IN CALIFORNIA:
CARE CAN’T WAIT

Building a Care Infrastructure that Works for All

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EXECUTIVE SUMMARY

Nearly everyone in California is a caregiver, will be a caregiver, or will need care at some point in their lives. Yet there is little infrastructure in place to support people who need care or their caregivers. Despite a rapidly aging population, California lacks universal access to long-term services and supports (LTSS) in the home and community for older adults and people with disabilities. State programs do not offer adequate child care or sufficient paid leave for all who need it. Care workers, who are primarily women of color, are not paid a family sustaining wage, leading to high rates of turnover that compromise quality and exacerbate gaps in access to care. Across the state, our current care systems are a patchwork that leave millions of Californians scrambling to find the essential care they need. This has been the status quo for decades, and it is as inefficient as it is unsustainable.

At the same time, the cost of living across the state continues to rise rapidly right along with the growing demand for affordable, quality care for both young and older populations. In response to the current failures in our care systems and California’s growing needs, we must work towards building a robust care infrastructure, supported by the human infrastructure of a well-paid workforce and family caregivers who have access to robust paid leave policies. This caregiving system is made up of three essential, connected pillars: Early Childhood Education (ECCE); Paid Family and Medical Leave (PFML); and Long Term Care Services and Supports (LTSS), with an emphasis on expanding access to Medicaid Home and Community-Based Services (HCBS).

This paper examines how the lack of a caregiving infrastructure in California has impacted those who need care across the state. This deep need existed well before the COVID-19 pandemic, but the pandemic laid bare serious inequities facing caregiving Californians. In partnership with advocacy, social welfare, and social justice organizations in Los Angeles, San Francisco, and Sacramento, we conducted a survey of 125 California caregivers. In their own words, they described the many challenges their families encounter as they navigate caregiving responsibilities, largely on their own. The pandemic highlighted the fragility of the care systems that so many Californians rely on, and that many cannot access. That, in combination with our local data collection and the strong advocacy work of groups on the ground, demonstrated a con-
sistent need in all areas of the state, across each of the care pillars. This led us to the conclusion that a statewide policy solution would be the most impactful.

Looking ahead, this paper demonstrates the urgent need to join together to create statewide policy solutions and build a strong, sustainable caregiving system for the 21st Century. Our work is rooted in the belief that a better future is possible for all California caregivers. Embracing that view can lead us to reimagine care by creating new state level policies that invest in HCBS, paid leave, and child care, while capitalizing on federal investments to strengthen existing programs. These policies will support paid and unpaid caregivers and care consumers alike, because in the context of care, our interests are undeniably interdependent.
CALIFORNIANS HAVE CARE IN COMMON
CAREGIVING IS UNIVERSAL

If someone asks you to picture a “caregiver,” who do you think of? You might think of a nurse, home health aide, or other health care professional. Or you might think of a mother, father, or grandparent. But would you think of yourself? Many of us don’t consider ourselves to be caregivers, and yet, nearly all of us have either acted as a caregiver or will become one at some point in our lives. In fact, in California and across America, 80% of care is provided by unpaid family members.¹

It’s no surprise that such a high percentage of Californians answer the call to care for their loved one—children, older adults, and people with disabilities. Family caregivers are the first line of defense for populations most in need, ensuring that those who require support can still live the lives they choose, even in the hardest of times. This is an enormous undertaking for families—particularly working families.

In California, the care infrastructure to support our caregiving needs is inadequate at best, non-existent and inequitable at worst. People with disabilities lack access to workers whose salaries are funded through MediCal, the state Medicaid program; aging adults don’t have the hours of support needed to keep them independent at home; and families are left with limited child care resources.

CAREGIVERS DESERVE BETTER

Today, because of the lack of a robust care infrastructure, 53 million Americans provide unpaid physical and emotional care for their ill, aging, or disabled loved ones at home.² That labor totals roughly $470 billion worth of unpaid care.³ In 2020, 1 in 4 California caregivers provided 20 or more hours of care to a family member or friend in a typical week, yet only 1 in 11 received payment for any of the hours spent providing care. More than 20 percent reported that caring for a family member or friend was “somewhat” to “extremely” financially stressful, with Black or African American (28%), Asian (23.4%), and Hispanic adult caregivers (21.9%) more likely than white adult caregivers (17.7%) to report financial hardship. These unpaid family caregivers, who are propping up a broken system, won’t be able to rejoin the economy as members of the workforce.

