labor market. Thus, it is difficult to draw definitive conclusions about why IHSS provider turnover dipped a year later than the rest of the labor market and why it increased so much in 2023.

As discussed in **Section II** (see **Figure 2.1**), the share of IHSS providers who are relative caregivers has been rising, from 68 percent in calendar year 2017 to 72 percent in the first half of 2024. As Howes hypothesized for a similar trend in San Francisco during the 2000s, nominal wage growth could induce greater participation by relative caregivers, even as the decline in the relative wage contributes to greater turnover among non-relative caregivers. This finding has implications for potential disparities in the ability of aged and disabled people to access care based on whether or not they have familial resources.

Figure 4.1. IHSS Annual Turnover Rates, By Provider Relationship to Recipient, 2017-2023



Note: UC Berkeley Labor Center analysis of CMIPS data.

C. Past and Current California Initiatives Related to Training, Recruitment, and Retention

The American Rescue Plan Act (ARPA), enacted in 2021, temporarily increased the FMAP for certain Medicaid HCBS by an additional 10 percentage points, resulting in approximately $3 billion in total enhanced federal funds for the state from 2021 to 2024. These funds were used to support a range of new HCBS initiatives, including IHSS-related initiatives to improve recruitment and retention.[37] For example, the funding was used for one-time $500 payments to IHSS providers who worked at least two months between March 2020 and March 2021.[38] This funding was also used for the IHSS Career Pathways Program, a training program for providers of IHSS and Waiver Personal Care Services that was free to providers and offered payments tied to attending and completing the training and meeting other criteria.[39] According to CDSS data from July 2024, a total of 40,445 providers attended this training; of these, 5,260 received the incentive for working one month after their training, and 2,408 received the incentive for working six months after their training.

As discussed in **Section III**, other states with consumer-directed home care and union-represented IPs have used a range of strategies to improve recruitment and retention. For example, wage differentials, incentive payments, bonuses, or stipends are used to incentivize longevity (six states), completion of development and training programs (four states), and working with consumers with more complex needs (three states), as shown in

Table 3.3. In Massachusetts, Personal Care Attendants are eligible for college tuition vouchers after at least a year of part-time employment.[40] Some states have Taft-Hartley Funds that administer statewide training programs. One example of a training program that can result in increased pay for workers is Washington's SEIU 775 Advanced Home Care Aide Specialist training, which supports providers in growing professionally, building relationships with clients, and learning advanced caregiving skills that help clients with complex needs. Providers who pass this program receive a $0.75 hourly raise and certification.[41] In addition, some states offer benefits as a recruitment and retention strategy: four states offer health benefits or premium assistance programs; two states have retirement programs; and another state is developing a retirement program.

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35 This is based on a two-year retention rate increase of 18 percent for every 10 percent increase in wages derived from Morris's findings.

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V. Potential Impact of Statewide Collective Bargaining on Program Cost

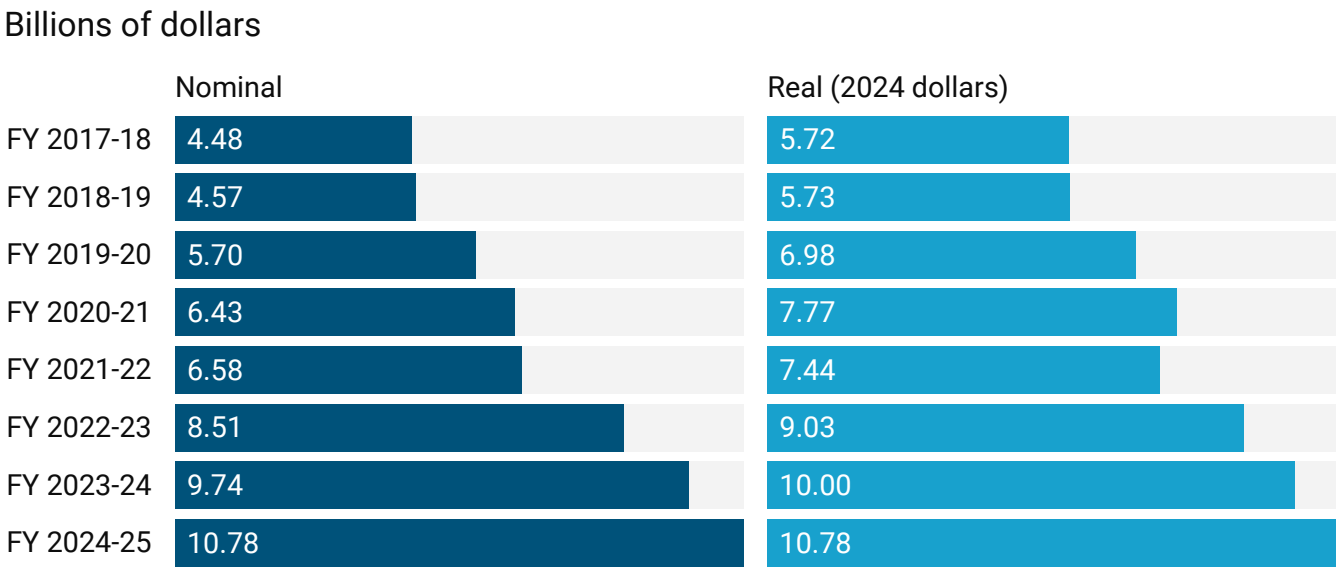
In this section, we analyze the potential cost impact of statewide or regional collective bargaining. We first analyze the overall cost trajectory of IHSS, given enrollment trends, historical wage growth, and demographic changes. We then examine the key results from CDSS cost projections for FY 2024-25 to FY 2031-32, including the baseline projection and estimated cost of each additional $1 in provider hourly compensation. Finally, we consider future wage growth trends, given the interaction between IHSS provider wages and the state minimum wage, as well as key factors at play in each bargaining scenario.

A. IHSS Program Cost Trajectory and Driving Factors

The total cost of the IHSS program—inclusive of federal funding—nearly doubled in real (inflation-adjusted) terms between FY 2017-18 and FY 2024-25. Rapid enrollment growth and significant increases in the state minimum wage were key contributors. County-level collective bargaining yielded modest average IHSS provider wage gains above the legal minimum during this period, mostly due to a small number of large urban counties, while providers in many counties saw little or no growth beyond minimum wage increases.

Figure 5.1 shows annual IHSS costs net of federal funding in both nominal and real (inflation-adjusted) terms.[1] Between FY 2017-18 and FY 2024-25, the total IHSS program cost net of federal funding grew from $4.5 billion to $10.8 billion—141 percent in nominal terms or 88 percent after adjusting for inflation. After growing rapidly from FY 2017-18 to FY 2019-20, cost growth stabilized due to increased federal funding during the COVID-19 pandemic.

Figure 5.1. Non-Federal IHSS Program Costs, FY 2017-18 to FY 2024-25



Note: UC Berkeley Labor Center analysis of IHSS program cost data (excluding administration and CMIPS) based on the May Revision of the Governor's Budget for each fiscal year. Real values based on CPI-U in December of each period. December 2024 CPI estimated by authors based on the CBO projection of 2.7% in 2024.

Rapid Enrollment Growth Due to Demographic Trends and Increased Uptake

IHSS has grown rapidly over the past two decades, and this trend is projected to continue given an aging population and higher disability rates among seniors.[2] Between 2017 and 2023, IHSS paid hours increased 46 percent from 54 million to 80 million, reflecting an average compound annual growth rate of 6.6 percent.[3] In comparison, the 65+ population grew by 29 percent, while the overall state population declined 1 percent during this period.[4,5]

The Department of Finance estimates that the senior population is projected to grow 19 percent from 2024 to 2032, while the total population will grow by just 2 percent.[6] In addition to demographic-driven growth, incremental changes in Medi-Cal eligibility rules—part of a policy strategy to expand health insurance coverage—have contributed to program growth on the margins.[7] CDSS currently estimates that the IHSS caseload will grow 4.01 percent per year and average authorized hours per case will rise 1.24 percent per year after FY 2024-25. This trend translates to an increase of 5.3 percent per year in monthly paid hours, reflecting a 1 percentage point decrease in the program's growth rate compared to 2017-2023. Based on our analysis of paid hours between 2017 and 2023, this is a conservative estimate of future growth

in paid hours. If annual paid hours continue to grow at the same rate as between 2017 and 2023 (6.6 percent average annual growth rate), they will be higher than what is projected in the CDSS Fiscal Impact of Statewide Collective Bargaining report.

Labor Cost and Minimum Wage Growth

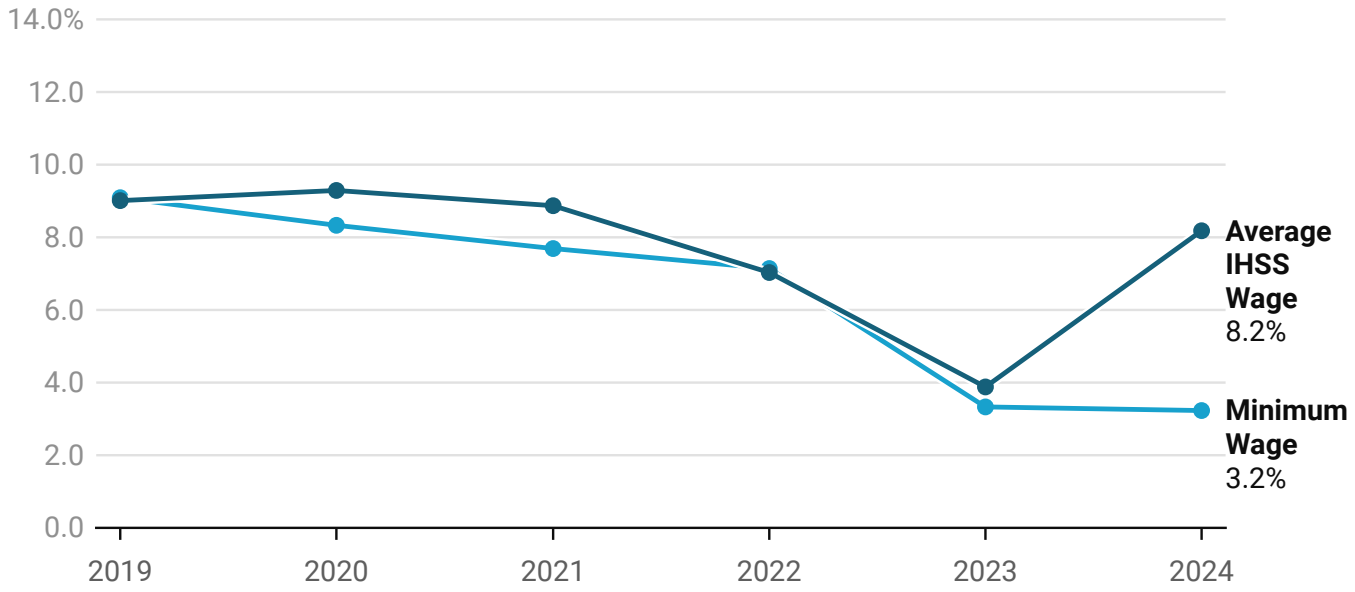
IHSS provider wages grew significantly between FY 2017-18 and FY 2023-24, largely due to the state's minimum wage policy. Growth in the statewide minimum wage not only directly increases wages in counties with wages at or close to the minimum, but also indirectly increases wages due to negotiated wage supplements that float above the minimum wage in 56 counties.

Between January 2018 and January 2024, the average IHSS provider wage (weighted by paid hours) increased at a rate similar to that of the minimum wage. In nominal terms, the average provider wage grew between 3.9 percent and 9.3 percent each year (**Figure 5.2**), a compound annual rate of 7.7 percent. Because the statewide minimum wage was phased in through successive $1 raises to reach $15 an hour by 2022, the minimum wage grew 7.1 percent to 9.1 percent a year in nominal terms between January 2018 and January 2022. After 2022, the state minimum wage was indexed to inflation with a cap of 3.5 percent. Yearly growth in the weighted average IHSS wage generally follows this pattern—except in January 2024, when average provider wages diverged from the minimum wage and grew by 8.2 percent.

Figure 5.3 shows the IHSS provider hourly wage level between January 2018 and January 2024, distinguishing the component made up by the minimum wage from the increment above the minimum wage. The average IHSS provider wage increased by $6.45, or 56.0 percent, from $11.51 to $17.95. During the same period, the statewide minimum wage increased by $5.00, from $11.00 to $16.00. In other words, much of the growth of IHSS provider wages was due to statewide minimum wage increases. Average IHSS provider pay above the minimum wage increased from $0.51 an hour in 2018 to $1.95 in 2024, or from 4.4 percent to 10.9 percent of the total wage.

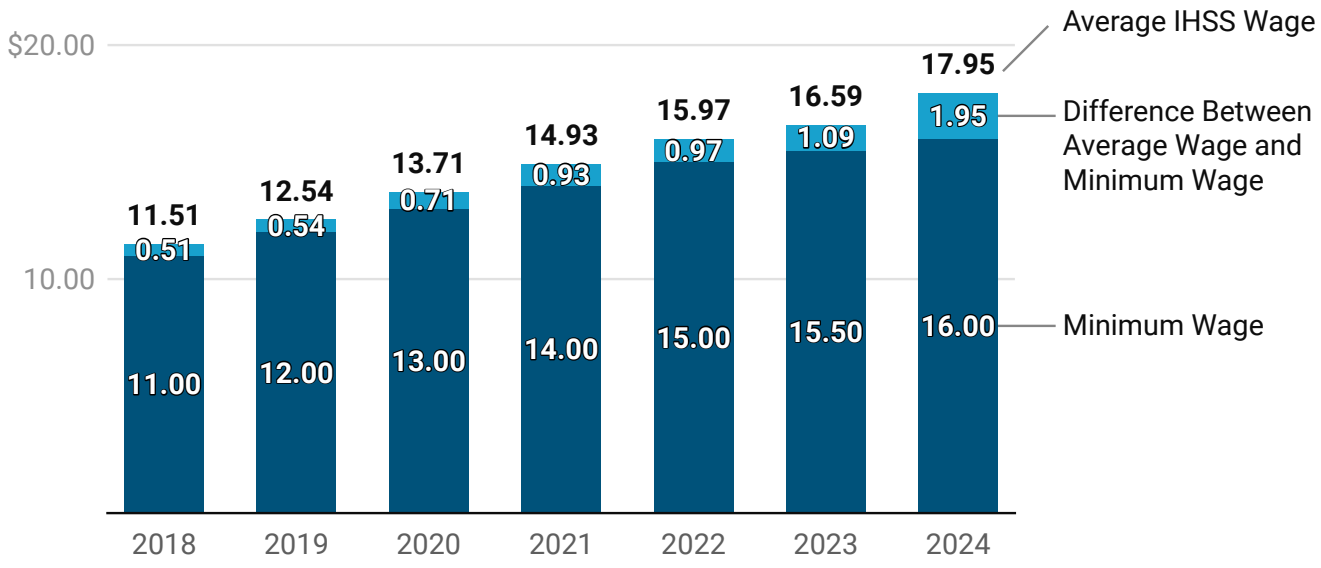
As discussed in **Section II**, there is significant variation in provider pay and benefits among counties, reflecting differences in regional economic characteristics, resources available to counties, and how counties prioritize investments in IHSS providers' wages and benefits. Under the status quo of county-level collective bargaining, IHSS provider unions have modestly increased wages beyond the minimum wage in key large urban counties. In contrast, other counties have seen little or no growth beyond the minimum wage in recent years.

Figure 5.2. Nominal Wage Growth, Average IHSS Provider Wage, and the State Minimum Wage, 2018-2024



Note: UC Berkeley Labor Center analysis of data from the California Department of Social Services. Average wage is weighted by paid hours.

Figure 5.3. Average IHSS Provider Wage vs. the State Minimum Wage, 2018-2024

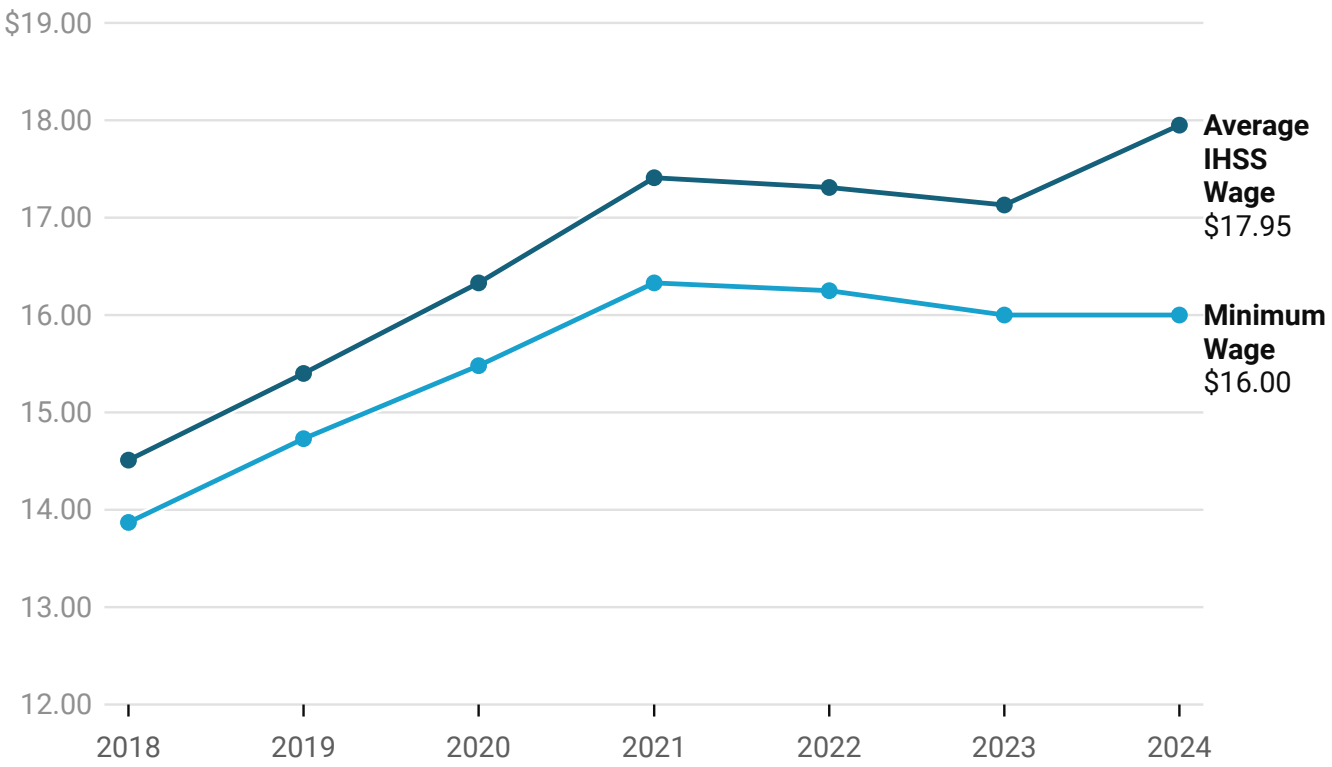


Note: UC Berkeley Labor Center analysis of data from the California Department of Social Services. Average provider wage weighted by paid hours. Wage levels are for January of each year.

Figure 5.4 shows the real value, in 2024 dollars, of weighted average IHSS provider wages between January 2018 and January 2024 after accounting for inflation. The average provider real wage increased by $3.44, or 23.7 percent, during this time period. Providers realized most of this gain between January 2019 and January 2021. IHSS providers' wages lost value between January 2021 and January 2023 due to high inflation (**Figure 5.5**). Between January 2023 and January 2024, the average IHSS provider wage grew in real terms, though only $0.54 (in 2024 dollars) above where it was in January 2021.

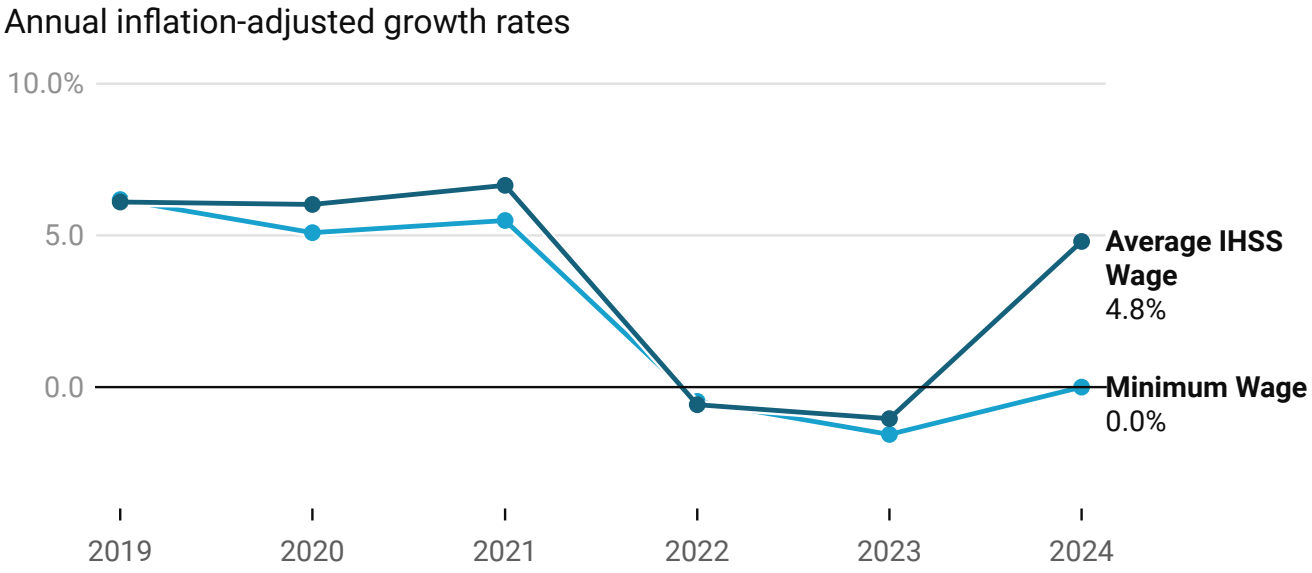
Importantly, as of January 2024, not all providers had experienced positive wage growth. **Appendix Table A.3** shows that IHSS provider wages in some counties were lower than their value in January 2021 or January 2022. Overall, 34 counties had lower wages in real terms in January 2024 than they did in either January 2021 or January 2022. These counties tend to employ a smaller number of providers and represent about 20 percent of the total provider population. Six of the 34 counties had reversed this trend and reported higher wages in real terms by July 2024.

Figure 5.4. Average IHSS Provider Wage and the State Minimum Wage in 2024 Dollars, 2018-2024



Note: UC Berkeley Labor Center analysis of data from the California Department of Social Services. Average wage is weighted by paid hours. Dollars inflation-adjusted to 2024 values using CPI-W. Wage levels are for January of each year.

Figure 5.5. Real Growth of Average IHSS Provider Wage and the State Minimum Wage, 2019-2024



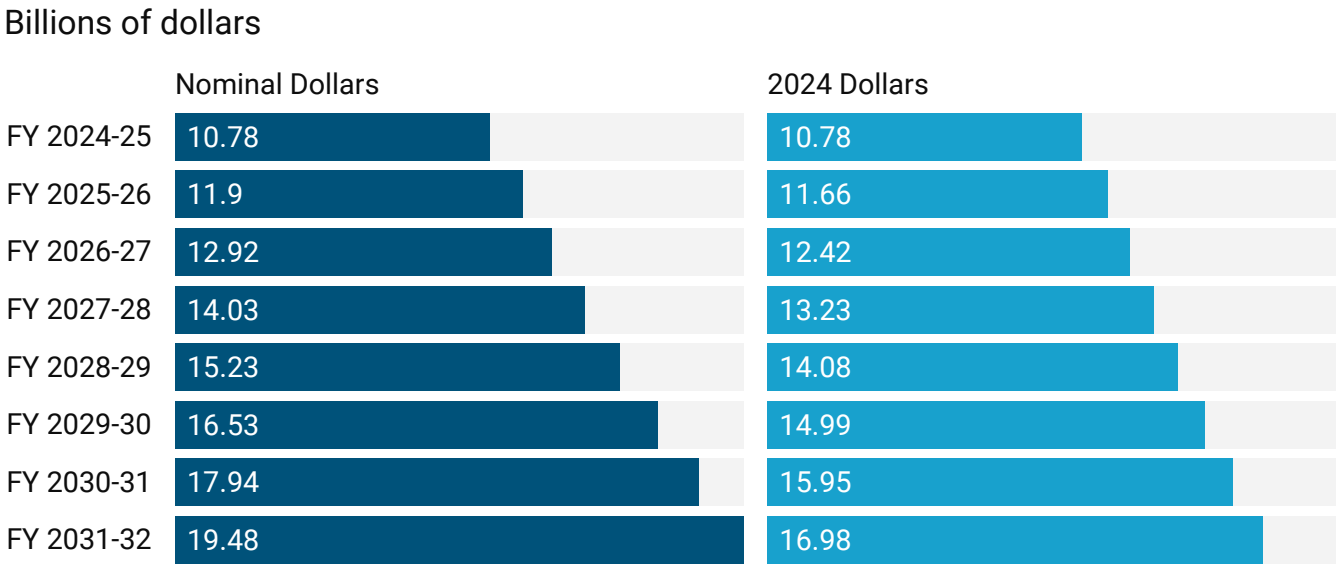
Note: UC Berkeley Labor Center analysis of provider wage and paid hours data obtained from the California Department of Social Services. Average wage are weighted by paid hours. Annual growth rates are inflation-adjusted using CPI-W.

B. CDSS Cost Projections: Baseline Scenario and Impact of $1 Increment Pay Increases

This section reflects on the IHSS cost projections produced by CDSS, which are reported in detail in the main report to which this report is attached. CDSS projects slower cost growth in the future, with slightly lower enrollment growth rates and significantly slower wage growth compared to the past seven years. CDSS assumes IHSS baseline costs will grow by an annual rate of 8.56 percent, based on estimates of 4.01 percent caseload growth, 1.24 percent growth in authorized hours per case based on the last few years, and 3.1 percent annual wage growth for FY 2025-26 and later. The 3.1 percent wage growth estimate is inclusive of a projected annual minimum wage inflation adjustment of 50 cents.[8, 9]

Figure 5.6 depicts CDSS baseline projections for the non-federal share of IHSS service costs, with and without inflation adjustment. These costs are expected to nearly double between FY 2024-25 and FY 2031-32, from $10.8 billion to $19.5 billion. Adjusted for projected inflation, costs are projected to grow 57.5 percent during this time.

Figure 5.6. Projected Non-Federal Baseline IHSS Service Costs



Note: Nominal cost data provided by CDSS. UC Berkeley Labor Center calculated 2024 dollar values based on U.S. BLS CPI-U and CBO inflation projections.

CDSS projects that each compensation increase of $1 an hour (consisting of a wage increase as well as associated employer payroll taxes) would increase non-federal service costs for the program by $586 million in the first year that a state-bargained contract could take effect, FY 2028. The cost would rise to $721 million in FY 2032 due to growth in paid hours alone, as inflation adjustment to the $1 hourly increase is not assumed in the cost model. These costs are equal to 4.2 percent and 3.7 percent above baseline projected costs, respectively (see **Figure 5.7**).

The $1 increment wage increase in a single year is large compared to average wage growth negotiated at the county level over the past several years. There were relatively few increases of this magnitude (outside of minimum wage increases) between January 2018 and January 2023 (see **Table A.1** in **Appendix A**), and these usually only occurred after periods of no wage increase other than the minimum wage or no increase at all while the minimum wage caught up to 100 percent of negotiated wages. However, between January 1, 2023, and January 1, 2024, a majority of IHSS providers received wage increases of at least $1 in addition to the $0.50 minimum wage increase, due primarily to negotiated increases in five large Southern California counties: Los Angeles, Orange, Riverside, San Bernardino, and San Diego.

Figure 5.7. Impact of Each Additional $1/Hour Provider Pay on Projected Non-Federal Service Costs for IHSS

Billions of dollars

	FY 2027-28	FY 2028-29	FY 2029-30	FY 2030-31	FY 2031-32
Baseline	14.03	15.23	16.53	17.94	19.48
$1 increase	0.59	0.62	0.65	0.68	0.72
$2 increase	1.17	1.23	1.30	1.37	1.44
$3 increase	1.76	1.85	1.95	2.05	2.16
$4 increase	2.35	2.47	2.60	2.74	2.88
$5 increase	2.93	3.09	3.25	3.42	3.60

Note: Cost projection data provided by California Department of Social Services. Costs reflect IHSS service costs only.

C. Future IHSS Wage Growth Under the Baseline and Interaction With Minimum Wage

Starting in 2024, the California minimum wage is adjusted annually by the Consumer Price Index (CPI), with a maximum increase of 3.5 percent in any given year. The state covers the full cost of the minimum wage increase for IHSS and adjusts the state participation compensation cap each year to account for the increase in the minimum wage. County MOUs generally set wages as a supplement above the state minimum wage.

As we have seen, between 2018 and 2023, the weighted average IHSS wage grew at an overall rate slightly above the growth of the minimum wage, which increased faster than inflation between 2018 and 2021 and grew slower than the rate of inflation in the two subsequent years. In 2024, IHSS wages grew by 8.2 percent, 5 percentage points more than the increase in the minimum wage. The nominal 2024 wage increases represent an increase of 4.8 percent in real terms, following a 1.6 percent decline over the previous two years.

If there is no change in the state minimum wage policy,[10] we would anticipate future wage growth to be in the range of 2 percent to 5.3 percent each year, on average. The low end of

the range is in line with projected CPI and assumes no further wage increases are negotiated beyond those that occur automatically due to changes in the statewide minimum wage. The high end of the range would occur if all counties were to fully utilize the 10 percent option and spread out the raises evenly over three years, equivalent to approximately 3.3 percent annual growth on top of CPI.

Wage Growth Under Statewide and Regional vs. County-Level Bargaining

The impact of statewide bargaining on IHSS wage growth is not predetermined. Statewide bargaining would create a new framework and process for collective bargaining, not a determined outcome. Multiple factors could affect the outcome. The first is the state budget context. The results of statewide collective bargaining could be expected to differ in times when the state is facing a deficit versus times of budget surpluses. While state and county finances are affected similarly by recessions, with the state's reliance on highly progressive income taxes, the state budget tends to be more volatile than Realignment funding, which comes from sales tax.

The second major factor will be the capacity of IHSS workers to negotiate higher wage increases through their unions under statewide bargaining. More focused union mobilization on a single negotiation could potentially give IHSS workers greater bargaining power at the state level. This is especially true in comparison to areas where wages remain at the minimum wage (Siskiyou County) or close to the state minimum wage (the majority of counties).[11] It may be less true in relation to counties where IHSS workers have achieved increases well above the state average. Current collective bargaining outcomes in those counties may also be impacted by the fact that counties are only responsible for a little more than 17 percent of the negotiated wage increases within the 10 percent option and state participation cap, factoring in the state and federal funds.

Statewide bargaining is likely to decrease the variance in wages and benefits among counties. Workers in counties with wages lower than their peers elsewhere would likely see greater growth than under the status quo. Workers in counties with higher wages could potentially experience slower wage growth than they would have seen under county-level collective bargaining. A uniform statewide wage is not likely in the near future, given California's size and the large regional differences in the cost of living.

Research indicates that the size and structure of collective bargaining units significantly affect wage outcomes, although the impact varies by context. Studies show that larger bargaining units or those engaged in sectoral and multi-employer agreements often lead to wage

compression, reducing wage disparities across positions and skill levels, and this effect is particularly strong in public-sector collective bargaining. Larger units have more leverage to establish standardized wage scales across industries, which lowers wage inequality both within and among firms.[12]

A third major factor will be the state's ability to bring in further federal funds or identify new funding sources for IHSS. The degree to which the state is able to access new sources of funding for the IHSS program is likely to have a large impact on the outcome of collective bargaining. Finally, there may be administrative savings to the IHSS program from moving from 58 separate collective bargaining processes to a single statewide process.

The same uncertainty in outcomes would exist for wage growth under regional bargaining. In a scenario in which counties bargained jointly at the regional level, we would likely see wages grow at a slower rate than under either statewide or county bargaining. If all counties must agree to the MOU, the county in the region with the least capacity to pay—or with the least political support for raising wages—would have veto power over any wage increases, resulting in lower wage growth across the region.

Endnotes

1 Estimates of total non-federal program cost for IHSS were calculated from the May Revise budget for each fiscal year, e.g., "2024 May Revision Local Assistance Estimates Binder for the 2024-25 Governor's Budget for CDSS," Table Number 3. To back out non-federal cost, we added the County MOE to state costs.

2 Mac Taylor, "A Long-Term Outlook: Disability Among California's Seniors" (Legislative Analyst's Office, November 2016), https://lao.ca.gov/Publications/Report/3509.

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5 California Department of Finance, "E-8 Historical Population and Housing Estimates for Cities, Counties, and the State - January 1, 2010-2020" (Department of Finance, November 2023), https://dof.ca.gov/forecasting/demographics/estimates/estimates-e8-2010-2020/.

6 California Department of Finance, "P-1: State Population Projections (2020-2060)" (Department of Finance, Demographic Research Unit, 2024), https://dof.ca.gov/forecasting/demographics/projections/.

7 Under the Affordable Care Act (ACA), California expanded Medi-Cal to low-income childless adults and certain parents who were not already eligible, beginning in 2014. As of December 2023, nearly 24,000 of those who are enrolled under the ACA expansion were IHSS recipients, based on data from CDSS. Additionally, state policymakers incrementally expanded Medi-Cal eligibility to all low-income Californians regardless of immigration status between 2016 and 2024. In May 2024, CDSS projected 1,560 undocumented IHSS recipients in budget year 2023-24. California Department of Social Services, "2024 May Revision for the 2024-25 Governor's Budget," accessed September 8, 2024, https://www.cdss.ca.gov/inforesources/fiscal-financial/local-assistance-estimates/2024-may-revision-for-the-2024-25-governors-budget.

8 This compares to 7.7 percent average growth from 2018-2024, which was largely driven by increases in the minimum wage.

9 Authors' calculations based on 2 percent inflation rate.

10 An initiative on the ballot in November 2024 would raise the California minimum wage to $18 an hour starting on January 1, 2025 for employees of large employers, including IHSS providers. Wages would rise with CPI as in current law starting in 2027. We project that would increase IHSS base pay over the current baseline by $1.60 in 2025 and $1.30 in subsequent years.

11 Siskiyou County is at the statewide minimum wage and has not negotiated an MOU. A majority of counties have wages that are no more than 10 percent above the minimum wage.

12 Oliver Denk et al., "The Role of Collective Bargaining Systems for Labour Market Performance," in *Negotiating Our Way Up* (Organisation for Economic Co-operation and Development, 2019), https://doi.org/10.1787/1fd2da34-en; Andrea Garnero, "The Impact of Collective Bargaining on Employment and Wage Inequality: Evidence from a New Taxonomy of Bargaining Systems," *European Journal of Industrial Relations* 27, no. 2, accessed November 1, 2024, https://doi.org/10.1177/0959680120920771; David Card, Thomas Lemieux, and W. Craig Riddell, "Unions and Wage Inequality: The Roles of Gender, Skill and Public Sector Employment," Working Paper, Working Paper Series (National Bureau of Economic Research, November 2018), https://doi.org/10.3386/w25313; David Card, Thomas Lemieux, and W. Craig Riddell, "Unionization and Wage Inequality: A Comparative Study of the U.S, the U.K., and Canada," Working Paper, Working Paper Series (National Bureau of Economic Research, February 2003), https://doi.org/10.3386/w9473; Maarten Keune, "Inequality between Capital and Labour and among Wage-Earners: The Role of Collective Bargaining and Trade Unions," *Transfer: European Review of Labour and Research* 27, no. 1 (February 1, 2021): 29–46, https://doi.org/10.1177/10242589211000588.

VI. Implications for MOE and Realignment

In this section, we analyze the potential impact of statewide collective bargaining on Maintenance of Effort (MOE)—the set of rules governing how IHSS costs are divided between counties and the state—and 1991 Realignment, which provides most of the funding that counties use to pay for IHSS.[1] We first outline key interwoven issues related to IHSS financing, including existing long-term financing challenges, given demographic trends and current state policies, as well as policy questions concerning county funding for IHSS, given the constitutional restriction on state mandates and county revenue limits. The second and third segments of this section explain 1991 Realignment and the current MOE, respectively. The fourth segment analyzes the recent history of County MOE obligations compared to 1991 Realignment revenues. The final part of this discussion compares 1991 Realignment revenues to County MOE under various scenarios based on CDSS cost projections for IHSS presented in **Section V**.

A. Key IHSS Financing Issues Under Statewide Collective Bargaining

We have identified four key policy questions related to the potential impact of statewide collective bargaining on MOE and Realignment, based on a review of past analyses from the LAO and DOF, IHSS stakeholder group discussions, interviews with stakeholder group members, and our analysis of historical data on MOE and 1991 Realignment revenues:

- Local funding responsibility in the context of the state mandates clause and control over program cost;
- County-level ability to pay;
- Predictability of IHSS costs for counties; and
- Adequacy of 1991 Realignment funding for mandated county expenditures on IHSS.

Local funding responsibility in the context of the state mandates clause and control over program cost. The California Constitution prohibits the state from passing on unfunded mandates to counties. Funding obligations imposed on counties by the state must in principle be paired with reasonably matching revenues. The principle behind 1991 Realignment was to substantially increase county funding responsibility for certain social programs while providing revenues (a portion of the state sales tax and Vehicle License Fee [VLF] revenue) that counties could use to fund those programs at their discretion. In reality, counties have little control over the cost of entitlement programs, including IHSS, in which eligibility criteria and benefit levels are set at the state and federal levels.[2] Counties have had some discretion in setting wage levels through county-level collective bargaining with IHSS providers, and current MOE policy accommodates this by limiting county responsibility to wage increases above the minimum wage. An important question, then, is whether and how the IHSS funding structure would need to change if the state, rather than counties, were to control wage growth above the minimum wage.

County-level ability to pay. County spending on IHSS and provider compensation above and beyond Realignment funding—i.e., county General Fund spending—is heavily constrained. Proposition 13 capped *ad valorem* property taxes to 1 percent of assessed property value, constricted property value assessment growth, and imposed a two-thirds popular vote requirement on other taxes and levies, including parcel taxes. While some of Proposition 13's restrictions have been slightly eased at the state level, the law continues to severely restrict counties' ability to raise General Fund revenues. As a result, nearly half of county revenues are from state and federal funding.[3] Beyond this reality, county General Funds also vary widely in their economic bases and responsibility for providing municipal services to unincorporated residents. A few affluent counties, like San Francisco and San Mateo, are financially able (and politically willing) to spend General Funds on IHSS providers' pay and benefits, but most are entirely reliant on 1991 Realignment revenues to fund their IHSS obligations. This manifests in wide variation in IHSS provider compensation across the state, as discussed in **Section II**, and makes it more difficult to meet the needs of a growing IHSS recipient population, given the clear link between wages and benefits, turnover/retention, and continuity of care discussed in **Section IV**.