¹ Who Will Provide Your Care? (U.S. Department of Health and Human Services).
² Caregiving in the U.S. 2020 (The National Alliance for Caregiving and the AARP Public Policy Institute, May 2020).
until there are enough paid child care providers and direct care workers to do these jobs.

Care workforces, predominantly made up of women of color, have long been unpaid or underpaid for the value of their work. Care workers across the state of California receive poverty wages and do not have adequate job security protections. The median wage for direct care workers in California is $13.18 per hour. Year after year, low wages persist, including through a pandemic, despite the essential role that care workers play for people with disabilities and older adults. The work includes providing support with personal care, communication, household tasks, building relationships, and navigating the community. Because of the low wages, states and provider agencies report job vacancies for direct care workers at 20 percent or higher with an annual turnover rate of 40 to 60 percent.4 The same issues regarding low wages and high turnover exist in California’s childcare system, in which the average wage for a child care worker is $17.02.5

THE WORK THAT CARE WORKERS DO MAKES ALL OTHER WORK POSSIBLE; THEIR WAGES MUST REMAIN COMPETITIVE OR THE WORKFORCE SHORTAGE WILL SHIFT FROM A CRISIS TO CATASTROPHE.

The fact that care workers across the pillars of care earn such low wages, and that wages are stagnating when compared to wages in other industries that have risen during pandemic recovery, underscores the need for investments in higher wages for care workers in California. The work that care workers do makes all other work possible; their wages must remain competitive or the workforce shortage will shift from a crisis to catastrophe.

Investments in raising care worker wages will increase recruitment and retention of workers in the field, allow more people to gain access care to supports, and offer families the ability to maintain their financial well-being.

BIPOC FAMILIES AND CAREGIVERS BEAR THE GREATEST BURDEN

The lack of a care infrastructure places the heaviest burden upon women in Black, Indigenous, and People of Color (BIPOC) communities in California, due to two key factors. First, women in these communities make up the vast majority of the historically unpaid or underpaid care workforce, and 58.3 percent of domestic workers are women of color. Second, unpaid caregiving is more common among women of color, who have long been expected to ‘make do’ earning a living and caring for loved ones at the same time. This situation has long trapped BIPOC women, children, and families in generational poverty. Overhauling and strengthening California’s caregiving infrastructure can break that bleak cycle.

THE CAREGIVING STATUS QUO WEAKENS FAMILIES, PERPETUATES INTERGENERATIONAL POVERTY, AND WEAKENS THE ECONOMY BY CREATING INSTABILITY FOR WORKERS AND EMPLOYERS ALIKE.

While frequently unnoticed by policy makers, women of color are often the economic nucleus of their families. According to the Center for American Progress, many mothers of color are also breadwinners, who are either the sole earner for their family or earn as much as or more than their partners. If a working mother must leave work to care for a child or an aging parent, she loses wages and may even lose her job. The fact that working mothers find themselves in this untenable situation is both a moral and economic issue. The caregiving status quo weakens families, perpetuates intergenerational poverty, and weakens the economy by creating instability for workers and employers alike.

More than a fifth of Black adults and nearly a third of Black caregivers fall into the Sandwich Generation, meaning they care for both a child and an adult loved one. Furthermore, 57 percent of Black family caregivers fall in the “high burden” caregiving

bracket—providing an average of thirty hours of care per week.\textsuperscript{9} For these caregivers—the majority of whom are women—the double-duty caregiving responsibilities for children and adult family members cause especially acute financial and emotional stress, forcing families to cut back on work hours and navigate complex and confusing care systems with little to no formal support.\textsuperscript{10}

While one in five U.S. households are multigenerational, the prevalence of multigenerational living varies by race and ethnicity. Only 13 percent of non-Hispanic White households are multigenerational, compared to 34.7 percent of Black households.\textsuperscript{11} The assumed caregiving responsibilities that many of these households’ caregivers face result in additional life stressors. A survey released in 2021 by the Diverse Elders Coalitions’ Caregiving Initiative found that approximately one third of Black caregivers report feeling isolation and physical and mental strain as a result of caregiving responsibilities.\textsuperscript{12}