Predictability. Another general principle for county funding for IHSS is the predictability of cost. Under county-level collective bargaining—or a regional collective bargaining model in which counties bargain in coalition—local budgets can inform negotiations over wages and benefits. If bargaining is centralized at the state level, counties might not find a straight pass-through of a share of state-negotiated wage increases workable without knowing what those wages are likely to be. The state and counties could consider an alternative model in which the MOE inflator is periodically re-set in accordance with Realignment revenue growth—as has occurred in the past—subject to adequacy of 1991 Realignment revenues.

Adequacy of Realignment revenue growth compared to MOE growth. Given state law on mandates and counties' reliance on 1991 Realignment revenues to fund their share of IHSS costs, a critical question is whether Realignment revenues are likely to be adequate to fund county obligations to IHSS. This applies to the status quo of county-level collective bargaining as well as to potential statewide bargaining. As we will describe below, the state has made significant adjustments to Realignment and MOE in the recent past, although IHSS continues to claim an increasing share of Realignment revenues available for social services.

Ultimately, implementation of statewide collective bargaining for IHSS providers would require a new MOE policy because the current MOE statute only provides for the allocation of locally negotiated wage increases and state minimum wage increases. Neither statewide nor regional collective bargaining is likely to change the fundamental existing need to make the growth of county obligations (MOE) better align with the growth of 1991 Realignment revenues. However, the substitution of county-level collective bargaining with statewide collective bargaining is likely to sharpen the need to match MOE and 1991 Realignment, given the constitutional provision on state mandates.

B. 1991 Realignment of Social Services

Under the 1991 Realignment, the state delegated to counties both more control over and greater fiscal responsibility for a range of social service, health, and mental health programs.[4] To help offset the increase in county service costs that resulted from Realignment, the state also established new dedicated revenue sources.

Legislative Intent Behind 1991 Realignment

The state legislature enacted 1991 Realignment to help resolve its own fiscal challenges and control realigned programs' future cost growth.[5] In the short term, because Realignment shifted roughly $2 billion in program costs to counties, it helped address a budget shortfall projected in the FY 1991-92 Governor's Budget. By shifting both costs and greater administrative responsibilities to counties, it was also hoped that Realignment could better control future cost growth, as counties would have a greater fiscal incentive to run locally administered programs efficiently.

Increase in County Funding Responsibilities

1991 Realignment increased counties' share of non-federal costs across a broad range of social services programs, including IHSS as well as foster care assistance, other child welfare services, and various CalWORKs programs. Prior to 1991 Realignment, counties were responsible for just

3 percent of non-federal IHSS costs; Realignment increased the county share to 35 percent. In total, 1991 Realignment shifted $2.2 billion in costs to counties in its first fiscal year, including $235 million in IHSS service costs.[6] **Table 6.1** shows the change in county social service program costs (as a share of total non-federal costs) that resulted from 1991 Realignment.[7]

Table 6.1. County Shares of Non-Federal Realignment Program Costs, Pre- and Post- Realignment

Realigned Program	Pre-Realignment	Post-Realignment
CalWORKs Aid	11%	5%
CalWORKs Eligibility	50%	30%
CalWORKs Employment Services	0%	30%
Foster Care	5%	60%
Child Welfare Services	24%	30%
Adoption Assistance	0%	25%
County Services Block Grant	16%	30%
In-Home Supportive Services	3%	35%
California Children's Services	25%	50%

Note: Table reproduced from Department of Finance (2019).

Diversion of State Sales Tax and Vehicle License Fee Revenue

The state constitution requires that the state reimburse local governments for the costs they incur providing state-mandated programs and services. To offset the county cost increases imposed by Realignment, the state passed a half-cent increase to the sales tax and adjusted the formula used to calculate the VLF paid annually by vehicle owners to increase fee revenue.

Though the additional revenue generated by these two measures was dedicated to counties to cover the increased costs associated with realigned programs, there was no mechanism that guaranteed that the growth in these revenue sources would cover the growth in county costs that resulted from Realignment. In fact, because demands for social services are more likely to increase during periods when economic growth slows or reverses, Realignment revenues may fall while county costs rise.[8]

Base Funding and Growth Allocations Under 1991 Realignment

For the first fiscal year, 1991 Realignment revenues were allocated across three "subaccounts"—Health, Mental Health, and Social Services—funded by sales tax and VLF revenues. Today, there are six separate subaccounts under 1991 Realignment. In addition to the three above, there are now the Child Poverty, Family Support, and CalWORKS MOE Subaccounts.

All six subaccounts receive both sales tax and VLF funding. In each fiscal year, the available revenue is first used to fund each subaccount's "base"—i.e., the amount of funding it received from that revenue source in the prior fiscal year. Caseload growth for a given social service program is generally a positive number but may in certain years be negative. A county's allocation of sales tax caseload growth is equal to the net increase in caseload costs across all realigned social service programs. If revenues have declined, each subaccount's base allocation is reduced proportionally, and that reduced funding level becomes the subaccount's base for the subsequent fiscal year.

If revenues have increased over the prior year and there is more revenue available to distribute after funding each account's base, state law determines how such "growth" funding is allocated. The rules governing the allocation of growth revenues have changed several times since 1991 Realignment's enactment. Since the FY 2019-20 MOE update, growth allocations work as follows:

- *Sales tax growth*: Sales tax growth first funds "caseload growth" and then provides "general growth" revenues.
    - *Caseload growth*: Any sales tax revenue remaining after funding each subaccount's sales tax base is first allocated to the Social Services Subaccount to cover "caseload growth." Social services caseload growth represents the change in costs each county incurs paying for realigned social service programs as a result of 1991 Realignment. Caseload growth for IHSS is equal to the change in the county's MOE.[9] To the extent that growth revenues in a given fiscal year are insufficient to fully cover caseload growth, the unpaid caseload growth remainder is added to the caseload growth amount determined in the subsequent fiscal year.
    - *General growth*: If there is still sales tax revenue remaining after paying all caseload growth owed for the current year and any unpaid remainder from prior years, the remaining sales tax funds are distributed to the Health Subaccount (18.5 percent of the remainder), the Mental Health Subaccount (37.4 percent), and the Child Poverty Subaccount (44.1 percent).
- *VLF growth*: All growth in VLF revenues is general growth that is allocated to the same Subaccounts in the same proportions as general growth revenues from the sales tax.

C. County Cost Share (Maintenance of Effort)

Over the 20-year period following 1991 Realignment, counties remained responsible for 35 percent of the non-federal share of IHSS costs. As a result, both the county and state IHSS cost responsibilities grew at the same rate as non-federal IHSS costs overall. Beginning in FY 2012-13, the state replaced this IHSS share-of-cost model with the Maintenance of Effort model in which counties' IHSS costs increased by a fixed annual inflation rate determined by state legislation, regardless of the actual increase in total non-federal IHSS costs. In addition to the annual inflation factor, counties' MOE payments also increased to reflect added service costs that resulted from locally negotiated wage and benefit increases that exceeded wage thresholds set by the state. This model was designed to create more fiscal predictability for counties. At the same time, the MOE model and its evolution over time has shifted an increasing share of funding responsibility for IHSS to the state general fund. The current policy, 2019 MOE, is described in the CDSS report to which this study is attached. **Table 6.2** shows the growth of the MOE since FY 2018-19, including the base, the inflation adjustment based on a 4 percent factor, and rate change adjustment based on locally negotiated wage and benefit increases.[10]

Table 6.2. Changes in County IHSS MOE, FY 2019-20 to FY 2023-24 (preliminary)

Millions of dollars	**FY 2019-20**	**FY 2020-21**	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**
MOE Base	**$1,563**	**$1,671**	**$1,766**	**$1,854**	**$2,015**
+ Inflation Factor	$64	$68	$71	$78	
+ Rate Change Adjustments	$43	$28	$16	$84	

Note: Data from California Department of Social Services County Fiscal Letters. FY 2023-24 MOE base is a preliminary estimate; inflation factor and rate change adjustment amounts not yet available.

D. 1991 Realignment Revenue Growth vs. IHSS Cost Growth, FY 2017-18 to FY 2023-24

Due to a rapid increase in program participation, IHSS service costs in recent years have grown substantially faster than Realignment revenues.

Trends in Recent Fiscal Years

IHSS services and administration costs are paid by the state with partial reimbursement from the federal government and county governments through the IHSS MOE. Counties use 1991 Realignment revenue, which consists of a share of the state sales tax and VLF revenues, to pay for IHSS costs and the costs of other realigned programs and services. To the extent that growth in the IHSS MOE exceeds the growth in Realignment revenue, less revenue is available to pay for the counties' share of other realigned programs.

IHSS costs in recent years have grown substantially faster than Realignment revenues. Between FY 2017-18 and FY 2023-24, non-federal IHSS costs more than doubled, increasing from $4.55 billion to $10.01 billion, as shown in **Table 6.3**.[11]

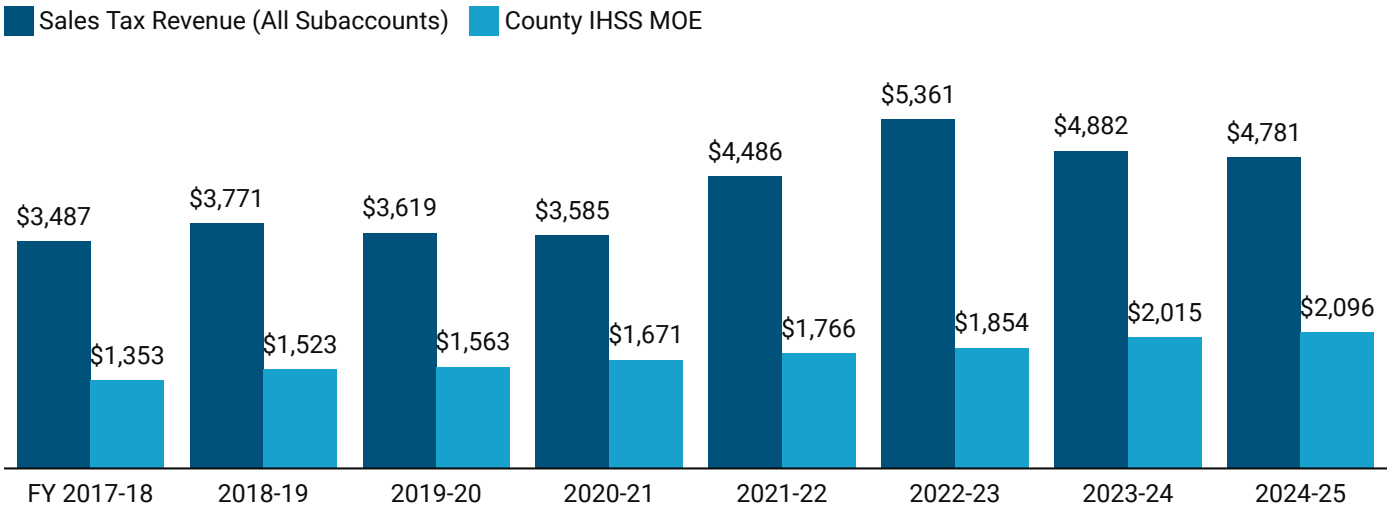
Because growth in the County IHSS MOE is partially limited by the annual inflation factor set by state law, the MOE has increased at a slower rate than overall cost inflation, while the state's share of service costs has grown more rapidly. As shown in **Table 6.3**, state IHSS costs increased by 16.5 percent annually over the FY 2017-18 to FY 2023-24 period, while the County MOE grew at a 6.9 percent annual rate.

Table 6.3. Growth in Total IHSS Costs, FY 2017-18 to FY 2023-24

Billions of dollars	FY 2017-18	FY 2023-24	Net Change ($)	Rate of Increase (annual)
Total IHSS Costs	**$11.13**	**$22.99**	**$11.85**	**12.8%**
Federal Costs	$6.58	$12.98	$6.40	12.0%
Non-Federal Costs	$4.55	$10.01	$5.46	11.9%
State Costs	$3.20	$7.99	$4.79	16.5%
County Costs (IHSS MOE)	$1.35	$2.02	$0.66	6.9%

Note: Blue Sky Consulting Group analysis of data from the California Department of Finance and California Department of Social Services. Total IHSS costs shown include all "Local Assistance" spending reported by the California Department of Finance. Local Assistance for IHSS includes service costs (the focus of this report) as well as county administration costs and costs related to the IHSS Case Management Info Payrolling System (CMIPS). Service costs comprise roughly 95% of total Local Assistance spending.

Figure 6.1. Growth in County MOE vs. 1991 Realignment Sales Tax Revenues, FY 2017-18 to FY 2024-25 (est.)

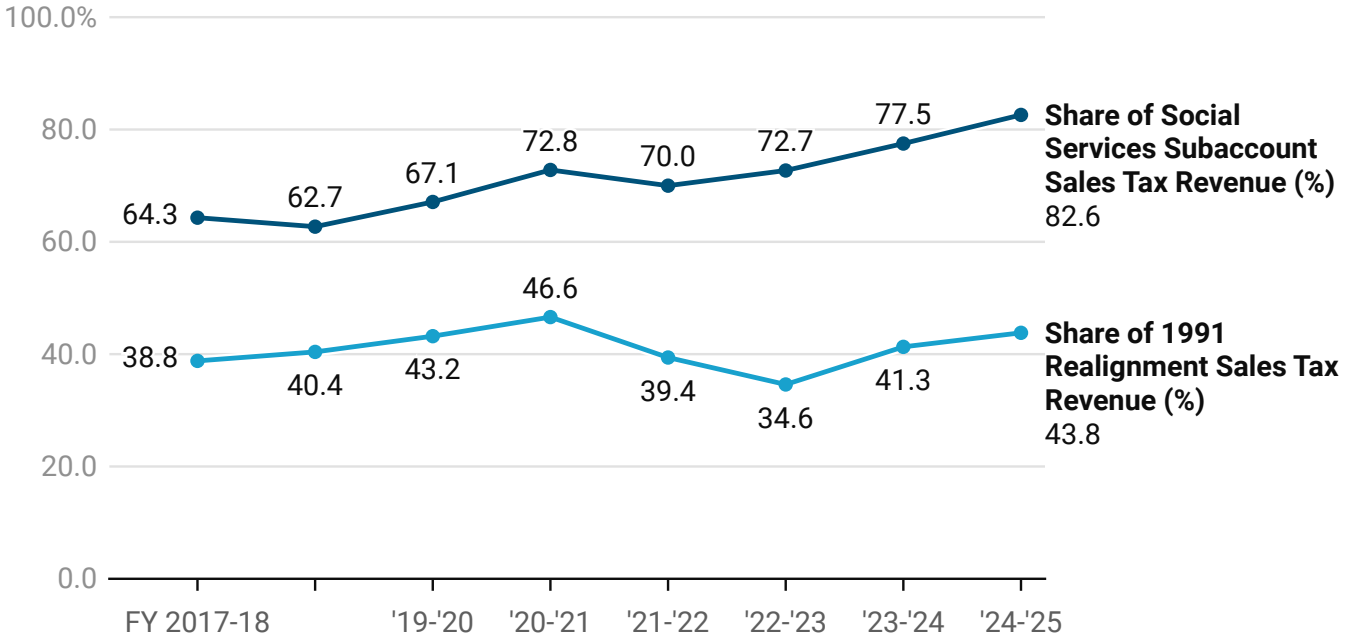


Note: Blue Sky Consulting Group analysis of data from California Department of Finance and the California Department of Social Services.

Even though the County MOE has not grown as rapidly as IHSS service costs overall, its growth has nevertheless outpaced the increase in 1991 Realignment sales tax funding during this period. **Figure 6.1** compares annual total MOE with 1991 Realignment sales tax revenues from FY 2017-18 to preliminary FY 2024-25 estimates that do not account for county share of wage increases that will become effective this year. MOE grew 55 percent, from $1.4 billion to $2.1 billion, while Realignment sales tax revenue grew 39 percent, from $3.5 billion to $4.8 billion during this period. These findings reflect nominal average annual growth rates of 6.5 percent vs. 4.6 percent, or real growth rates of 2.8 percent vs. 1.0 percent after adjusting for inflation.

Consequently, the MOE's share of Realignment sales tax revenue increased from 38.8 percent in FY 2017-18 to 43.8 percent in FY 2024-25 (**Figure 6.2**).[12, 13] The MOE's share of Realignment sales tax revenues rose between FY 2017-18 and FY 2020-21 (from 38.8 percent to 46.6 percent), then fell to 34.6 percent in FY 2022-23 due to increases in consumer spending during the COVID-19 pandemic. Between FY 2021-22 and FY 2023-24, however, sales tax revenues increased only 1.8 percent in aggregate. As a result, the MOE's share of total Realignment sales tax revenue climbed to 41.3 percent in FY 2023-24 and is expected to increase further to 43.8 percent of sales tax revenue in FY 2024-25. **Figure 6.2** shows a similar trend for the MOE's share of Social Service Subaccount revenues under 1991 Realignment, despite the fact that the subaccount grows with caseload. Because growth in the MOE has outpaced growth in sales tax revenues, counties today have a smaller share of Realignment funding available to pay for other realigned social service, health, and mental health programs than in the period prior to the pandemic.

Figure 6.2. County MOE Share of 1991 Realignment Sales Tax Revenues and Social Services Subaccount Revenues, FY 2017-18 to FY 2024-25 (est.)



Note: Blue Sky Consulting Group analysis of data from the California Department of Finance and IHSS program cost data obtained from the California Department of Social Services.

Future IHSS Cost Trends

Growth in total IHSS service costs over the next decade is expected to exceed historical rates of sales tax growth. As discussed in **Section V**, CDSS projects total IHSS service costs will grow at an 8.56 percent annual rate through FY 2031-32 due to a mix of increases in caseload, provider hours per case, and wages. These projections assume that wages grow at 3.1 percent a year.

At this projected program growth rate, IHSS cost inflation is likely to far exceed growth in Realignment sales tax revenues. During the prior decade's statewide economic expansion (FY 2013-14 to FY 2023-24), the sales tax base grew at an annual rate of 4.5 percent (or 1.2 percent in real terms), and DOF's most recent state economic forecast (May 2024) suggests that sales tax revenue is unlikely to exceed this rate of growth over the next several years.[14] DOF projects nominal personal income growth of roughly 4.8 percent statewide between CY 2024 and CY 2028 (or 2.2 percent in real terms), and over the past decade, the growth in personal income has outpaced growth in the sales tax by roughly 0.6 percentage points. For purposes of the analysis in this report, sales tax revenues are projected to grow at roughly 4.2 percent annually through FY 2031-32.

E. Exploration of Cost-Sharing Scenarios for Statewide Bargaining

Introduction to IHSS Service Cost and MOE Growth Modeling

This section of the report examines the impact that several possible wage increase and MOE formula adjustment scenarios ("MOE Scenarios") would have on state and county IHSS costs through FY 2031-32. Because the *net* fiscal impact under each MOE Scenario also depends on the growth in Realignment revenues from the state sales tax base, this section further considers how the results for each MOE scenario change due to changes in statewide economic conditions ("Economic Scenarios").

As the following analysis demonstrates, absent future reforms of the MOE, if county expenditures for IHSS provider wages continue to increase (beyond existing wage supplements tied to increases in the state's minimum wage), the County MOE will likely grow at a higher rate than sales tax Realignment revenues. As a result, counties will have less revenue available to pay for other realigned programs.[15] In addition, state costs for IHSS are expected to increase faster than County MOE costs under all scenarios examined.

IHSS Service Cost Drivers

Future growth in total IHSS service costs depends on the growth in IHSS service hours as well as future increases in IHSS provider wages. Absent future state reforms to the MOE formula, counties' cost burden will depend on the extent to which future wage increases trigger rate change adjustments, which effectively push MOE growth rates above the 4 percent annual inflation factor.

All MOE Scenarios adopt the following CDSS modeling[16] assumptions with regard to total IHSS service growth and state–county cost sharing:

- *IHSS beneficiaries and hours per beneficiary:* Beginning FY 2025-25, CDSS projects the IHSS beneficiary population will grow at a 4.01 percent annual rate and projects service hours per enrollee will grow at a 1.24 percent annual rate. As a result, total IHSS service hours are projected to grow by 5.3 percent annually.
- *IHSS provider wages*: Except where the MOE Scenario entails a negotiated wage increase, CDSS projects wages to grow by 3.1 percent annually.

- *Federal share:* Under all MOE Scenarios, CDSS projects the federal government's share of total IHSS service costs to remain fixed at 54.7 percent. The state (General Fund) and counties (MOE) contribute the remainder.

- *Rate change adjustments following wage increases*: For the MOE Scenarios that entail rate change adjustments following wage increases, this analysis allocates 35 percent of the added non-federal cost to the County MOE and the remaining 65 percent to the state.

Realignment Revenue Drivers

The growth in total Realignment revenues for counties depends on the growth in the state sales tax base and VLF revenues. Social Services Subaccount growth relies exclusively on increases in the sales tax base.[17]

Generally, sales tax revenues increase more quickly under favorable economic conditions and will grow more slowly, or even decline, during economic recessions. In nominal terms, the state sales tax base increased by roughly 4.5 percent annually over the period FY 2013-14 to FY 2023-24 (or 1.2 percent annually in real terms). However, over the prior 10-year period (FY 2003-04 to FY 2013-14) the sales tax base increased just 2.3 percent annually in nominal terms, or -0.1 percent in real terms, due to the Great Recession.

The most recent economic forecast published by the DOF, which provides the basis for this report's Economic Baseline Scenario, projects a growing statewide economy through the end of CY 2027. Given the possibility that future economic growth slows or reverses, however, this report also assesses how changes in sales tax base growth rates interact with alternative MOE Scenarios to impact funds available for other Realignment programs.

The modeling results below reflect the following Realignment revenue assumptions, common to all Economic Scenarios:

- *Caseload growth:* Social services caseload growth has the first priority on any available sales tax revenue growth. Measured caseload growth depends on changes in both the IHSS MOE and county costs incurred for other realigned social services programs. Changes in the IHSS MOE depend on the MOE Scenario chosen. Across all scenarios, the net change in other programs' caseloads is set equal to the average change over the six-year period FY 2017-18 to FY 2022-23, or -$6.5 million.

- *Timing of Realignment revenue receipts:* The modeling below shows county revenues based on the year in which the revenue will be received (regardless of when the revenue allocation is calculated). As a result, growth revenues determined in a given fiscal year do not appear as revenues in the results until the subsequent fiscal year.[18]

MOE and Economic Scenarios Modeled

The IHSS cost and revenue results presented below reflect both the MOE Scenario and Economic Scenario in effect.

This report considers six MOE Scenarios:

1. Under the "CDSS Baseline Cost Scenario" (from CDSS program cost projection), the MOE annual inflation factor remains set at 4 percent. Although wages grow at 3.1 percent a year, counties do not bear 35 percent of the cost of this growth (net of minimum wage increases) as they would under the current MOE.

2. The "CDSS $1 Alternative Scenario" retains the 4 percent annual inflation factor and adds a one-time $1 increase to provider wages in FY 2027-28. Counties bear 35 percent of this added cost.

3. The "CDSS $3 Alternative Scenario" retains the 4 percent annual inflation factor and adds a $3 increase to provider wages in FY 2027-28. Counties bear 35 percent of this added cost.

4. The "4 percent NRC Alternative Scenario" adds the $1 wage increase, but there is no rate change (NRC) adjustment imposed on the County MOE (i.e., the state incurs 100 percent of this cost increase).

5. The "5 percent NRC Alternative Scenario" adds the $1 wage increase without any rate change adjustment.

6. The "7 percent NRC Alternative Scenario" adds the $1 wage increase without any rate change adjustment.

The first three scenarios directly reflect CDSS cost projection model results for the allocation of costs between counties and the state. The latter three scenarios take the aggregate costs generated by CDSS for a $1-per-hour increase in provider compensation in addition to the baseline but allocate the counties' share of these costs based only on the hypothetical fixed MOE inflator for that scenario (i.e., they do not impose 35 percent of the wage increase cost on counties).

Results for each MOE Scenario are shown under four Economic Scenarios:

1. Under the "Economic Baseline Scenario," sales tax revenues grow by 1.4 percent in FY 2024-25[19] and by 4.2 percent annually, on average, over the period FY 2024-25 to FY 2031-32.

2. Under the "Slower Growth Scenario," sales tax revenues increase by 3.2 percent annually after FY 2024-25.

3. The "Zero Real Growth Scenario" has sales tax growth equal to the estimated rate of inflation in California (roughly 2.7 percent annually).

4. Finally, under the "Great Recession Repeat Scenario," annual changes in the sales tax base mirror the changes the state experienced over the seven-year period FY 2004-05 to FY 2011-12, when the sales tax base grew by only 0.7 percent annually, on average.

Section 1 of **Appendix B** provides the methodologies and further assumptions underlying the MOE and Economic Scenarios.

MOE Scenarios Results: Economic Baseline Scenario

The tables in this section summarize the results of the MOE Scenario analysis under the Economic Baseline Scenario. **Section 2** of **Appendix B** includes more detailed results tables with additional Realignment revenue and cost metrics across all years through FY 2031-32.

Table 6.4, below, shows how the County MOE and the state's IHSS service cost share change under each MOE Scenario. Under the Baseline MOE Scenario, the County MOE increases by 4 percent annually, reaching $2.76 billion by FY 2031-32. Under the $1 and $3 Alternatives, the County MOE increases by more than 4 percent in FY 2027-28, due to the rate change adjustments triggered by each scenario's wage increase. State costs are also higher under these scenarios, given the state's 65 percent share of costs from wage increases. Under the three NRC Alternatives, due to the exclusion of rate change adjustments, the MOE increases more steadily.

Of all the scenarios assessed, the $3 Alternative imposes both the highest County MOE and highest state cost by the end of the period, at roughly $3.51 billion and $18.13 billion, respectively. Because total IHSS service costs are expected to increase at a rate well above the MOE annual inflation factor, state costs increase far more rapidly than the County MOE under all scenarios shown. State costs are expected to increase by 9.8 percent annually on average under the Baseline Scenario. The $3 Alternative would cause state costs to increase at an average annual rate of 11.1 percent over the seven-year period.

Table 6.4. Projected Growth in County IHSS MOE and State Share of IHSS Service Costs Under Economic Baseline Scenario, By MOE Scenario, FY 2024-25 to FY 2031-32

Billions of dollars		FY 24-25	FY 25-26	FY 26-27	FY 27-28	FY 28-29	FY 29-30	FY 30-31	FY 31-32	Avg. Annual % Increase
CDSS Baseline	County MOE	$2.10	$2.18	$2.27	$2.36	$2.45	$2.55	$2.65	$2.76	4.0%
	State Cost	$8.68	$9.72	$10.65	$11.67	$12.77	$13.98	$15.29	$16.72	9.8%
$1 Alternative	County MOE	$2.10	$2.18	$2.27	$2.56	$2.67	$2.78	$2.89	$3.01	5.3%
	State Cost	$8.68	$9.72	$10.65	$12.05	$13.18	$14.40	$15.74	$17.19	10.2%
$3 Alternative	County MOE	$2.10	$2.18	$2.27	$2.97	$3.10	$3.23	$3.37	$3.51	7.7%
	State Cost	$8.68	$9.72	$10.65	$12.81	$13.98	$15.25	$16.63	$18.13	11.1%
4% NRC Alternative	County MOE	$2.10	$2.18	$2.27	$2.36	$2.45	$2.55	$2.65	$2.76	4.0%
	State Cost	$8.68	$9.72	$10.65	$12.25	$13.39	$14.63	$15.98	$17.44	10.5%
5% NRC Alternative	County MOE	$2.10	$2.18	$2.27	$2.38	$2.50	$2.62	$2.76	$2.89	4.7%
	State Cost	$8.68	$9.72	$10.65	$12.23	$13.34	$14.56	$15.87	$17.31	10.4%
7% NRC Alternative	County MOE	$2.10	$2.18	$2.27	$2.43	$2.60	$2.78	$2.97	$3.18	6.1%
	State Cost	$8.68	$9.72	$10.65	$12.19	$13.25	$14.40	$15.66	$17.02	10.1%

Note: County MOE and state cost projections provided by the California Department of Social Services. Average annual percentage increase calculated by Blue Sky Consulting Group.

Table 6.5. Growth in County MOE and General Growth Realignment Sales Tax Allocation, By MOE Scenario, FY 2024-25 to FY 2031-32

Billions of dollars		FY 24-25	FY 25-26	FY 26-27	FY 27-28	FY 28-29	FY 29-30	FY 30-31	FY 31-32	Net General Growth
Total Realignment Sales Tax Revenue (all subaccounts)		**$4.78**	**$4.92**	**$5.25**	**$5.48**	**$5.71**	**$5.95**	**$6.20**	**$6.46**	
Scenario										
CDSS Baseline	County MOE Share of Total Sales Tax	43.8%	44.3%	43.2%	43.0%	42.9%	42.8%	42.8%	42.7%	$0.707
	General Sales Tax Growth (other subaccounts)	$0	$0	$0	$0.098	$0.143	$0.149	$0.155	$0.162	
$1 Alternative	County MOE Share of Total Sales Tax	43.8%	44.3%	43.2%	46.8%	46.7%	46.7%	46.6%	46.6%	$0.479
	General Sales Tax Growth (other subaccounts)	$0	$0	$0	$0.098	$0.143	$0.000	$0.088	$0.150	
$3 Alternative	County MOE Share of Total Sales Tax	43.8%	44.3%	43.2%	54.3%	54.3%	54.3%	54.3%	54.4%	$0.241
	General Sales Tax Growth (other subaccounts)	$0	$0	$0	$0.098	$0.143	$0.000	$0.000	$0.000	
4% NRC Alternative	County MOE Share of Total Sales Tax	43.8%	44.3%	43.2%	43.0%	42.9%	42.8%	42.8%	42.7%	$0.707
	General Sales Tax Growth (other subaccounts)	$0	$0	$0	$0.098	$0.143	$0.149	$0.155	$0.162	
5% NRC Alternative	County MOE Share of Total Sales Tax	43.8%	44.3%	43.2%	43.4%	43.8%	44.1%	44.4%	44.8%	$0.632
	General Sales Tax Growth (other subaccounts)	$0	$0	$0	$0.098	$0.143	$0.126	$0.130	$0.135	
7% NRC Alternative	County MOE Share of Total Sales Tax	43.8%	44.3%	43.2%	44.3%	45.5%	46.7%	47.9%	49.2%	$0.480
	General Sales Tax Growth (other subaccounts)	$0	$0	$0	$0.098	$0.143	$0.081	$0.080	$0.078	

Note: Blue Sky Consulting Group analysis of data from the California Department of Finance and IHSS program cost data obtained from the California Department of Social Services.

Table 6.5, above, shows how the allocation of Realignment sales tax revenue changes under each County MOE Scenario. Under both the CDSS Baseline and the 4 percent NRC Alternative Scenarios, the County MOE declines slightly as a share of total sales tax Realignment revenue, from 43.8 percent in FY 2024-25 to 42.7 percent in FY 2031-32. Because the lower rates of MOE growth under these scenarios result in lower social service caseload growth measurements, more sales tax funding is available as general growth for programs outside of the Social Services Subaccount. The net gain for Health, Mental Health, and Child Poverty Subaccounts totals roughly $707 million over the seven-year period. In real terms sales tax revenue for these other 1991 Realignment programs grows at an average annual rate of 2.7 percent, and Social Services Subaccount sales tax revenue remaining after funding MOE grows at an annual rate of 1.2 percent.

Under the $3 Alternative Scenario, which has the highest rate of MOE growth, the MOE accounts for 54.4 percent of 1991 Realignment sales tax revenue allocated to counties in FY 2031-32—a share that is more than 10 percentage points higher than in FY 2024-25. As a result of the faster IHSS MOE growth, the $3 Alternative allows for just $241 million of general growth for the other 1991 Realignment subaccounts. The $1, 5 percent NRC, and 7 percent NRC Alternatives generate results in between the extremes of the CDSS Baseline and $3 Alternative; under these three scenarios, the IHSS MOE's share of total sales tax Realignment revenue grows over the period. In both the $3 wage increase and 7 percent MOE inflator scenarios, Social Services Subaccount sales tax revenue remaining after MOE declines by an annual average of 2.9 percent and 2.2 percent, respectively, after adjusting for inflation.

Economic Sensitivity Analysis

Total sales tax Realignment funding available in future fiscal years depends on the growth in the state sales tax base. **Table 6.6**, below, summarizes how MOE and Economic Scenarios interact to affect county costs and Realignment revenues. For each MOE Scenario, the results presented below show how sales tax revenues decline and the MOE share of available revenue increases by FY 2031-32 under alternative Economic Scenarios (i.e., the four right-hand columns). For any given MOE Scenario, slower sales tax revenue growth rates result in the MOE accounting for higher shares of available sales tax funding (and less available for other 1991 Realignment programs). The total Realignment sales tax funding available in FY 2031-32 (see top row) depends on the Economic Scenario. Under the Economic Baseline Scenario, $6.46 billion in sales tax revenue is generated in FY 2031-32, while revenues under the Great Recession Repeat Scenario are roughly 20 percent lower, at $5.15 billion. Results for the Slower Growth and Zero Real Growth Scenarios fall in between ($6.05 billion and $5.83 billion, respectively).

Under every MOE Scenario, if sales taxes follow the Slower Growth, Zero Real Growth, or Great Recession Repeat trends, the County MOE's share of total sales tax revenue increases between FY 2024-25 and FY 2031-32, leaving less revenue for other realigned programs. For example, under the CDSS Baseline, the MOE share of revenues increases from 43.8 percent in FY 2024-25 to between 45.6 percent (under the Slower Growth Scenario) and 53.6 percent (under the Great Recession Repeat Scenario). Under the $3 MOE Scenario, the MOE share ranges from 58.1 percent (Slower Growth) to 68.3 percent (Great Recession Repeat).

Table 6.6 also shows how, given faster MOE growth and slower sales tax growth, changes in the social services caseload growth calculation may exceed the sales tax growth funding available, depriving the other 1991 Realignment subaccounts of sales tax growth allocations. For instance, under the $1 Alternative, the other 1991 Realignment subaccounts receive $2.87 billion in FY 2031-32 under Economic Baseline conditions, an increase of $630 million to these subaccounts over the FY 2024-25 level. However, under the Zero Real Growth Scenario, all available sales tax growth revenue generated through FY 2031-32 is allocated to the Social Services Subaccount, and other Realignment subaccounts therefore do not grow over the seven-year period (i.e., funding for FY 2024-25 and FY 2031-32 would be $2.24 billion).

Table 6.6. Realignment Revenues and MOE Costs, By Economic and MOE Scenario, FY 2024-25 and FY 2031-32

Billions of dollars

	FY 2024-25	FY 2031-32			
Economic Scenario	**All**	**Baseline**	**Slower Growth**	**Zero Real Growth**	**Great Recession Repeat**
Total Realignment Sales Tax Revenue	**$4.78**	**$6.46**	**$6.05**	**$5.83**	**$5.15**
CDSS Baseline					
Revenue – Social Services Subaccount	$2.54	$3.35	$3.35	$3.35	$3.16
Revenue – Other 1991 subaccounts	$2.24	$3.11	$2.70	$2.48	$1.99
County MOE – Share of Sales Tax	43.8%	42.7%	45.6%	47.3%	53.6%
$1 Alternative					
Revenue – Social Services Subaccount	$2.54	$3.59	$3.63	$3.58	$3.22
Revenue – Other 1991 subaccounts	$2.24	$2.87	$2.42	$2.24	$1.93
County MOE – Share of Sales Tax	43.8%	46.6%	49.8%	51.7%	58.5%
$3 Alternative					
Revenue – Social Services Subaccount	$2.54	$3.98	$3.72	$3.58	$3.22
Revenue – Other 1991 subaccounts	$2.24	$2.49	$2.33	$2.24	$1.93
County MOE – Share of Sales Tax	43.8%	54.4%	58.1%	60.3%	68.3%
4% NRC Alternative					
Revenue – Social Services Subaccount	$2.54	$3.35	$3.35	$3.35	$3.16
Revenue – Other 1991 subaccounts	$2.24	$3.11	$2.70	$2.48	$1.99
County MOE – Share of Sales Tax	43.8%	42.7%	45.6%	47.3%	53.6%
5% NRC Alternative					
Revenue – Social Services Subaccount	$2.54	$3.45	$3.45	$3.45	$3.22
Revenue – Other 1991 subaccounts	$2.24	$3.01	$2.59	$2.37	$1.93
County MOE – Share of Sales Tax	43.8%	44.8%	47.8%	49.6%	56.2%
7% NRC Alternative					
Revenue – Social Services Subaccount	$2.54	$3.66	$3.66	$3.58	$3.22
Revenue – Other 1991 subaccounts	$2.24	$2.80	$2.38	$2.24	$1.93
County MOE – Share of Sales Tax	43.8%	49.2%	52.6%	54.6%	61.8%

Note: Blue Sky Consulting Group analysis of data from the California Department of Finance and IHSS program cost data obtained from the California Department of Social Services. Sales Tax revenues are the same in FY 2024-25 across all economic scenarios.

Implications of Statewide Collective Bargaining for MOE and 1991 Realignment

As suggested by the results of this analysis, future growth in Realignment revenues may not be sufficient to keep pace with County IHSS MOE cost increases under the status quo, resulting in less revenue available for other realigned program obligations over the next decade. Since the implementation of the 4 percent inflation factor in FY 2019-20, rate change adjustments tied to IHSS provider wage increases have resulted in an average annual growth rate of 6.6 percent in the County MOE. Even if MOE grows by 4 percent plus 35 percent of a $1 hourly wage increase—a modest one-time 5 percent increase over baseline wages in the context of a five-year timeframe—IHSS will continue to absorb an increasing share of 1991 Realignment revenues. The same results apply to the MOE inflator being raised to 5 percent with no additional adjustment for wage growth. However, in both cases the sales tax revenue available for non-IHSS Realignment programs still increases slightly in real terms.

Regardless of whether the state opts to move to statewide collective bargaining or continues the status quo, the state will need to address these issues going forward. The legislature commissioned a DOF study to recommend changes to 1991 Realignment to reflect the impact of the FY 2017-18 MOE revision (SB90).[20] A significant change to MOE to accommodate statewide bargaining is likely to require the same in-depth analysis.