\textsuperscript{9} Deborah Bonello, The Unequal Burden for Black Caregivers (OZY).
\textsuperscript{10} Sarita Gupta, Burning the Candle at Both Ends: Sandwich Generation Caregiving in the U.S. (National Alliance for Caregiving and Caring Across Generations, Nov 2019).
\textsuperscript{11} Fighting Poverty in a Bad Economy, Americans Move in with Relatives (Pew Research Center, Oct 2021).
\textsuperscript{12} Ocean Le, Angie Boddie, It's Time to Meet the Needs of African American and Black Caregivers (American Society on Aging, Nov-Dec, 2020)
Despite experiencing higher burdens of care and stress, Hispanic (61 percent) and African American (59 percent) caregivers more often report that caregiving provides them with a sense of purpose at a significantly higher rate than for both White (46 percent) and Asian American (48 percent) caregivers.\textsuperscript{13}

The disproportionate impacts of caregiving in BIPOC communities, compared with other communities, is deeply rooted in the brutal system of chattel slavery. That system relied heavily upon the dehumanization and labor of Black women, and created the context for the erasure of the care needs of Black women and their families while devaluing the caregiving work performed by Black, Indigenous and other women of color. Over 156 years following slavery’s abolition, care remains devalued and women of color experience the deepest inequities. Our current caregiving infrastructure in California and the U.S. has failed to remedy this historical, structural injustice. Addressing this injustice is both a moral imperative and a practical one, to meet the caregiving needs of today and promote equity across our communities long-term.

A NEW VISION FOR CARE IN CALIFORNIA

The following policy principles and values define our framework of universal family care in California.

1. Because we are all caregivers, our caregiving infrastructure must facilitate anyone being able to step into a caregiving role with minimal financial shock or disruption.

2. Quality care must be accessible and available to all.

3. We must strengthen our caregiving workforce with family sustaining wages, training and opportunities for career advancement.

4. Our policy solutions must be tailored to meet the unique needs of the most vulnerable, underserved and BIPOC communities.

It’s time for our country to redefine “critical infrastructure.” While roads and bridges are the transportation infrastructure that enables commerce and connectivity, families and caregivers represent the infrastructure that comes before the physical – the labor

\textsuperscript{13} Mousumi Bose, Lauren Tokarewich, Reed W.R. Bratches, Paul J. Barr, \textit{Caregiving in a Diverse America} (National Alliance for Caregiving, National Minority Quality Forum and Diverse Elders Coalition, Nov 2021).
and human capital that enables economic development and growth in every arena. If politicians are serious about strengthening the economy and the American family, they must invest robust, meaningful, and permanent public funding to create a new care infrastructure that supports all people providing care and in need of care, at every stage of life.

DEFINING THE PILLARS OF CARE

EARLY CHILDHOOD CARE AND EDUCATION (ECCE)

WHAT IS EARLY CHILDHOOD CARE AND EDUCATION?

Early Childhood Care and Education (ECCE) is a series of federal and state funded programs that provide care for children from birth to age five. A common misconception is that ECCE is strictly about learning basic skills as a basis of compulsory education like reading, writing, and arithmetic. However, it is also about learning critical social and emotional skills that will aid in a child’s broader development. In addition, unlike compulsory public primary and secondary education—which is free—ECCE typically requires families to make a substantial financial commitment. Today, families, on average, pay more than half the cost of ECCE out of pocket, while many families pay the full cost of care with no public financial support.

CURRENT STATE OF ECCE IN CALIFORNIA

The majority of child care programs are funded by the federal government, including: the Child Care and Development Block Grant (CCDBG) and Head Start. These programs are administered by state, local, and tribal governments consistent with federal guidelines. ECCE is not universal. The quality, accessibility, and affordability of ECCE varies widely depending on location. In California, access to child care remains fragmented by city and region.

There are many child care and development programs in California, but they are fragmented by city and region. These programs have varying eligibility, and are for children from birth to age twelve. They offer early learning, pre-K and after-school services to babies, toddlers, children in preschool, and children in kindergarten through sixth grade. Some programs assist children with disabilities. Others support children of migrant farm workers. Many of these programs were set up to help parents with child...

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14 Early childhood care and education (UNESCO).
care while they work. Child care and development programs can provide care, education, and food for children. They are paid for with state and federal tax money, and in some cases, parent fees.