The above MOE Scenario analysis considers only how future county IHSS cost obligations may affect counties' ability to sustain funding for other realigned programs. This report does not consider historical trends in the costs these programs have imposed on counties or how costs for these other programs are expected to change in future years. Development of recommendations for future changes to the County MOE formula to accommodate statewide bargaining would therefore require further fiscal and legislative analysis.

A legal analysis is likely also necessary to evaluate how MOE could be restructured to accommodate statewide collective bargaining, given the state constitutional restriction on unpaid mandates and the fact that wage increases would be negotiated by the state, rather than by counties.

Endnotes

1 Blue Sky Consulting provided the background on MOE and Realignment, compiled data on IHSS program cost and 1991 Realignment revenue history, and projected future 1991 Realignment revenues based on available economic forecasts and CDSS program cost projections.

2 Mac Taylor, "Rethinking the 1991 Realignment" (California Legislative Analyst's Office, 2018), https://lao.ca.gov/reports/2018/3886/1991-realignment-101518.pdf.

3 Scott Graves, "County Budgets: Where Does the Money Come From? How Is It Spent?," Fact Sheet (Public Policy Institute of California, April 2018), https://calbudgetcenter.org/resources/county-budgets-where-does-the-money-come-from-how-is-it-spent/.

4 This section and the following section were written by Blue Sky Consulting and edited by project co-investigators.

5 Taylor, "Rethinking the 1991 Realignment."

6 *Senate Bill 90: 1991 Realignment Report* (Department of Finance, 2019), https://dof.ca.gov/wp-content/uploads/sites/352/Reports/Other/documents/Senate_Bill_90-1991_Realignment_Report.pdf.

7 *Senate Bill 90: 1991 Realignment Report*.

8 Local governments may seek enforcement of the California Constitution's state mandate provisions by filing claims for additional reimbursement if the revenues dedicated to pay for a state-mandated service are insufficient to cover local government costs. To discourage these claims, the legislature included "poison pill" in the 1991 Realignment. Under this clause, if any county claims additional reimbursement under the state mandate, 1991 Realignment becomes inoperative for every county, thus reducing counties' shares of realigned program costs while also depriving counties of the new Realignment revenue sources.

9 Caseload growth for a given social service program is generally a positive number but may in certain years be negative. A county's allocation of sales tax caseload growth is equal to the net increase in caseload costs across all realigned social service programs.

10 See Note 11 for a list of the County Fiscal Letters cited for each fiscal year's County MOE.

11 For total IHSS costs and the state's share of costs, see Department of Finance, *2024-25 State Budget: 5180 Department of Social Services*, June 26, 2024, https://ebudget.ca.gov/budget/2024-25EN/#/Department/5180; Department of Finance, *2019-20 State Budget: 5180 Department of Social Services*, June 27, 2019, https://ebudget.ca.gov/budget/2024-25EN/#/Department/5180.

The FY 2017-18 County MOE is net of state General Fund offsets of roughly $400 million. For County MOE obligations, see Salena Chow (Chief, Fiscal Forecasting and Policy Branch, CDSS) to all County Welfare Directors, "FINAL FISCAL YEAR 2017-18 MAINTENANCE OF EFFORT REQUIREMENT FOR THE IN-HOME SUPPORTIVE SERVICES PROGRAM" (PDF), COUNTY FISCAL LETTER (CFL) NO. 18/19-56, February 12, 2019, https://cdss.ca.gov/Portals/9/CFL/2019/18-19_56.pdf?ver=2019-02-13-145942-397; Nathan Hart (Chief, Financial Management Branch, Finance and Accounting Division) to all County Welfare Directors, "FINAL FISCAL YEAR 2022-23 MAINTENANCE OF EFFORT REQUIREMENT AND PRELIMINARY FISCAL YEAR 2023-24 MAINTENANCE OF EFFORT REQUIREMENT FOR THE IN-HOME

SUPPORTIVE SERVICES PROGRAM" (PDF), COUNTY FISCAL LETTER NO. 23/24-52, January 29, 2024, https://cdss.ca.gov/Portals/9/Additional-Resources/Letters-and-Notices/CFLs/2024/23-24_52.pdf?ver=2024-02-08-104014-010.

Federal costs were set equal to total costs less the sum of state costs and county costs.

12 Although a portion of the vehicle license fee (VLF) is available to fund IHSS costs, the amount of VLF available does not increase over time. Therefore, any increases in IHSS costs must be paid for with increases in sales tax revenue.

13 For 1991 Realignment sales tax revenues received in FY 2017-18, see Department of Finance, *2019-20 State Budget: 5195 1991 State-Local Realignment*, https://ebudget.ca.gov/budget/publication/#/e/2019-20/Department/5195; for FY 2018-19 revenues, see Department of Finance, *2020-21 State Budget: 5195 1991 State-Local Realignment*, https://ebudget.ca.gov/budget/publication/#/e/2020-21/Department/5195; for FY 2019-20 revenues, see Department of Finance, *2021-22 State Budget: 5195 1991 State-Local Realignment*, https://ebudget.ca.gov/budget/publication/#/e/2021-22/Department/5195; for FY 2020-21 revenues, see *2022-23 State Budget: 5195 1991 State-Local Realignment*, https://ebudget.ca.gov/budget/2022-23EN/#/Department/5195; for FY 2021-22 revenues, see *2023-24 State Budget: 5195 1991 State-Local Realignment*, https://ebudget.ca.gov/budget/2023-24EN/#/Department/5195; and for revenues received in FY 2022-23, FY 2023-24 (estimated), and FY 2024-25 (preliminary), see Department of Finance, *2024-25 State Budget: 5195 1991 State-Local Realignment*, https://ebudget.ca.gov/budget/2024-25EN/#/Department/5195.

The County MOEs in FY 2017-18 and FY 2018-19 are net of General Fund contributions of $400 million and $330 million, respectively.

For the FY 2017-18 County IHSS MOE obligations, see Chow, "COUNTY FISCAL LETTER (CFL) NO. 18/19-56"; for the FY 2018-19 MOE obligation, see Salena Chow (Chief, Fiscal Forecasting and Policy Branch, CDSS) to all County Welfare Directors, "COUNTY FISCAL LETTER (CFL) No. 19/20-55," December 27, 2019, https://cdss.ca.gov/Portals/9/Additional-Resources/Letters-and-Notices/CFLs/2019/19-20_55.pdf; for the FY 2019-20 MOE obligation, see Yang Lee (Acting Chief, Fiscal Forecasting and Policy Branch, CDSS) to all County Welfare Directors, "COUNTY FISCAL LETTER (CFL) No. 20/21-82," April 15, 2021, https://cdss.ca.gov/Portals/9/Additional-Resources/Letters-and-Notices/CFLs/2021/20-21_82.pdf?ver=2021-04-16-143147-630; for the FY 2020-21 and FY 2021-22 MOE obligations, see Kira Younger (Chief, Fiscal Forecasting and Policy Branch, CDSS), to all County Welfare Directors, "COUNTY FISCAL LETTER (CFL) No. 21/22-42," November 24, 2021, https://cdss.ca.gov/Portals/9/Additional-Resources/Letters-and-Notices/CFLs/2022/21-22_42.pdf?ver=2021-12-09-112634-450; for the FY 2023-24 MOE obligation, see Hart, "COUNTY FISCAL LETTER NO. 23/24-52"; data for FY 2024-25 MOE obligation was obtained from IHSS cost projections developed by CDSS.

14 Department of Finance, "Economic Forecasts, U.S. and California," accessed September 23, 2024, https://dof.ca.gov/forecasting/economics/economic-forecasts-u-s-and-california/.

15 If sales tax grows as projected in this report, County MOE could grow by 4 percent plus 35 percent of modest annual provider wage growth—under 1 percent net of inflation—and still allow for real growth in 1991 Realignment revenues for other social programs. Due to the two-year delay between caseload growth and Realignment revenue allocation, it would take some time for this to become evident.

16 IHSS program cost projection data provided by CDSS.

17 In other words, because the Social Services Subaccount does not receive any VLF growth regardless of increases in social service program caseload costs, the VLF revenues available for other realigned programs are the same under all of the MOE Scenarios assessed.

18 Eileen Cubanski, "1991 Realignment," County Welfare Directors Association of California, February 10, 2017, https://www.cwda.org/sites/main/files/file-attachments/1991_realignment_hot_topic-feb._2017_meeting_0.pdf?1488216966. The caseload growth allocation for a given fiscal year is equal to the change in expenditures between the fiscal year two years earlier and the fiscal year immediately prior; caseload growth allocations are not disbursed to counties until the beginning of the subsequent fiscal year. For instance, caseload growth for FY 2022-23 is equal to the difference between FY 2020-21 costs and FY 2021-22 costs. The county does not receive this revenue until October of FY 2023-24, however. Effectively, counties' reimbursement for any cost increase is received two fiscal years after it occurs.

19 Department of Finance, *2024-25 State Budget: 5195 1991 State-Local Realignmen*t, https://ebudget.ca.gov/budget/2024-25EN/#/Department/5195.

20 *Senate Bill 90: 1991 Realignment Report*.

VII. Potential Funding Sources

It is not known whether spending would increase under a new bargaining model (as discussed in **Section V**), nor is it known how the non-federal share of any increased costs would be allocated in terms of state versus county responsibility. This section discusses several sources of funding that could be considered to cover increased costs to the state and/or counties if regional or statewide bargaining increases spending relative to the status quo. Potential sources of funding discussed include General Fund spending, increased federal contributions if federal law is changed, and Realignment funding for any increased county costs.

A. General Fund

The state IHSS share has historically been paid out of the General Fund. Any new collective bargaining agreement under statewide or regional bargaining would need to be approved by the legislature and governor and weighed against other priorities in the budgeting process.

Given the projected increases in IHSS program costs due to the aging of the population, the state may want to partner with IHSS stakeholders to explore additional revenue streams for the program separately from the issue of a change in the collective bargaining model. This exploration could include seeking federal solutions to the nationwide issue of increased demand for long-term services and supports and exploring new state revenue options. Detailing the options for new revenue is beyond the scope of this project.

In considering the General Fund impacts of potential increased spending on wage and benefits, it is important to also consider the impacts of increased spending on California's economy and tax revenues. Every state and county dollar spent on IHSS brings an additional $1.21 in federal IHSS dollars into California's economy on average.[1] These federal dollars have a multiplier effect that ripples throughout our state economy as IHSS providers spend their increased disposable income at local businesses, those businesses spend more on supplies, and workers at local businesses and suppliers spend more, recirculating the dollars through the economy multiple times. Given that each dollar spent on home care is estimated to boost the economy by more than a dollar,[2] each state and county dollar spent on IHSS brings in at least $2.42 in total economic benefit to the state. This impact also means increased state income, property, and sales tax revenues, which could partially offset any additional spending.

Another potential offset to increased spending is Medi-Cal General Fund savings on institutional care. As discussed in **Section IV**, research indicates that higher wages are strongly correlated with reduced turnover and increased retention, especially among non-family caregivers. To the extent that improved wages and benefits result in improved recruitment and retention, more Californians may receive the care they need in their homes and avoid institutional care. Reduced Medi-Cal spending on skilled nursing facility and other institutional care could partially offset the increased Medi-Cal spending on improved wages and benefits.

B. Federal Funding

Currently, the federal government pays at least half of the cost of IHSS services and administration. The exact Federal Medical Assistance Percentage (FMAP) for IHSS services varies by program: 90 percent for services received by adults ages 19 to 64 who became eligible for Medi-Cal under the Affordable Care Act expansion; 56 percent for Community First Choice Option recipients; and 50 percent for the Personal Care Services Program and IHSS Plus Option. The FMAP for IHSS administrative costs is 50 percent for all IHSS programs other than the Residual Program. No federal funding applies for services or administrative costs in the IHSS Residual Program, which comprised 2.6 percent of all IHSS recipients in June 2024.[3]

Federal COVID relief laws temporarily increased federal funds available to support the IHSS program. The Families First Coronavirus Response Act (enacted in 2020) temporarily increased the FMAP by 6.2 percentage points for all Medicaid services during the Public Health Emergency, and ARPA (enacted in 2021) temporarily increased the FMAP for certain HCBS by an additional 10 percentage points. Enhanced federal funding was used to support a range of new HCBS initiatives, including one-time $500 payments to IHSS providers and the IHSS Career Pathways Program (see **Section IV** for further details). After the end of the Public Health Emergency, the enhanced FMAP was phased down to normal levels by the beginning of 2024.[4]

Additional proposals to increase federal funding were considered by Congress during the pandemic, but not enacted. The Better Jobs Better Care Act, introduced in 2021 and re-introduced in 2023, would have provided a permanent 10 percentage point increase in Medicaid HCBS FMAP for states with approved plans to expand HCBS access and support the direct care workforce. The act would have also provided a temporary additional 2 percentage point FMAP increase for states that adopt a program to support self-direction and increased the FMAP for administrative costs for certain activities from 50 to 80 percent, among other provisions. A reduced version of the Better Jobs Better Care Act was included in the Build Back Better Act, a COVID relief package that passed the House in 2021 but was not ultimately enacted.

If federal funding for Medicaid HCBS increases permanently in the future, those additional federal dollars could be used to support any increased state and/or county spending due to a new collective bargaining model or program growth.

C. 1991 Realignment Revenues

The use of 1991 Realignment as a source of funding for any county responsibility for wage increases bargained at the state level faces a critical challenge: County MOE growth already exceeds 1991 Realignment revenue growth. Even without a change in collective bargaining—and assuming negligible wage growth for providers beyond inflation—IHSS will continue to absorb an increasing share of 1991 Realignment revenues.

As demonstrated in **Section VI** of this report, County MOE growth has historically outstripped Realignment revenue growth. For example, county-level IHSS costs grew by an average annual rate of 6.9 percent between FY 2017-18 and FY 2023-24, while the 1991 Realignment sales tax revenue increased by 4.6 percent annually.[5] Assuming a 4.2 percent growth rate in sales tax revenue based on somewhat lower inflation than has occurred in recent years, this trend will continue into the future under current MOE policy, even if provider compensation growth decreases significantly from the FY 2017-2024 average of 7.7 percent. While Realignment can hypothetically absorb a higher wage growth rate in the short term, Realignment funding for other non-entitlement social service programs would be flattened. A slower all-in MOE growth rate of 4 percent would stabilize the IHSS share of 1991 Realignment but result in the state absorbing an increasing share of future program costs.

Endnotes

1 This assumes a 54.7 percent FMAP for IHSS based on the estimates in **Section VI**.

2 Cassandra Robertson, Marokey Sawo, and David Cooper, "All States Must Set Higher Wage Benchmarks for Home Health Care Workers" (Economic Policy Institute, June 2, 2022), https://www.epi.org/publication/state-home-health-care-wages/.

3 California Department of Social Services, "In-Home Supportive Services (IHSS) Program Data" (California Department of Social Services, July 2024), https://www.cdss.ca.gov/Portals/9/IHSS/Data/IHSS_Program_Data-Jun2024.xlsx.

4 Nita M. [D-NY-17 Rep. Lowey, "H.R.6201 - 116th Congress (2019-2020): Families First Coronavirus Response Act," legislation, March 18, 2020, 2020-03-11, https://www.congress.gov/bill/116th-congress/house-bill/6201/text.

5 See **Section VI** for further details.

VIII. Conclusion

The IHSS program for Medi-Cal recipients helps more than 700,000 low-income disabled, aged, and blind Californians live safely in their own homes, while supporting recipient choice and autonomy. The vast majority of IHSS home care workers are employed through the Individual Provider mode, in which individual recipients hire, supervise, and terminate their own caregivers but have no control over pay and benefits. These workers are paid with public funds. Current IP collective bargaining rights are based on state law, passed in the 1990s, which required each county to establish a public authority or other employer of record for the purposes of collective bargaining with IPs over a limited set of employment issues, including wages and benefits. IPs are represented by UDW or SEIU Local 2015, depending on their county of work.

This study analyzed the potential impacts of transitioning collective bargaining with IHSS providers from the current county-based model to a statewide or regional model. We documented the challenge of meeting the growing need for home care workers in general and IHSS providers in particular, given an aging California, limited labor supply, and low wages. We reviewed academic research on the drivers of recruitment and retention of home care providers and investigated collective bargaining models from other states. We also analyzed the potential impacts of statewide collective bargaining on labor cost growth and program financing (including MOE, 1991 Realignment, and potential funding sources). The present section summarizes the key findings of this research.

To begin, IHSS employs a large and diverse provider workforce. There are currently more than 700,000 active providers in the IHSS program. Providers are significantly older than the state workforce as a whole, and 72 percent are family members of the recipients. Three quarters of IHSS providers are women, and one in four speak a language other than English. Among the home care workforce more broadly in California, approximately one half are foreign-born and a significant share are women of color.

The IHSS program is also growing rapidly, which has significant ramifications for two broad themes raised by AB 102 related to collective bargaining: 1) the ability of IHSS to muster sufficient workforce to meet the needs of service recipients; and 2) fiscal impacts in terms of overall cost and program financing. CDSS baseline projection for non-federal spending on IHSS reflects an annual growth rate of 8.56 percent, with costs nearly doubling over the next seven years. This estimate is based on recent caseload growth and conservative assumptions

about future provider wage growth. The following discussion first focuses on workforce-related findings of this study, highlights structures and outcomes of statewide collective bargaining for home care providers in other states, then concludes with key findings related to the cost and financing implications of statewide or regional collective bargaining for IHSS.

California faces a projected shortage of home care workers, creating uncertainty in how the workforce will expand to meet rising demand given slow growth of the overall population and workforce. This forecast is significant for IHSS recipients and the program as a whole because the program employs an estimated 71 percent of all home care workers in the state.

A major obstacle to meeting growing demand for home care labor in the IHSS program is the low level of wages and benefits. The average IHSS provider wage was $18.13 as of July 2024, approximately $2 above the statewide minimum wage. IHSS providers who worked year-round in 2023 had median annual earnings of $23,006. IHSS providers—and home care workers identified in Census data more broadly—earn less than half of what other workers in California earn annually. Home care workers in the state at large are more than twice as likely to experience poverty.

Under the current model of county-level collective bargaining, there is significant variation in IHSS pay and benefits across California counties. Though the state minimum wage serves as the foundation for provider pay, wages vary from $16.00, the current statewide minimum wage, to $21.50 per hour. Health benefits also vary. Although health benefits are nominally offered in more than half of California counties, only 16 percent of all IHSS providers receive these benefits and two thirds of those enrolled work in three counties. Negotiated terms of employment also vary by county.

These findings are significant because in existing academic research on direct care workers, there is broad consensus that wages and quality health benefits are two of the most important job quality indicators correlated with home care provider retention. Research also shows that increased continuity of care through consistency of caregivers leads to improved health outcomes and greater satisfaction among service recipients. For IHSS specifically, studies have shown that the level of provider wages relative to the wage floor impacts non-relative caregiver turnover, while wages may influence relative caregivers' decision to join IHSS. Indeed, IHSS relative caregivers' share of the IHSS grew from 68 percent to 72 percent between 2017 and 2024. Turnover for both relative and non-relative providers declined slightly from 2017 through 2021 and then rose significantly in 2023. More than 28 percent of non-relative providers left IHSS in 2023. This trend is concerning given that an increasing share of seniors with care needs lack a spouse or adult child to care for them.

While the impact of statewide collective bargaining on overall wages is uncertain, based on elasticities from existing studies on the impact of wages on turnover, each $1 increase in

provider compensation in July 2027—the earliest that a statewide contract could reasonably take effect—could reduce overall annual turnover in IHSS by 2 percentage points. Improved retention could lead to incremental improvements in recipient health outcomes compared to baseline.

We found that at least six other states have implemented statewide bargaining for Medicaid-funded consumer-directed home care workers. In some states, unions bargain directly with state agencies, while in other states, unions bargain with councils and commissions that include state and consumer representation. In Washington, a unique model combines a rate-setting board and "agency with choice" model. As in California county-based bargaining, bargaining in these other states covers a wide range of topics, including: wages; benefits like health insurance, paid time off, retirement, and workers' compensation; terms of employment such as paid training programs; and new structures such as the establishment of a racial justice committee.

In these other states, starting wages are generally higher for IPs compared to wages for the vast majority of California IHSS providers, primarily reflecting differences in bargained wage levels—all but one of these states have minimum wages that are lower than California's minimum wage. A number of states offer wage differentials or bonuses based on longevity, training, or recipient characteristics in an effort to institutionalize career ladders, consistent with recommendations in academic and policy research on home care workforce development.

Statewide bargaining has provided the opportunity to promote consistent standards statewide and create efficiency. Statewide bargaining has also enabled substantial structural changes that are best implemented at the state level, such as a health benefits plan in one state that leverages its large scale when negotiating with health insurers and health care premium assistance programs in two states that were implemented in coordination with state insurance marketplaces. The establishment of councils or commissions in some states have created a formal mechanism for consumer voice in the bargaining process.

The experiences of other states notwithstanding, the impact of statewide bargaining on overall IHSS cost growth is not predetermined. Statewide bargaining would create a new framework and process for collective bargaining, not a set outcome. Key determining factors would include state budget context, the capacity of workers to negotiate higher wages through their unions, and the ability of the state and IHSS stakeholders to identify new revenue sources. However, wage compression—decreased wage inequality among providers statewide—is a potential outcome based on existing research on wage compression in centralized bargaining, particularly in the public sector, and the fact that a range of stakeholders have identified raising the wage floor for the lowest-paid providers as a goal of statewide bargaining. We would expect the greatest wage increases in counties with lower wage levels.

Given the uncertainty about the exact impact of statewide bargaining on wages and benefits—and as required by AB 102—CDSS analyzed hypothetical wage scenarios of $1-5 per hour under statewide bargaining and found that each across-the-board $1 compensation increase is estimated to cost $590 million in increased non-federal spending in the first year. This amount would be equivalent to a 3.7 to 4.2 percent increase (depending on year) above CDSS projected baseline cost between FY 2027-28 and FY 2031-32.

While it is not clear what kind of impact statewide collective bargaining will have on the overall cost of the program, it does have implications for how the cost of wage growth is allocated among the state and counties, which raises two issues. First, the current County Maintenance of Effort (MOE) statute for allocating IHSS program costs is predicated on county-level collective bargaining and will need to be amended to address how costs will be shared under statewide bargaining. Second, County MOE has grown at a faster rate than 1991 Realignment revenues—the primary funding source for county IHSS costs—over the past seven years. The Realignment projection model results presented in this study show that County MOE is likely to continue growing at a faster rate than Realignment revenues unless MOE is limited to share only a low level of real wage growth. A deeper analysis would be required to re-calibrate MOE policy to work within the bounds of 1991 Realignment, as has happened in the past.

Appendix A. County-Level Wage Statistics

Table A.1. IHSS Provider and State Minimum Nominal Wage Growth, By County, 2019-2024

	2019	2020	2021	2022	2023	2024	2019-2024	Compound Annual Growth
Average IHSS Wage	**9.0**	**9.3**	**8.9**	**7.0**	**3.9**	**8.2**	**56.0**	**7.7**
State Minimum Wage	**9.1**	**8.3**	**7.7**	**7.1**	**3.3**	**3.2**	**45.5**	**6.4**
Alameda	0.0	18.0	6.8	6.3	8.1	5.2	52.4	7.3
Alpine	9.1	12.5	7.4	6.9	3.2	3.1	50.0	7.0
Amador	9.1	8.3	7.7	7.1	3.3	12.9	59.1	8.0
Butte	9.1	8.3	7.7	10.7	3.2	3.1	50.0	7.0
Calaveras	9.1	8.3	7.7	7.1	3.3	3.2	45.5	6.4
Colusa	9.1	8.3	11.5	6.9	3.2	3.1	50.0	7.0
Contra Costa	0.0	6.1	15.4	6.7	3.1	11.7	50.4	7.0
Del Norte	9.1	12.5	7.4	6.9	10.3	2.9	60.0	8.1
El Dorado	9.1	8.3	11.5	6.9	3.2	3.1	50.0	7.0
Fresno	9.1	8.3	12.3	6.8	3.2	3.1	50.9	7.1
Glenn	9.1	8.3	7.7	7.1	3.3	8.1	52.3	7.3
Humboldt	9.1	12.5	7.4	6.9	3.2	3.1	50.0	7.0
Imperial	9.1	11.7	7.5	6.9	6.5	4.6	55.9	7.7
Inyo	9.1	8.3	11.5	8.6	3.2	3.1	52.3	7.3
Kern	9.1	8.3	7.7	7.1	3.3	3.2	45.5	6.4
Kings	9.1	8.3	7.7	7.1	7.3	3.1	50.9	7.1
Lake	9.1	8.3	7.7	11.8	3.2	3.1	51.4	7.2
Lassen	9.1	8.3	7.7	7.1	7.7	3.1	51.4	7.2
Los Angeles	12.7	9.5	8.7	6.7	3.1	9.1	61.0	8.3
Madera	9.1	8.3	7.7	10.7	3.2	3.1	50.0	7.0
Marin	2.9	4.2	3.0	10.5	0.6	2.9	26.4	4.0
Mariposa	7.7	8.3	12.3	6.8	3.2	3.1	49.0	6.9
Mendocino	9.1	8.3	15.4	6.7	3.1	3.0	54.5	7.5
Merced	9.1	8.3	12.3	6.8	3.2	3.1	50.9	7.1
Modoc	9.1	8.3	7.7	13.2	3.2	3.1	53.2	7.4
Mono	9.1	12.5	7.4	6.9	3.2	3.1	50.0	7.0
Monterey	0.0	14.3	7.0	6.5	6.8	5.8	47.1	6.6
Napa	0.0	7.4	18.8	6.5	3.0	2.9	44.2	6.3

continued

Table A.1 continued

	2019	2020	2021	2022	2023	2024	2019-2024	Compound Annual Growth
Average IHSS Wage	**9.0**	**9.3**	**8.9**	**7.0**	**3.9**	**8.2**	**56.0**	**7.7**
State Minimum Wage	**9.1**	**8.3**	**7.7**	**7.1**	**3.3**	**3.2**	**45.5**	**6.4**
Nevada	9.1	8.3	11.5	6.9	3.2	3.1	50.0	7.0
Orange	9.1	12.5	7.4	6.9	3.2	12.5	63.6	8.6
Placer	9.1	8.3	10.8	6.9	3.2	10.7	60.0	8.1
Plumas	9.1	8.3	11.5	6.9	3.2	3.1	50.0	7.0
Riverside	4.3	10.4	9.4	6.9	3.2	12.5	56.5	7.8
Sacramento	18.2	7.7	7.1	6.7	3.1	3.0	54.5	7.5
San Benito	9.1	15.0	7.2	6.8	3.2	3.1	52.7	7.3
San Bernardino	9.1	8.3	11.5	6.9	3.2	9.4	59.1	8.0
San Diego	8.7	8.0	7.4	6.9	3.2	15.6	60.9	8.2
San Francisco	7.1	10.0	4.5	4.3	6.9	7.8	48.2	6.8
San Joaquin	9.1	8.3	11.5	6.9	3.2	3.1	50.0	7.0
San Luis Obispo	9.7	7.7	7.9	16.7	2.8	2.8	57.3	7.8
San Mateo	9.9	2.5	7.0	16.1	2.8	3.4	48.7	6.8
Santa Barbara	0.8	7.4	13.6	6.8	6.4	5.6	47.7	6.7
Santa Clara	0.0	7.7	11.6	6.4	9.0	7.8	50.3	7.0
Santa Cruz	4.7	14.0	0.0	24.9	0.0	5.6	57.6	7.9
Shasta	9.6	7.9	7.4	6.8	9.6	2.9	53.0	7.4
Sierra	9.1	8.3	11.5	6.9	3.2	3.1	50.0	7.0
Siskiyou	9.1	8.3	7.7	7.1	3.3	3.2	45.5	6.4
Solano	8.7	8.0	7.4	11.7	3.1	3.0	49.6	6.9
Sonoma	0.0	0.0	15.4	9.0	3.1	3.0	33.5	4.9
Stanislaus	9.1	8.3	11.5	6.9	3.2	7.8	56.8	7.8
Sutter	9.1	8.3	10.8	6.9	3.2	3.1	49.1	6.9
Tehama	9.1	8.3	7.7	7.1	3.3	3.2	45.5	6.4
Trinity	8.7	8.0	7.4	6.9	8.7	3.0	50.9	7.1
Tulare	9.1	8.3	7.7	11.4	3.2	3.1	50.9	7.1
Tuolumne	13.6	8.0	7.4	6.9	6.5	3.0	54.5	7.5
Ventura	2.2	5.3	8.8	11.7	5.8	5.5	46.0	6.5
Yolo	8.9	8.3	13.5	6.8	3.2	3.1	52.0	7.2
Yuba	9.1	8.3	11.5	7.9	3.2	3.1	51.4	7.2

Note: UC Berkeley Labor Center analysis of In-Home Supportive Services (IHSS) Program Data. Average IHSS wage is weighted by paid hours. Wage growth is calculated as of January 1 of each year compared to January 1 of the prior year.

Table A.2. IHSS Provider and State Minimum Real Wage Growth, By County, 2019-2024

	2019	2020	2021	2022	2023	2024	2019-2024	Compound Annual Growth
Average IHSS Wage	**6.1**	**6.0**	**6.6**	**-0.6**	**-1.0**	**4.8**	**23.7**	**3.6**
State Minimum Wage	**6.2**	**5.1**	**5.5**	**-0.5**	**-1.6**	**0.0**	**15.3**	**2.4**
Alameda	-2.7	14.5	4.6	-1.2	2.9	2.0	20.8	3.2
Alpine	6.2	9.1	5.2	-0.7	-1.7	-0.1	18.9	2.9
Amador	6.2	5.1	5.5	-0.5	-1.6	9.4	26.1	3.9
Butte	6.2	5.1	5.5	2.8	-1.7	-0.1	18.9	2.9
Calaveras	6.2	5.1	5.5	-0.5	-1.6	0.0	15.3	2.4
Colusa	6.2	5.1	9.3	-0.7	-1.7	-0.1	18.9	2.9
Contra Costa	-2.7	2.9	13.0	-0.9	-1.8	8.2	19.3	3.0
Del Norte	6.2	9.1	5.2	-0.7	5.1	-0.3	26.9	4.0
El Dorado	6.2	5.1	9.3	-0.7	-1.7	-0.1	18.9	2.9
Fresno	6.2	5.1	10.0	-0.7	-1.7	-0.1	19.6	3.0
Glenn	6.2	5.1	5.5	-0.5	-1.6	4.7	20.7	3.2
Humboldt	6.2	9.1	5.2	-0.7	-1.7	-0.1	18.9	2.9
Imperial	6.2	8.3	5.3	-0.7	1.4	1.3	23.6	3.6
Inyo	6.2	5.1	9.3	0.9	-1.7	-0.1	20.7	3.2
Kern	6.2	5.1	5.5	-0.5	-1.6	0.0	15.3	2.4
Kings	6.2	5.1	5.5	-0.5	2.2	-0.1	19.6	3.0
Lake	6.2	5.1	5.5	3.8	-1.7	-0.1	20.0	3.1
Lassen	6.2	5.1	5.5	-0.5	2.6	-0.1	20.0	3.1
Los Angeles	9.7	6.2	6.5	-0.9	-1.8	5.7	27.6	4.2
Madera	6.2	5.1	5.5	2.8	-1.7	-0.1	18.9	2.9
Marin	0.2	1.1	0.9	2.6	-4.2	-0.3	0.3	0.0
Mariposa	4.8	5.1	10.0	-0.7	-1.7	-0.1	18.1	2.8
Mendocino	6.2	5.1	13.0	-0.9	-1.8	-0.2	22.5	3.4
Merced	6.2	5.1	10.0	-0.7	-1.7	-0.1	19.6	3.0
Modoc	6.2	5.1	5.5	5.2	-1.7	-0.2	21.4	3.3
Mono	6.2	9.1	5.2	-0.7	-1.7	-0.1	18.9	2.9
Monterey	-2.7	10.9	4.8	-1.0	1.7	2.4	16.6	2.6
Napa	-2.7	4.2	16.4	-1.1	-1.8	-0.3	14.3	2.3
Nevada	6.2	5.1	9.3	-0.7	-1.7	-0.1	18.9	2.9
Orange	6.2	9.1	5.2	-0.7	-1.7	9.0	29.7	4.4

continued

Table A.2 continued

	2019	2020	2021	2022	2023	2024	2019-2024	Compound Annual Growth
Average IHSS Wage	**6.1**	**6.0**	**6.6**	**-0.6**	**-1.0**	**4.8**	**23.7**	**3.6**
State Minimum Wage	**6.2**	**5.1**	**5.5**	**-0.5**	**-1.6**	**0.0**	**15.3**	**2.4**
Placer	6.2	5.1	8.5	-0.7	-1.6	7.2	26.9	4.0
Plumas	6.2	5.1	9.3	-0.7	-1.7	-0.1	18.9	2.9
Riverside	1.6	7.1	7.2	-0.7	-1.7	9.0	24.1	3.7
Sacramento	15.0	4.5	5.0	-0.9	-1.8	-0.2	22.5	3.4
San Benito	6.2	11.6	5.1	-0.8	-1.7	-0.2	21.1	3.2
San Bernardino	6.2	5.1	9.3	-0.7	-1.7	6.0	26.1	3.9
San Diego	5.8	4.8	5.2	-0.7	-1.7	12.0	27.5	4.1
San Francisco	4.3	6.7	2.4	-3.1	1.9	4.4	17.5	2.7
San Joaquin	6.2	5.1	9.3	-0.7	-1.7	-0.1	18.9	2.9
San Luis Obispo	6.8	4.5	5.7	8.4	-2.0	-0.5	24.7	3.7
San Mateo	6.9	-0.6	4.8	7.8	-2.0	0.1	17.9	2.8
Santa Barbara	-1.9	4.2	11.3	-0.8	1.4	2.3	17.1	2.7
Santa Clara	-2.7	4.5	9.3	-1.2	3.9	4.5	19.2	3.0
Santa Cruz	1.9	10.6	-2.0	16.0	-4.7	2.3	24.9	3.8
Shasta	6.6	4.7	5.2	-0.7	4.4	-0.3	21.3	3.3
Sierra	6.2	5.1	9.3	-0.7	-1.7	-0.1	18.9	2.9
Siskiyou	6.2	5.1	5.5	-0.5	-1.6	0.0	15.3	2.4
Solano	5.8	4.8	5.2	3.8	-1.8	-0.2	18.6	2.9
Sonoma	-2.7	-3.0	13.0	1.3	-1.8	-0.3	5.8	0.9
Stanislaus	6.2	5.1	9.3	-0.7	-1.7	4.4	24.3	3.7
Sutter	6.2	5.1	8.5	-0.7	-1.6	-0.1	18.2	2.8
Tehama	6.2	5.1	5.5	-0.5	-1.6	0.0	15.3	2.4
Trinity	5.8	4.8	5.2	-0.7	3.6	-0.3	19.6	3.0
Tulare	6.2	5.1	5.5	3.5	-1.7	-0.1	19.6	3.0
Tuolumne	10.6	4.8	5.2	-0.7	1.4	-0.2	22.5	3.4
Ventura	-0.5	2.2	6.5	3.7	0.8	2.2	15.8	2.5
Yolo	6.0	5.1	11.1	-0.8	-1.7	-0.1	20.5	3.2
Yuba	6.2	5.1	9.3	0.3	-1.7	-0.1	20.0	3.1

Note: UC Berkeley Labor Center analysis of In-Home Supportive Services (IHSS) Program Data. Average IHSS wage is weighted by paid hours. Wages were inflated to 2024 dollars using California Department of Industrial Relations Consumer Price Index for all Urban Wage Earners and Clerical Workers. Real wage growth is calculated as of January 1 of each year compared to January 1 of the prior year.

Table A.3. IHSS Provider and State Minimum Wage Rates in 2024 Dollars, By County, 2018-2024

	2018	2019	2020	2021	2022	2023	2024
Average IHSS Wage	**14.51**	**15.40**	**16.33**	**17.41**	**17.31**	**17.13**	**17.95**
State Minimum Wage	**13.87**	**14.73**	**15.48**	**16.33**	**16.25**	**16.00**	**16.00**
Alameda	15.77	15.35	17.57	18.37	18.15	18.68	19.05
Alpine	13.87	14.73	16.08	16.92	16.80	16.52	16.50
Amador	13.87	14.73	15.48	16.33	16.25	16.00	17.50
Butte	13.87	14.73	15.48	16.33	16.80	16.52	16.50
Calaveras	13.87	14.73	15.48	16.33	16.25	16.00	16.00
Colusa	13.87	14.73	15.48	16.92	16.80	16.52	16.50
Contra Costa	15.45	15.04	15.48	17.50	17.34	17.03	18.43
Del Norte	13.87	14.73	16.08	16.92	16.80	17.65	17.60
El Dorado	13.87	14.73	15.48	16.92	16.80	16.52	16.50
Fresno	13.87	14.73	15.48	17.03	16.90	16.62	16.60
Glenn	13.87	14.73	15.48	16.33	16.25	16.00	16.75
Humboldt	13.87	14.73	16.08	16.92	16.80	16.52	16.50
Imperial	13.87	14.73	15.96	16.80	16.69	16.93	17.15
Inyo	13.87	14.73	15.48	16.92	17.07	16.77	16.75
Kern	13.87	14.73	15.48	16.33	16.25	16.00	16.00
Kings	13.87	14.73	15.48	16.33	16.25	16.62	16.60
Lake	13.87	14.73	15.48	16.33	16.96	16.67	16.65
Lassen	13.87	14.73	15.48	16.33	16.25	16.67	16.65
Los Angeles	14.10	15.47	16.43	17.50	17.34	17.03	18.00
Madera	13.87	14.73	15.48	16.33	16.80	16.52	16.50
Marin	17.41	17.43	17.62	17.79	18.26	17.50	17.45
Mariposa	14.05	14.73	15.48	17.03	16.90	16.62	16.60
Mendocino	13.87	14.73	15.48	17.50	17.34	17.03	17.00
Merced	13.87	14.73	15.48	17.03	16.90	16.62	16.60
Modoc	13.87	14.73	15.48	16.33	17.18	16.88	16.85
Mono	13.87	14.73	16.08	16.92	16.80	16.52	16.50
Monterey	15.77	15.35	17.02	17.84	17.65	17.95	18.39
Napa	15.26	14.85	15.48	18.02	17.83	17.50	17.45
Nevada	13.87	14.73	15.48	16.92	16.80	16.52	16.50
Orange	13.87	14.73	16.08	16.92	16.80	16.52	18.00
Placer	13.87	14.73	15.48	16.80	16.69	16.41	17.60

continued

Table A.3 continued

	2018	2019	2020	2021	2022	2023	2024
Average IHSS Wage	**14.51**	**15.40**	**16.33**	**17.41**	**17.31**	**17.13**	**17.95**
State Minimum Wage	**13.87**	**14.73**	**15.48**	**16.33**	**16.25**	**16.00**	**16.00**
Plumas	13.87	14.73	15.48	16.92	16.80	16.52	16.50
Riverside	14.50	14.73	15.78	16.92	16.80	16.52	18.00
Sacramento	13.87	15.96	16.67	17.50	17.34	17.03	17.00
San Benito	13.87	14.73	16.43	17.26	17.12	16.83	16.80
San Bernardino	13.87	14.73	15.48	16.92	16.80	16.52	17.50
San Diego	14.50	15.35	16.08	16.92	16.80	16.52	18.50
San Francisco	17.66	18.41	19.65	20.12	19.51	19.87	20.75
San Joaquin	13.87	14.73	15.48	16.92	16.80	16.52	16.50
San Luis Obispo	14.95	15.96	16.67	17.63	19.12	18.73	18.64
San Mateo	15.96	17.06	16.97	17.79	19.18	18.79	18.81
Santa Barbara	15.14	14.85	15.48	17.23	17.09	17.32	17.72
Santa Clara	16.40	15.96	16.67	18.22	18.01	18.70	19.54
Santa Cruz	15.01	15.30	16.92	16.58	19.23	18.32	18.75
Shasta	14.50	15.47	16.20	17.03	16.90	17.65	17.60
Sierra	13.87	14.73	15.48	16.92	16.80	16.52	16.50
Siskiyou	13.87	14.73	15.48	16.33	16.25	16.00	16.00
Solano	14.50	15.35	16.08	16.92	17.55	17.24	17.20
Sonoma	16.40	15.96	15.48	17.50	17.72	17.39	17.35
Stanislaus	13.87	14.73	15.48	16.92	16.80	16.52	17.25
Sutter	13.87	14.73	15.48	16.80	16.69	16.41	16.40
Tehama	13.87	14.73	15.48	16.33	16.25	16.00	16.00
Trinity	14.50	15.35	16.08	16.92	16.80	17.39	17.35
Tulare	13.87	14.73	15.48	16.33	16.90	16.62	16.60
Tuolumne	13.87	15.35	16.08	16.92	16.80	17.03	17.00
Ventura	15.77	15.69	16.03	17.08	17.72	17.86	18.25
Yolo	13.90	14.73	15.48	17.21	17.07	16.77	16.75
Yuba	13.87	14.73	15.48	16.92	16.96	16.67	16.65

Note: UC Berkeley Labor Center analysis of In-Home Supportive Services (IHSS) Program Data. Average IHSS wage is weighted by paid hours. Wages represent real wages as of January of each year in 2024 dollars. Wages were inflated to 2024 dollars using California Department of Industrial Relations Consumer Price Index for all Urban Wage Earners and Clerical Workers.