These programs must be updated to ensure universal access to these supports for family caregivers and children all over California. We also must ensure that child care providers are paid a family sustaining wage. The average wage for a child care worker in California is $13.43/hour. California early educators with a bachelor’s degree are paid 37.8 percent less than their colleagues in the K-8 system. The poverty rate for early educators in California is 17 percent, much higher than for California workers in general (8.7 percent) and 6.7 times as high as for K-8 teachers (2.5 percent).16

PAID FAMILY AND MEDICAL LEAVE

WHAT IS PAID FAMILY AND MEDICAL LEAVE?

Generally, paid family and medical leave (PFML) “provides a set number of weeks or months to be used for a worker’s own serious, longer-term health condition, to care for a family member with a serious health condition, to care for or bond with a new child, and for reasons related to a family member’s military service. On average, it provides six to twelve weeks of fully or partially paid leave per year, with no need for accrual. Paid family and medical leave may be provided through insurance programs in which policies are funded by contributions from the employer and/or worker.”17

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16 Early Childcare Workforce Index 2020: California (Center for the Study of Child Care Employment - University of California Berkeley, 2020).
CURRENT STATE OF PFML IN CALIFORNIA

Currently, PFML is only available at the state and local level, and not all states offer it. At the federal level, people can only access unpaid family and medical leave, provided under the Family and Medical Leave Act of 1993. It mandates that certain U.S. workers are eligible for a maximum of 12 weeks of unpaid leave in the event of the birth, adoption, or foster placement of a child; the serious health condition of a close family member; a worker’s own serious health condition; or the military deployment of a worker’s spouse, child, or parent.

California is one of 10 states that has a state-level paid leave policy, called Paid Family Leave (PFL). This program provides benefit payments to people who need to take time off work to: care for a seriously ill family member; bond with a new child; or participate in a qualifying event because of a family member’s military deployment. If a California resident is found eligible, they will qualify for up to eight weeks of paid leave. On average, payments are 60–70% of an employee’s weekly wages.¹⁸ PFL provides benefit payments but not job protection.

LONG TERM SERVICES AND SUPPORTS (LTSS) INCLUDING HOME AND COMMUNITY-BASED SERVICES (HCBS)

WHAT ARE LTSS AND HCBS?

LTSS are a broad range of health-related and social services that include assistance with activities of daily living (ADLs), such as bathing, dressing, eating, toileting and

¹⁸ California Paid Family Leave (California Employment Department).
personal hygiene, as well as with instrumental activities of daily living (IADLs), such as meal preparation, money management, house cleaning, medication management, shopping, and telephone use.\textsuperscript{19} LTSS does not include medical or nursing or acute care services, such as health services provided for the prevention, diagnosis, or treatment of a medical condition.\textsuperscript{20} LTSS is the broad term that includes both LTSS in facilities as well as care provided in people’s homes and communities.

Seventy percent of all individuals turning 65 today will need LTSS. However, LTSS is not exclusively limited to the elderly. In fact, around 40 percent of those needing LTSS today are under 65.\textsuperscript{21} The only federal program that provides LTSS is Medicaid. LTSS is the larger set of programs that includes HCBS, or the caregiving supports and services in the home and community that allow for people to age and live independently as opposed to in an institution or congregate setting. It is also the context most people with disabilities and older adults prefer. Federal Medicaid law requires that institutional care be funded but HCBS is optionally funded through a waiver, leading to an institutional bias and decades of under-investment in infrastructure and options for care in the home and community.

\textsuperscript{20} Overview of Long-Term Services and Supports (Washington, DC: Congressional Research Service, 2021).
CURRENT STATE OF LTSS/ HCBS IN CALIFORNIA

Most older adults, if they think about their LTSS needs at all, assume that Medicare will cover them when they need support as they age and their needs and abilities change. In reality, Medicare does not include a LTSS benefit. Though long-term care can be funded through private insurance, very few Californians (less than 10%) have long-term care insurance as premiums are prohibitively expensive. Therefore, the only program that funds LTSS/HCBS is Medicaid, or MediCal in California. However, because of strict financial eligibility requirements, MediCal, like all Medicaid programs, requires people with disabilities and older adults to live in poverty in order to access these services.

Since Medicaid is a means-tested benefit, a person does not qualify for the program unless they meet a certain income level, which is often extremely low. Therefore, families just above the Medicaid cut off are forced to rely on family and friends for support or deplete their personal savings to pay for care.