Table A.4. IHSS Provider and State Minimum Wage Rates, By County, 2018-2024

	2018	2019	2020	2021	2022	2023	2024
Average IHSS Wage	**11.51**	**12.54**	**13.71**	**14.93**	**15.97**	**16.59**	**17.95**
Minimum Wage	**11.00**	**12.00**	**13.00**	**14.00**	**15.00**	**15.50**	**16.00**
Alameda	12.50	12.50	14.75	15.75	16.75	18.10	19.05
Alpine	11.00	12.00	13.50	14.50	15.50	16.00	16.50
Amador	11.00	12.00	13.00	14.00	15.00	15.50	17.50
Butte	11.00	12.00	13.00	14.00	15.50	16.00	16.50
Calaveras	11.00	12.00	13.00	14.00	15.00	15.50	16.00
Colusa	11.00	12.00	13.00	14.50	15.50	16.00	16.50
Contra Costa	12.25	12.25	13.00	15.00	16.00	16.50	18.43
Del Norte	11.00	12.00	13.50	14.50	15.50	17.10	17.60
El Dorado	11.00	12.00	13.00	14.50	15.50	16.00	16.50
Fresno	11.00	12.00	13.00	14.60	15.60	16.10	16.60
Glenn	11.00	12.00	13.00	14.00	15.00	15.50	16.75
Humboldt	11.00	12.00	13.50	14.50	15.50	16.00	16.50
Imperial	11.00	12.00	13.40	14.40	15.40	16.40	17.15
Inyo	11.00	12.00	13.00	14.50	15.75	16.25	16.75
Kern	11.00	12.00	13.00	14.00	15.00	15.50	16.00
Kings	11.00	12.00	13.00	14.00	15.00	16.10	16.60
Lake	11.00	12.00	13.00	14.00	15.65	16.15	16.65
Lassen	11.00	12.00	13.00	14.00	15.00	16.15	16.65
Los Angeles	11.18	12.60	13.80	15.00	16.00	16.50	18.00
Madera	11.00	12.00	13.00	14.00	15.50	16.00	16.50
Marin	13.80	14.20	14.80	15.25	16.85	16.95	17.45
Mariposa	11.14	12.00	13.00	14.60	15.60	16.10	16.60
Mendocino	11.00	12.00	13.00	15.00	16.00	16.50	17.00
Merced	11.00	12.00	13.00	14.60	15.60	16.10	16.60
Modoc	11.00	12.00	13.00	14.00	15.85	16.35	16.85
Mono	11.00	12.00	13.50	14.50	15.50	16.00	16.50
Monterey	12.50	12.50	14.29	15.29	16.29	17.39	18.39
Napa	12.10	12.10	13.00	15.45	16.45	16.95	17.45
Nevada	11.00	12.00	13.00	14.50	15.50	16.00	16.50
Orange	11.00	12.00	13.50	14.50	15.50	16.00	18.00
Placer	11.00	12.00	13.00	14.40	15.40	15.90	17.60

continued

Table A.4 continued

	2018	2019	2020	2021	2022	2023	2024
Average IHSS Wage	**11.51**	**12.54**	**13.71**	**14.93**	**15.97**	**16.59**	**17.95**
Minimum Wage	**11.00**	**12.00**	**13.00**	**14.00**	**15.00**	**15.50**	**16.00**
Plumas	11.00	12.00	13.00	14.50	15.50	16.00	16.50
Riverside	11.50	12.00	13.25	14.50	15.50	16.00	18.00
Sacramento	11.00	13.00	14.00	15.00	16.00	16.50	17.00
San Benito	11.00	12.00	13.80	14.80	15.80	16.30	16.80
San Bernardino	11.00	12.00	13.00	14.50	15.50	16.00	17.50
San Diego	11.50	12.50	13.50	14.50	15.50	16.00	18.50
San Francisco	14.00	15.00	16.50	17.25	18.00	19.25	20.75
San Joaquin	11.00	12.00	13.00	14.50	15.50	16.00	16.50
San Luis Obispo	11.85	13.00	14.00	15.11	17.64	18.14	18.64
San Mateo	12.65	13.90	14.25	15.25	17.70	18.20	18.81
Santa Barbara	12.00	12.10	13.00	14.77	15.77	16.78	17.72
Santa Clara	13.00	13.00	14.00	15.62	16.62	18.12	19.54
Santa Cruz	11.90	12.46	14.21	14.21	17.75	17.75	18.75
Shasta	11.50	12.60	13.60	14.60	15.60	17.10	17.60
Sierra	11.00	12.00	13.00	14.50	15.50	16.00	16.50
Siskiyou	11.00	12.00	13.00	14.00	15.00	15.50	16.00
Solano	11.50	12.50	13.50	14.50	16.20	16.70	17.20
Sonoma	13.00	13.00	13.00	15.00	16.35	16.85	17.35
Stanislaus	11.00	12.00	13.00	14.50	15.50	16.00	17.25
Sutter	11.00	12.00	13.00	14.40	15.40	15.90	16.40
Tehama	11.00	12.00	13.00	14.00	15.00	15.50	16.00
Trinity	11.50	12.50	13.50	14.50	15.50	16.85	17.35
Tulare	11.00	12.00	13.00	14.00	15.60	16.10	16.60
Tuolumne	11.00	12.50	13.50	14.50	15.50	16.50	17.00
Ventura	12.50	12.78	13.46	14.64	16.35	17.30	18.25
Yolo	11.02	12.00	13.00	14.75	15.75	16.25	16.75
Yuba	11.00	12.00	13.00	14.50	15.65	16.15	16.65

Note: UC Berkeley Labor Center analysis of In-Home Supportive Services (IHSS) program data. Average IHSS wage is weighted by paid hours. Wages represent nominal wages as of January of each year.

Table A.5. Share of Total IHSS Paid Provider Hours, By County, 2018-2024

	2018	2019	2020	2021	2022	2023	2024	Percent Change 2018-2024	Percentage Point Change 2018-2024
Alameda	4.4	4.3	4.2	4.1	4.1	4.0	3.9	-11.6	0.5
Alpine	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-10.3	0.0
Amador	0.0	0.0	0.0	0.0	0.1	0.1	0.0	6.4	0.0
Butte	0.8	0.7	0.6	0.6	0.6	0.6	0.5	-29.3	0.2
Calaveras	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.6	0.0
Colusa	0.0	0.0	0.0	0.0	0.1	0.0	0.0	66.6	0.0
Contra Costa	1.6	1.7	1.8	1.8	1.9	2.0	2.0	24.5	-0.4
Del Norte	0.1	0.1	0.1	0.1	0.1	0.1	0.0	-35.0	0.0
El Dorado	0.3	0.3	0.3	0.3	0.3	0.3	0.3	6.0	0.0
Fresno	3.7	3.6	3.6	3.7	3.6	3.7	3.8	3.3	-0.1
Glenn	0.1	0.1	0.1	0.1	0.1	0.1	0.1	-16.4	0.0
Humboldt	0.3	0.3	0.3	0.3	0.3	0.3	0.3	2.0	0.0
Imperial	0.8	0.8	0.9	0.8	0.8	0.9	0.9	14.9	-0.1
Inyo	0.0	0.0	0.0	0.0	0.0	0.0	0.0	37.9	0.0
Kern	0.9	1.1	1.2	1.3	1.4	1.5	1.8	105.2	-0.9
Kings	0.4	0.4	0.4	0.4	0.4	0.4	0.5	11.5	0.0
Lake	0.4	0.4	0.3	0.3	0.3	0.3	0.3	-18.2	0.1
Lassen	0.0	0.0	0.0	0.0	0.0	0.0	0.0	13.2	0.0
Los Angeles	38.3	37.8	36.3	36.3	35.7	34.9	34.4	-10.3	3.9
Madera	0.3	0.3	0.3	0.3	0.4	0.4	0.4	23.6	-0.1
Marin	0.3	0.3	0.3	0.3	0.3	0.3	0.3	-19.5	0.1
Mariposa	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.8	0.0
Mendocino	0.3	0.3	0.3	0.2	0.2	0.2	0.2	-20.6	0.1
Merced	0.5	0.5	0.5	0.5	0.5	0.6	0.6	18.2	-0.1
Modoc	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	0.0
Mono	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-25.7	0.0
Monterey	0.8	0.8	0.8	0.8	0.8	0.8	0.8	4.0	0.0
Napa	0.2	0.2	0.2	0.2	0.2	0.2	0.2	-11.7	0.0
Nevada	0.1	0.1	0.1	0.1	0.1	0.1	0.1	10.9	0.0
Orange	5.0	5.1	5.1	5.4	5.6	5.7	5.7	14.4	-0.7
Placer	0.8	0.8	0.8	0.8	0.8	0.8	0.7	-2.7	0.0

continued

Table A.5 continued

	2018	2019	2020	2021	2022	2023	2024	Percent Change 2018-2024	Percentage Point Change 2018-2024
Plumas	0.0	0.0	0.1	0.0	0.0	0.0	0.0	-23.0	0.0
Riverside	6.0	6.1	6.7	6.5	6.6	6.9	7.3	21.7	-1.3
Sacramento	5.3	5.2	5.3	5.3	5.3	5.2	5.0	-4.8	0.3
San Benito	0.1	0.1	0.1	0.1	0.1	0.1	0.1	6.2	0.0
San Bernardino	5.4	5.6	5.8	5.7	5.7	5.7	6.0	10.8	-0.6
San Diego	4.8	5.0	5.1	5.3	5.5	5.6	5.7	18.9	-0.9
San Francisco	3.7	3.6	3.5	3.5	3.4	3.3	3.2	-13.2	0.5
San Joaquin	1.0	1.0	1.0	1.0	1.0	1.1	1.0	5.5	-0.1
San Luis Obispo	0.3	0.3	0.3	0.4	0.3	0.4	0.4	7.3	0.0
San Mateo	1.0	1.0	1.0	1.0	1.0	1.0	1.0	4.9	0.0
Santa Barbara	0.5	0.5	0.6	0.6	0.6	0.6	0.6	10.5	-0.1
Santa Clara	4.4	4.5	4.6	4.6	4.7	4.6	4.6	3.8	-0.2
Santa Cruz	0.4	0.4	0.4	0.4	0.4	0.4	0.4	-16.3	0.1
Shasta	0.5	0.5	0.5	0.5	0.6	0.5	0.5	-1.6	0.0
Sierra	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-3.2	0.0
Siskiyou	0.1	0.1	0.1	0.1	0.1	0.1	0.1	-35.7	0.0
Solano	1.0	0.9	0.9	0.8	0.8	0.8	0.8	-11.6	0.1
Sonoma	1.1	1.0	1.1	1.1	1.0	1.0	1.0	-7.6	0.1
Stanislaus	1.0	1.0	1.0	1.0	1.0	1.0	0.9	-8.8	0.1
Sutter	0.2	0.2	0.2	0.2	0.2	0.2	0.2	-1.2	0.0
Tehama	0.2	0.2	0.2	0.2	0.2	0.2	0.2	-6.6	0.0
Trinity	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-34.3	0.0
Tulare	0.6	0.7	0.8	0.8	0.9	0.9	1.0	68.8	-0.4
Tuolumne	0.1	0.1	0.1	0.1	0.1	0.1	0.1	23.1	0.0
Ventura	1.2	1.2	1.2	1.1	1.2	1.2	1.2	-1.2	0.0
Yolo	0.5	0.5	0.5	0.5	0.5	0.5	0.4	-6.2	0.0
Yuba	0.1	0.1	0.1	0.1	0.1	0.2	0.2	32.1	0.0
Statewide Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**		

Note: UC Berkeley Labor Center analysis of In-Home Supportive Services (IHSS) program data.

Appendix B: CMIPS Data Analysis Notes

CDSS provided the Labor Center with IHSS administrative data related to providers from the Case Management Information and Payroll System (CMIPS) for the purposes of analyzing provider characteristics, earnings, and turnover. The data we received consisted of provider payroll warrant data from January 2017 to July 2024, as well as provider information files for active and terminated providers as of August 2024. The dataset was de-identified by CDSS, but included demographic information including gender, birth year, language, county of work, and the provider's relationship to each recipient they worked for, as well as codes for the IHSS programs under which they worked. CDSS also excluded variables that entailed Protected Health Information about IHSS recipients. Each provider and each recipient in the dataset had a unique identification number. Each record contained information about the pay period—which is semimonthly—type of payment, payment amount, hourly wage, and hours worked. The two provider information files contained records for each provider-recipient relationship. Likewise, there was a separate payroll warrant for each recipient that a provider worked for during a given pay period.

We used the active provider management file for the demographic and earnings analysis in Section II. This was a straightforward exercise, and the methods are explained in endnotes.

For turnover rates in Section IV, we first merged the warrant data with demographic and relationship-to-recipient variables from the provider management files. We excluded warrants that were coded as voided or replaced, and then subsetted the dataset to include only records with service hours, resulting in approximately 118 million records. We did not use sick leave or one-time bonuses as part of the determination of active provider status for the purposes of this analysis, because these payments could lag several months (and, in the case of the January 2022 pandemic retention bonuses, well over a year) after the last date worked.

Exit dates were identified for each provider based on their last pay period in this dataset. We generated monthly and annual summary variables for relationship to recipient, hours worked, and other characteristics for each provider, then de-duplicated the dataset to the year-month-provider level and year-provider level to complete the turnover analysis.

There are several methods for estimating turnover. Given the rapid growth of the program, we calculated turnover as the number of separations divided by the active workforce size each year. The numerator for the annual turnover rate is the number of providers who left each calendar year, determined by the end date of the last semi-monthly pay period in which they reported paid service hours. The denominator is the annual average of monthly active provider

headcounts. Both the number of leavers each year and average active monthly headcounts were calculated separately for relative and non-relative providers.

The above method reflects statewide program-level IHSS provider turnover. Since non-relative providers often change IHSS recipients, turnover at the individual recipient level is higher than program-level turnover.

Appendix C. Realignment Analysis Supplemental Data

1. Historical Realignment Revenues

Table C.1. Realignment Revenues, By Revenue Source and Subaccount, FY 2017-18 to FY 2024-25 (projected)

	FY 17-18	FY 18-19	FY 19-20	FY 20-21	FY 21-22	FY 22-23	FY 23-24	FY 24-25 (proj.)
Total 1991 Realignment Funding	**$5,573**	**$5,985**	**$5,796**	**$5,658**	**$7,142**	**$7,730**	**$7,486**	**$7,553**
Social Services Subaccount Total	**$2,292**	**$2,678**	**$2,609**	**$2,512**	**$2,740**	**$2,766**	**$2,818**	**$2,752**
Sales Tax	$2,103	$2,430	$2,330	$2,296	$2,524	$2,550	$2,602	$2,536
VLF	$189	$249	$279	$216	$216	$216	$216	$216
Other 1991 Realignment Subaccounts Total	**$3,281**	**$3,307**	**$3,186**	**$3,146**	**$4,402**	**$4,963**	**$4,668**	**$4,801**
Sales Tax	$1,384	$1,341	$1,289	$1,289	$1,963	$2,811	$2,280	$2,245
VLF	$1,897	$1,966	$1,898	$1,857	$2,440	$2,152	$2,388	$2,557

Note: Blue Sky Consulting Group analysis of data from the California Department of Finance, California Department of Social Services, and CDSS cost projections for IHSS.

Table C.2 below shows, for each fiscal year, the net change in caseload growth for each realigned program category across all counties, excluding IHSS. As shown, for the six-year fiscal period surveyed, the average net caseload growth was roughly -$6.56 million. This amount is added to IHSS caseload growth to estimate the net caseload growth for each fiscal year under each MOE Scenario.[1]

Table C.2. Net Caseload Growth, By Realigned Program, FY 2017-18 to FY 2022-23

Fiscal Year	CalWORKS Payments	CalWorks/ Foster Care/ CalFresh Admin	Foster Care	Child Welfare Services	Adoption Assistance	California Children's Services	Total Non-IHSS Caseload Growth
2017-18	$6,062,335	($1,615,989)	($20,336,308)	($1,455,121)	$4,296,763	($763,304)	**($13,811,624)**
2018-19	$7,873,282	$13,390,314	($15,002,394)	$1,374,984	$6,956,431	($530,231)	**$14,062,386**
2019-20	$4,298,915	($8,840,177)	$10,597,939	$2,959,452	$8,209,755	$1,549,858	**$18,775,741**
2020-21	($7,620,800)	($7,940,726)	$4,066,310	$10,156,667	($1,588,857)	$6,101,978	**$3,174,572**
2021-22	$2,300,631	($24,209,246)	($6,881,678)	($1,088,329)	($4,790,638)	($2,118,829)	**($36,788,089)**
2022-23	($551,340)	($31,859,767)	($35,004,764)	$38,204,558	$630,766	$3,796,441	**($24,784,106)**
Average	**$2,060,504**	**($10,179,265)**	**($10,426,816)**	**$8,358,702**	**$2,285,703**	**$1,339,319**	**($6,561,853)**

Note: Blue Sky Consulting Group analysis of data from the California Department of Finance.