A more robust HCBS infrastructure will allow older adults and people with disabilities to choose whether to receive care in institutions or in their homes and communities. A stronger HCBS system will also give those who may one day need HCBS the security of knowing they will not need to rely on family members alone to care for them. Federal investment in HCBS has the potential to stimulate job and economic growth by increasing the number of paid caregiving jobs and raising wages to improve the quality of care jobs.22

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UNIVERSAL FAMILY CARE LOCAL
BENEFIT PILOT:
OUR ORIGINAL IDEA
To address the major and pressing care needs of families across the care pillars, Caring Across Generations partnered with the Georgetown Center for Poverty and Inequality and the Institute for Taxation and Economic Policy to examine what a local universal family care benefit pilot could do to impact the lives of caregivers in those cities. We studied the potential impacts of implementing a policy framework for providing access to LTSS, PMFL, and ECCE in San Francisco, Los Angeles, and Sacramento.

**BACKGROUND ON THE CITIES ANALYZED**

These three cities were selected because they make up a large portion of California’s population and economy. Therefore, if a successful universal family care system could be implemented in these jurisdictions, it would indicate that success could be replicated statewide. In addition, these three cities have tremendous demographic and income diversity that reflect the breadth of diversity of the state of California at-large.

<table>
<thead>
<tr>
<th>CITY</th>
<th>POPULATION</th>
<th>COUNTY GDP IN DOLLARS</th>
<th>CITY PROPOSED FISCAL YEAR BUDGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>Los Angeles</td>
<td>3,898,747</td>
<td>$747,523,558,000</td>
<td>$10,710,000,000</td>
</tr>
<tr>
<td>San Francisco</td>
<td>874,961</td>
<td>$201,547,346,000</td>
<td>$12,260,900,000</td>
</tr>
<tr>
<td>Sacramento</td>
<td>500,930</td>
<td>$96,667,833,000</td>
<td>$1,300,000,000</td>
</tr>
</tbody>
</table>

**DIRECT INPUT FROM FAMILY CAREGIVERS IN CALIFORNIA**

As part of the analysis across the three cities, we also conducted surveys partnering with advocacy, social welfare, and social justice organizations in Los Angeles, San Francisco, and Sacramento. In their own words, California caregivers who responded to the survey described the many challenges that families encounter as they navigate caregiving responsibilities across the care pillars, largely on their own.

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23 United States Census Bureau
24 FRED Economic Data, Economic Research.
OUR FINDINGS
The projected cost and participation figures below should be viewed as ballpark figures that give a sense of scale. They do not precisely predict cost and participation outcomes.

**TOPLINE TAKEAWAYS FROM FINDINGS**

- Care is not accessible and affordable to everyone in California. Care workers earn low wages with inadequate benefits, with inconsistencies from county to county, and are emblematic of California’s working poor.

- BIPOC experiences with discrimination were almost universal across cities, including when care was available, because programs too often lacked the cultural competence necessary to make care accessible for participants.

- Generational and systemic barriers faced by many workers continue to isolate many California caregivers, particularly Black, Indigenous, and undocumented caregivers. Programs need to take a whole life and intergenerational family approach to meeting the needs of caregivers.

**EARLY CHILDHOOD EDUCATION**

**ECCE KEY TAKEAWAYS**

- The cost of childcare is inversely proportional to the age of the child. Costs also decrease when care is provided in a home-based setting as opposed to a child care center.

- Caregivers are severely underpaid. This undermines the caregiving workforce, and limits the supply of caregivers needed to meet demand.
POPULATION & COST SIMULATION

The estimates are based on the following benefit design:

- **Residency Requirement**: Primary residence of participating children and families must be in the cities of Los Angeles, San Francisco and Sacramento, respectively.

- **Eligibility**: Families with children 5 years old and under.25

- **Benefit Amount**: Families with annual income at or less than 200 percent of federal poverty guidelines receive fully subsidized care.

- **Income Threshold**: In addition, families who have an income above that threshold pay no more than 7 percent of total family income. The benefit amount is structured so that families with lower incomes receive a greater subsidy than families with higher incomes.

- **Additional Elements**: All ECCE providers are licensed and paid salaries equivalent to kindergarten educators with comparable educational credentials.

For each city, researchers at GCPI estimated the number of people who would have been eligible, expected to have participated, and the total costs of benefits (including administration costs) in a hypothetical, fully-implemented, city-wide, universal, and voluntary ECCE program in 2019. (See Table 1 below for key findings.)

**GCPI Early Childhood Education Population & Cost Simulation (Table 1)**

<table>
<thead>
<tr>
<th>City</th>
<th>Eligibility</th>
<th>Number of Participants</th>
<th>Projected Total Costs (2019 Dollars)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Los Angeles</td>
<td>All families with children 5 years old and under</td>
<td>201,000 children</td>
<td>$2.5 billion</td>
</tr>
<tr>
<td>San Francisco</td>
<td>All families with children 5 years old and under</td>
<td>35,000 children</td>
<td>$414.3 million</td>
</tr>
<tr>
<td>Sacramento</td>
<td></td>
<td>31,000 children</td>
<td>$437.7 million</td>
</tr>
</tbody>
</table>

The process involved counting the number of children ages 5 and under in each family unit by age group and estimating the cost of ECCE per child. Using that cost per child estimate, the researchers then estimated the percentage of children under the age of 5 who would participate to find the cost of participating eligible children. Researchers estimated the weighted average ECCE cost per child for each age group, based on the

25 5 year-olds enrolled in kindergarten are assumed to not participate in the program.
share of children projected to participate in center-based or non-center-based care. They assigned participation\(^{26}\) at rates based on existing universal preschool programs and then estimated the subsidy amount per family. Then, they estimated the total subsidy cost for the city by aggregating projected cost per family across all participants, and estimating administrative costs.

For each city, the ECCE program would cover market rate costs in excess of that amount. The tables below outline the projected cost of child care depending on the child’s age and the type of site where care is provided.

### LOS ANGELES: AVERAGE CHILD CARE COSTS BY AGE AND TYPE OF CARE SITE PER CHILD (TABLE 2)

<table>
<thead>
<tr>
<th>AGE OF CHILD</th>
<th>TYPE OF CENTER</th>
<th>COST PER CHILD</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1</td>
<td>ECCE Center</td>
<td>$28,049</td>
</tr>
<tr>
<td>1-2</td>
<td>ECCE Center</td>
<td>$27,013</td>
</tr>
<tr>
<td>3-5</td>
<td>ECCE Center</td>
<td>$17,114</td>
</tr>
<tr>
<td>&lt;3</td>
<td>Home-Based ECCE</td>
<td>$15,971</td>
</tr>
<tr>
<td>3-5</td>
<td>Home-Based ECCE</td>
<td>$12,010</td>
</tr>
</tbody>
</table>

### SACRAMENTO: AVERAGE CHILD CARE COSTS BY AGE AND TYPE OF CARE SITE PER CHILD (TABLE 3)

<table>
<thead>
<tr>
<th>AGE OF CHILD</th>
<th>TYPE OF CENTER</th>
<th>COST PER CHILD</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1</td>
<td>ECCE Center</td>
<td>$25,940</td>
</tr>
<tr>
<td>1-2</td>
<td>ECCE Center</td>
<td>$24,850</td>
</tr>
<tr>
<td>3-5</td>
<td>ECCE Center</td>
<td>$17,016</td>
</tr>
<tr>
<td>&lt;3</td>
<td>Home-Based ECCE</td>
<td>$15,941</td>
</tr>
<tr>
<td>3-5</td>
<td>Home-Based ECCE</td>
<td>$13,060</td>
</tr>
</tbody>
</table>

\(^{26}\) A key assumption is that every family that wants to participate can do so. This simulation does not acknowledge the current shortage of ECCE slots for kids.
### SAN FRANCISCO: AVERAGE CHILD CARE COSTS BY AGE AND TYPE OF CARE SITE PER CHILD (TABLE 4)

<table>
<thead>
<tr>
<th>AGE OF CHILD</th>
<th>TYPE OF CENTER</th>
<th>COST PER CHILD</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1</td>
<td>ECCE Center</td>
<td>$32,072</td>
</tr>
<tr>
<td>1-2</td>
<td>ECCE Center</td>
<td>$31,259</td>
</tr>
<tr>
<td>3-5</td>
<td>ECCE Center</td>
<td>$22,592</td>
</tr>
<tr>
<td>&lt;3</td>
<td>Home-Based ECCE</td>
<td>$20,009</td>
</tr>
<tr>
<td>3-5</td>
<td>Home-Based ECCE</td>
<td>$16,565</td>
</tr>
</tbody>
</table>