2. MOE and Economic Scenario Assumptions

Table C.3. MOE Growth Drivers, By MOE Scenario, FY 2024-25 to FY 2031-32

MOE Scenario	Annual Inflation Factor (FY 24-25 – FY 26-27)	Annual Inflation Factor (FY 27-28 – FY 30-31)	FY 27-28 Wage Increase	County Share of Wage Increase Cost
Baseline	4%	4%	$0	n/a
$1 Alternative	4%	4%	$1	35%
$3 Alternative	4%	4%	$3	35%
4% NRC Alternative	4%	4%	$1	0%
5% NRC Alternative	4%	5%	$1	0%
7% NRC Alternative	4%	7%	$1	0%

Table C.4 below provides annual Sales Tax growth assumptions for the Economic Scenarios for this report, which were based on the analysis of nominal and real changes in the statewide sales tax base since FY 2004-05. The Economic Baseline Scenario is based on the Department of Finance's May economic forecast, which shows statewide personal income growing in real terms at a 2.2 percent annual rate. Over the 10-year period FY 2013-14 to FY 2023-24, the statewide sales tax base's average annual growth rate trailed personal income's growth rate by roughly 0.6 percent. Therefore, the Economic Baseline shows the sales tax base growing at roughly 1.6 percent in real terms, or 4.2 percent in nominal terms.

Table C.4. Assumed Sales Tax Revenue Growth Rates, By Economic Scenario, FY 2024-25 to FY 2031-32

Economic Scenario	FY 23-24	FY 24-25	FY 25-26	FY 26-27	FY 27-28	FY 28-29	FY 29-30	FY 30-31	FY 31-32
Economic Baseline	-0.4%	1.4%	4.1%	4.3%	4.2%	4.2%	4.2%	4.2%	4.2%
Slower Growth	-0.4%	1.4%	3.1%	3.3%	3.2%	3.2%	3.2%	3.2%	3.2%
Zero Real Growth	-0.4%	1.4%	2.6%	2.7%	2.7%	2.7%	2.7%	2.7%	2.7%
Great Recession Repeat	-0.4%	1.4%	5.6%	1.4%	-2.7%	-10.8%	-2.4%	8.5%	8.5%

3. Detailed Results Under Economic Baseline

Table C.5. Projected IHSS Service Cost Shares, By MOE Scenario, FY 2024-25 to FY 2031-32

Millions of dollars		FY 24-25	FY 25-26	FY 26-27	FY 27-28	FY 28-29	FY 29-30	FY 30-31	FY 31-32
Baseline	**Total IHSS Cost**	**$24,190**	**$26,261**	**$28,508**	**$30,949**	**$33,598**	**$36,474**	**$39,596**	**$42,986**
	Federal Cost	$13,410	$14,360	$15,589	$16,923	$18,372	$19,944	$21,652	$23,505
	State Cost	$8,684	$9,721	$10,653	$11,668	$12,774	$13,980	$15,293	$16,723
	County MOE	$2,096	$2,180	$2,267	$2,357	$2,452	$2,550	$2,652	$2,758
$1 Alternative	**Total IHSS Cost**	**$24,190**	**$26,261**	**$28,508**	**$32,249**	**$34,967**	**$37,915**	**$41,114**	**$44,584**
	Federal Cost	$13,410	$14,360	$15,589	$17,637	$19,123	$20,736	$22,485	$24,382
	State Cost	$8,684	$9,721	$10,653	$12,049	$13,176	$14,402	$15,738	$17,191
	County MOE	$2,096	$2,180	$2,267	$2,563	$2,668	$2,777	$2,891	$3,010
$3 Alternative	**Total IHSS Cost**	**$24,190**	**$26,261**	**$28,508**	**$34,849**	**$37,704**	**$40,798**	**$44,149**	**$47,779**
	Federal Cost	$13,410	$14,360	$15,589	$19,064	$20,626	$22,318	$24,151	$26,136
	State Cost	$8,684	$9,721	$10,653	$12,812	$13,978	$15,248	$16,628	$18,128
	County MOE	$2,096	$2,180	$2,267	$2,973	$3,100	$3,232	$3,371	$3,515
4% NRC Alternative	**Total IHSS Cost**	**$24,190**	**$26,261**	**$28,508**	**$32,249**	**$34,967**	**$37,915**	**$41,114**	**$44,584**
	Federal Cost	$13,410	$14,360	$15,589	$17,637	$19,123	$20,736	$22,485	$24,382
	State Cost	$8,684	$9,721	$10,653	$12,255	$13,392	$14,630	$15,977	$17,443
	County MOE	$2,096	$2,180	$2,267	$2,357	$2,452	$2,550	$2,652	$2,758
5% NRC Alternative	**Total IHSS Cost**	**$24,190**	**$26,261**	**$28,508**	**$32,249**	**$34,967**	**$37,915**	**$41,114**	**$44,584**
	Federal Cost	$13,410	$14,360	$15,589	$17,637	$19,123	$20,736	$22,485	$24,382
	State Cost	$8,684	$9,721	$10,653	$12,232	$13,345	$14,556	$15,874	$17,308
	County MOE	$2,096	$2,180	$2,267	$2,380	$2,499	$2,624	$2,755	$2,893
7% NRC Alternative	**Total IHSS Cost**	**$24,190**	**$26,261**	**$28,508**	**$32,249**	**$34,967**	**$37,915**	**$41,114**	**$44,584**
	Federal Cost	$13,410	$14,360	$15,589	$17,637	$19,123	$20,736	$22,485	$24,382
	State Cost	$8,684	$9,721	$10,653	$12,187	$13,248	$14,403	$15,658	$17,022
	County MOE	$2,096	$2,180	$2,267	$2,425	$2,595	$2,777	$2,971	$3,179

Note: Blue Sky Consulting Group Realignment projection model results.

Table C.6. Detailed IHSS Cost and Realignment Revenue Projections Under Economic Baseline Scenario, FY 2024-25 to FY 2031-32

Millions of dollars	FY 24-25	FY 25-26	FY 26-27	FY 27-28	FY 28-29	FY 29-30	FY 30-31	FY 31-32
Baseline								
Total IHSS Services Cost	$24,190	$26,261	$28,508	$30,949	$33,598	$36,474	$39,596	$42,986
County MOE	$2,096	$2,180	$2,267	$2,357	$2,452	$2,550	$2,652	$2,758
State Services Cost	$8,684	$9,721	$10,653	$11,668	$12,774	$13,980	$15,293	$16,723
Federal Services Cost	$13,410	$14,360	$15,589	$16,923	$18,372	$19,944	$21,652	$23,505
Revenue – Social Services – Sales Tax + VLF	$2,752	$2,888	$3,222	$3,255	$3,298	$3,384	$3,474	$3,568
Revenue – Social Services – VLF Only	$216	$216	$216	$216	$216	$216	$216	$216
Revenue – Social Services – Sales Tax Only	$2,536	$2,671	$3,006	$3,039	$3,081	$3,168	$3,258	$3,352
Revenue – Other 1991 Subaccounts – Sales Tax Only	$2,245	$2,245	$2,245	$2,441	$2,628	$2,783	$2,945	$3,113
Revenue – All 1991 Subaccounts – Sales Tax Only	$4,781	$4,916	$5,250	$5,480	$5,710	$5,951	$6,203	$6,465
MOE – Share of All 1991 Subaccount Sales Tax Revenue	43.8%	44.3%	43.2%	43.0%	42.9%	42.8%	42.8%	42.7%
MOE – Share of Social Services Sales Tax Revenue	82.6%	81.6%	75.4%	77.6%	79.6%	80.5%	81.4%	82.3%
Social Services Sales Tax Revenue Remaining after MOE	$440	$492	$739	$681	$630	$618	$606	$594
MOE – Share of Social Services Sales Tax + VLF Revenue	76.2%	75.5%	70.4%	72.4%	74.3%	75.3%	76.3%	77.3%
Other 1991 Subaccount – Share of Sales Tax Revenue	47.0%	45.7%	42.8%	44.5%	46.0%	46.8%	47.5%	48.2%

continued

Table C.6 continued (2/6)

Millions of dollars	FY 24-25	FY 25-26	FY 26-27	FY 27-28	FY 28-29	FY 29-30	FY 30-31	FY 31-32
$1 Alternative								
Total IHSS Services Cost	$24,190	$26,261	$28,508	$32,249	$34,967	$37,915	$41,114	$44,584
County MOE	$2,096	$2,180	$2,267	$2,563	$2,668	$2,777	$2,891	$3,010
State Services Cost	$8,684	$9,721	$10,653	$12,049	$13,176	$14,402	$15,738	$17,191
Federal Services Cost	$13,410	$14,360	$15,589	$17,637	$19,123	$20,736	$22,485	$24,382
Revenue – Social Services – Sales Tax + VLF	$2,752	$2,888	$3,222	$3,255	$3,298	$3,682	$3,758	$3,807
Revenue – Social Services – VLF Only	$216	$216	$216	$216	$216	$216	$216	$216
Revenue – Social Services – Sales Tax Only	$2,536	$2,671	$3,006	$3,039	$3,081	$3,465	$3,541	$3,591
Revenue – Other 1991 Subaccounts – Sales Tax Only	$2,245	$2,245	$2,245	$2,441	$2,628	$2,486	$2,661	$2,874
Revenue – All 1991 Subaccounts – Sales Tax Only	$4,781	$4,916	$5,250	$5,480	$5,710	$5,951	$6,203	$6,465
MOE – Share of All 1991 Subaccount Sales Tax Revenue	43.8%	44.3%	43.2%	46.8%	46.7%	46.7%	46.6%	46.6%
MOE – Share of Social Services Sales Tax Revenue	82.6%	81.6%	75.4%	84.3%	86.6%	80.1%	81.6%	83.8%
Social Services Sales Tax Revenue Remaining after MOE	$440	$492	$739	$476	$414	$688	$650	$580
MOE – Share of Social Services Sales Tax + VLF Revenue	76.2%	75.5%	70.4%	78.7%	80.9%	75.4%	76.9%	79.1%
Other 1991 Subaccount – Share of Sales Tax Revenue	47.0%	45.7%	42.8%	44.5%	46.0%	41.8%	42.9%	44.5%

continued

Table C.6 continued (3/6)

Millions of dollars	FY 24-25	FY 25-26	FY 26-27	FY 27-28	FY 28-29	FY 29-30	FY 30-31	FY 31-32
$3 Alternative								
Total IHSS Services Cost	$24,190	$26,261	$28,508	$34,849	$37,704	$40,798	$44,149	$47,779
County MOE	$2,096	$2,180	$2,267	$2,973	$3,100	$3,232	$3,371	$3,515
State Services Cost	$8,684	$9,721	$10,653	$12,812	$13,978	$15,248	$16,628	$18,128
Federal Services Cost	$13,410	$14,360	$15,589	$19,064	$20,626	$22,318	$24,151	$26,136
Revenue – Social Services – Sales Tax + VLF	$2,752	$2,888	$3,222	$3,255	$3,298	$3,682	$3,933	$4,195
Revenue – Social Services – VLF Only	$216	$216	$216	$216	$216	$216	$216	$216
Revenue – Social Services – Sales Tax Only	$2,536	$2,671	$3,006	$3,039	$3,081	$3,465	$3,717	$3,979
Revenue – Other 1991 Subaccounts – Sales Tax Only	$2,245	$2,245	$2,245	$2,441	$2,628	$2,486	$2,486	$2,486
Revenue – All 1991 Subaccounts – Sales Tax Only	$4,781	$4,916	$5,250	$5,480	$5,710	$5,951	$6,203	$6,465
MOE - Share of All 1991 Subaccount Sales Tax Revenue	43.8%	44.3%	43.2%	54.3%	54.3%	54.3%	54.3%	54.4%
MOE - Share of Social Services Sales Tax Revenue	82.6%	81.6%	75.4%	97.8%	100.6%	93.3%	90.7%	88.3%
Social Services Sales Tax Revenue Remaining after MOE	$440	$492	$739	$66	($19)	$233	$346	$464
MOE - Share of Social Services Sales Tax + VLF Revenue	76.2%	75.5%	70.4%	91.3%	94.0%	87.8%	85.7%	83.8%
Other 1991 Subaccount – Share of Sales Tax Revenue	47.0%	45.7%	42.8%	44.5%	46.0%	41.8%	40.1%	38.4%

continued

Table C.6 continued (4/6)

Millions of dollars	FY 24-25	FY 25-26	FY 26-27	FY 27-28	FY 28-29	FY 29-30	FY 30-31	FY 31-32
4% NRC Alternative								
Total IHSS Services Cost	$24,190	$26,261	$28,508	$32,249	$34,967	$37,915	$41,114	$44,584
County MOE	$2,096	$2,180	$2,267	$2,357	$2,452	$2,550	$2,652	$2,758
State Services Cost	$8,684	$9,721	$10,653	$12,255	$13,392	$14,630	$15,977	$17,443
Federal Services Cost	$13,410	$14,360	$15,589	$17,637	$19,123	$20,736	$22,485	$24,382
Revenue – Social Services – Sales Tax + VLF	$2,752	$2,888	$3,222	$3,255	$3,298	$3,384	$3,474	$3,568
Revenue – Social Services – VLF Only	$216	$216	$216	$216	$216	$216	$216	$216
Revenue – Social Services – Sales Tax Only	$2,536	$2,671	$3,006	$3,039	$3,081	$3,168	$3,258	$3,352
Revenue – Other 1991 Subaccounts – Sales Tax Only	$2,245	$2,245	$2,245	$2,441	$2,628	$2,783	$2,945	$3,113
Revenue – All 1991 Subaccounts – Sales Tax Only	$4,781	$4,916	$5,250	$5,480	$5,710	$5,951	$6,203	$6,465
MOE – Share of All 1991 Subaccount Sales Tax Revenue	43.8%	44.3%	43.2%	43.0%	42.9%	42.8%	42.8%	42.7%
MOE – Share of Social Services Sales Tax Revenue	82.6%	81.6%	75.4%	77.6%	79.6%	80.5%	81.4%	82.3%
Social Services Sales Tax Revenue Remaining after MOE	$440	$492	$739	$681	$630	$618	$606	$594
MOE – Share of Social Services Sales Tax + VLF Revenue	76.2%	75.5%	70.4%	72.4%	74.3%	75.3%	76.3%	77.3%
Other 1991 Subaccount – Share of Sales Tax Revenue	47.0%	45.7%	42.8%	44.5%	46.0%	46.8%	47.5%	48.2%

continued

Table C.6 continued (5/6)

Millions of dollars	FY 24-25	FY 25-26	FY 26-27	FY 27-28	FY 28-29	FY 29-30	FY 30-31	FY 31-32
5% NRC Alternative								
Total IHSS Services Cost	$24,190	$26,261	$28,508	$32,249	$34,967	$37,915	$41,114	$44,584
County MOE	$2,096	$2,180	$2,267	$2,380	$2,499	$2,624	$2,755	$2,893
State Services Cost	$8,684	$9,721	$10,653	$12,232	$13,345	$14,556	$15,874	$17,308
Federal Services Cost	$13,410	$14,360	$15,589	$17,637	$19,123	$20,736	$22,485	$24,382
Revenue – Social Services – Sales Tax + VLF	$2,752	$2,888	$3,222	$3,255	$3,298	$3,429	$3,546	$3,669
Revenue – Social Services – VLF Only	$216	$216	$216	$216	$216	$216	$216	$216
Revenue – Social Services – Sales Tax Only	$2,536	$2,671	$3,006	$3,039	$3,081	$3,213	$3,330	$3,453
Revenue – Other 1991 Subaccounts – Sales Tax Only	$2,245	$2,245	$2,245	$2,441	$2,628	$2,738	$2,873	$3,012
Revenue – All 1991 Subaccounts – Sales Tax Only	$4,781	$4,916	$5,250	$5,480	$5,710	$5,951	$6,203	$6,465
MOE – Share of All 1991 Subaccount Sales Tax Revenue	43.8%	44.3%	43.2%	43.4%	43.8%	44.1%	44.4%	44.8%
MOE – Share of Social Services Sales Tax Revenue	82.6%	81.6%	75.4%	78.3%	81.1%	81.7%	82.7%	83.8%
Social Services Sales Tax Revenue Remaining after MOE	$440	$492	$739	$659	$582	$589	$575	$560
MOE – Share of Social Services Sales Tax + VLF Revenue	76.2%	75.5%	70.4%	73.1%	75.8%	76.5%	77.7%	78.9%
Other 1991 Subaccount – Share of Sales Tax Revenue	47.0%	45.7%	42.8%	44.5%	46.0%	46.0%	46.3%	46.6%

continued

Table C.6 continued (6/6)

Millions of dollars	FY 24-25	FY 25-26	FY 26-27	FY 27-28	FY 28-29	FY 29-30	FY 30-31	FY 31-32
7% NRC Alternative								
Total IHSS Services Cost	$24,190	$26,261	$28,508	$32,249	$34,967	$37,915	$41,114	$44,584
County MOE	$2,096	$2,180	$2,267	$2,425	$2,595	$2,777	$2,971	$3,179
State Services Cost	$8,684	$9,721	$10,653	$12,187	$13,248	$14,403	$15,658	$17,022
Federal Services Cost	$13,410	$14,360	$15,589	$17,637	$19,123	$20,736	$22,485	$24,382
Revenue – Social Services – Sales Tax + VLF	$2,752	$2,888	$3,222	$3,255	$3,298	$3,520	$3,693	$3,879
Revenue – Social Services – VLF Only	$216	$216	$216	$216	$216	$216	$216	$216
Revenue – Social Services – Sales Tax Only	$2,536	$2,671	$3,006	$3,039	$3,081	$3,304	$3,477	$3,662
Revenue – Other 1991 Subaccounts – Sales Tax Only	$2,245	$2,245	$2,245	$2,441	$2,628	$2,647	$2,726	$2,803
Revenue – All 1991 Subaccounts – Sales Tax Only	$4,781	$4,916	$5,250	$5,480	$5,710	$5,951	$6,203	$6,465
MOE – Share of All 1991 Subaccount Sales Tax Revenue	43.8%	44.3%	43.2%	44.3%	45.5%	46.7%	47.9%	49.2%
MOE – Share of Social Services Sales Tax Revenue	82.6%	81.6%	75.4%	79.8%	84.2%	84.0%	85.5%	86.8%
Social Services Sales Tax Revenue Remaining after MOE	$440	$492	$739	$613	$486	$527	$506	$483
MOE – Share of Social Services Sales Tax + VLF Revenue	76.2%	75.5%	70.4%	74.5%	78.7%	78.9%	80.5%	82.0%
Other 1991 Subaccount – Share of Sales Tax Revenue	47.0%	45.7%	42.8%	44.5%	46.0%	44.5%	43.9%	43.4%

Note: Blue Sky Consulting Group Realignment projection model results. Cells highlighted in gray are the same across all scenarios.

Endnotes

1 Typically, DOF determines and transmits to counties their social services caseload growth for each fiscal year in the fall of the subsequent fiscal year. These letters for FY 2017-18 through FY 2022-23 were provided by the California State Association of Counties.

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