Finally, these cost estimates aim to address the lack of a strong caring workforce by assuming all ECCE providers are licensed and paid salaries equivalent to kindergarten educators with comparable educational credentials.
FEEDBACK FROM CAREGIVER SURVEY

1. DISCRIMINATION AND LACK OF CULTURALLY APPROPRIATE SERVICES IMPEDE ACCESS

Eliana’s experience with discrimination as a Hispanic woman captures the daily indignities that women of color face while finding care. When seeking early childcare services, she felt as if the information she received from providers depended on the color of her skin. In particular, she said, “Sometimes based on your name, last name, and the way you speak, people classify you differently and don’t really give you all the information you ask for or need.”

Across Sacramento, Los Angeles, and San Francisco, 20, 50, and 63 percent of respondents respectively reported experiencing discrimination while trying to obtain ECCE. The type of discrimination varied based on region. For example, respondents in San Francisco reported experiencing discrimination based on race, citizenship, language spoken, and having children with special needs. In contrast, respondents in Sacramento reported experiencing discrimination mostly due to having children with special needs. However, explicit discrimination is not the only culprit; cultural competence matters too.

One respondent from San Francisco, Rhonda, expressed frustration about the lack of Black ECCE service providers. Sharing what many Black parents feel when trying to find care services, she noted, “None of the professionals, counselors, etc. were Black... Most professionals were able-bodied presenting, white etc.” Similar to discrimination findings, the lack of culturally appropriate services were particularly high in Los Angeles (45 percent) and San Francisco (72 percent). Thirty-seven percent of respondents in Sacramento reported difficulty finding culturally sensitive care.

2. WAITING LISTS FOR CARE ARE TOO LONG

When it comes to receiving care, we’ve already established that demand for care is far outpacing the available supply. Jennifer from Sacramento described this problem when she said, “For my first pregnancy, I had to get on waitlists for infant daycare while still pregnant. I was unable to secure a spot in the top three facilities I wanted, and in fact I inexplicably lost my spot at one of the facilities who said I was guaranteed a spot by a certain date, but later changed their mind. I had to scramble to find a spot at a larger facility that was not among my top choices. The only way I secured a spot for my second child was by having an “in” as a sibling of an existing student and also by holding that spot early in my pregnancy, months before a spot was needed.” In Sacramento and Los Angeles, 50 percent of ECCE respondents felt that waitlists were an obstacle to access ECCE. In San Francisco, nearly three-quarters (72 percent) of ECCE respondents reported experiencing long waiting lists.
In addition, several parents noted that they spent several years on waitlists. Long waitlists often mean that parents are left to juggle working and caring for their child with little support. As Monique from San Francisco put it, these lists, “are super full in low-income communities,” so put an even greater strain on struggling families.

**PAID FAMILY & MEDICAL LEAVE**

**PFML KEY TAKEAWAYS**

- Several caregivers reported challenges in trying to get approval for PFML, often due to medical providers and employers being on different pages.

- When it comes to PFML, the burden of figuring out the cumbersome process of obtaining benefits is placed unfairly on employees and caregivers.
The estimate assumes the following benefit design for each city:

- **WORK-BASED ELIGIBILITY**: Eligibility rules for California’s statewide Paid Family Leave (PFL) (which are the most expensive among existing policies for which necessary data are readily available); workers must have worked in the city within the base period.

- **BENEFIT AMOUNT**: Additional amount needed to ensure a 100% wage replacement rate up to a maximum weekly benefit of $1,357 in combination with benefits received under California’s PFL and Disability Insurance (DI) programs.

- **TYPES OF LEAVE**: Workers can receive PFML for their own health, parental leave and bonding, or family care.

- **DISABILITY INSURANCE (DI) & PFL INTERACTION**: The benefit is intended to supplement California’s PFL and DI programs by increasing wage replacement rates to 100% and extending the number of weeks covered for parental and bonding and family care leaves from 8 weeks to 12 weeks. PFL provides benefits for parental leave and bonding and family care leave. DI “provides benefits to workers who are unable to work due to non-work-related illness, injury, or pregnancy” for at least eight days.

- **ANNUAL DURATION CAPS**: Maximum of 52 weeks leave for own health (same as CA DI), 12 weeks leave for parental leave and bonding, and 12 weeks for family care (4 weeks longer than CA PFL).

Researchers at GCPI estimated the number of people who would have been eligible and expected to have participated in a hypothetical, fully-implemented, city-wide, universal, and voluntary PFML program in 2018.

The process involved estimating the number of people employed (including self-employed) in each city. Then, they estimated the number of workers who would receive PFML benefits per year by projecting expected uptake for each of the three leave types. Researchers estimated the annual average total benefits per claim of PFML by the qualifying reason, the total annual cost of paid leave benefits, the marginal cost of covering workers under the existing California paid family leave program and disability insurance program, and estimating administrative costs.
GCPI PAID FAMILY & MEDICAL LEAVE POPULATION & COST SIMULATION

<table>
<thead>
<tr>
<th>CITY</th>
<th>ELIGIBILITY</th>
<th>NUMBER OF PARTICIPANTS</th>
<th>PROJECTED TOTAL COSTS (2020 DOLLARS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Los Angeles</td>
<td>State of CA Eligibility Based Rules</td>
<td>73,000 own health claims &amp; 60,000 parental &amp; bonding leave &amp; 8,000 family care participants</td>
<td>$551.6 million</td>
</tr>
<tr>
<td>San Francisco</td>
<td>State of CA Eligibility Based Rules</td>
<td>27,000 own health claims &amp; 22,000 parental &amp; bonding leave &amp; 3,000 family care participants</td>
<td>$154.3 million</td>
</tr>
<tr>
<td>Sacramento</td>
<td>State of CA Eligibility Based Rules</td>
<td>8,000 own health claims &amp; 7,000 parental &amp; bonding leave &amp; 1,000 family care participants</td>
<td>$55.2 million</td>
</tr>
</tbody>
</table>

FEEDBACK FROM CAREGIVER SURVEY

1. FAMILIES CANNOT AFFORD TO TAKE ADVANTAGE OF PFML

Even in California where PFML is available to families, the benefit amount is still not enough to meet the demands of working families. Across the three cities, at least half of participants reported loss of income as an obstacle to obtaining PFML. Ivana, a white woman from Los Angeles, was in a familiar bind – care for her mother or be laid off. If a robust and universal PFML existed, she wouldn’t have to make that choice. However, she was penalized at work for needing to provide care for her mother. Describing the experience, she shared that her “working hours were reduced to part-time” because the company thought of her as “unreliable”.

Similarly, Kim, an Asian woman, expressed concerns about the delay in receiving payments for PFML. When she took time off for her surgery, she had to wait months before she was paid. The failure to deliver benefits in a prompt manner left her without the steady income stream she needed.

2. PFML IS LARGELY UNAVAILABLE FOR WORKERS

As noted in the problem section, PMFL is largely unavailable to people who don’t work in certain industries. In San Francisco, nearly 60 percent of PFML respondents reported problems with availability of PFML for themselves, their loved ones, or their clients. Cassandra, an undocumented Hispanic woman from San Francisco, couldn’t access PFML after an accident at work in which she injured both legs. She said, “I was not able to work for 6 months, and all that was in my savings ran out, I had no money.”
Unfortunately, others across California faced similarly harrowing experiences. Edwin, from Sacramento, put it this way, “My main issue with paid family leave is that I do not get any type of paid family leave at all. I am fortunate in that I have been able to save my vacation time and my employer allows me to take dock time (time off without pay). I used that vacation time in lieu of working and also took dock time to stay with my child and to care for my wife. However, my hours and my time off was limited, because I do not have a lot of vacation hours saved.”

3. THE APPLICATION PROCESS FOR PFML IS CUMBERSOME AND CONFUSING

When the process of applying for public benefits is prohibitively difficult, people most in need will likely not seek out care. When it comes to PFML, the burden of figuring out the cumbersome process of obtaining benefits is unfairly placed on employees and caregivers. This sentiment was echoed among participants across the three cities.

For example, one employee named Miriam from Los Angeles, stated that, “the entire process was convoluted. There were so many parts that didn’t connect, and the onus was on the employee.” Another employee named Eugene, a Black man, explained that his biggest obstacle to obtaining PFML was having to “look up information” prior to getting the services. When information is not readily available or offered to those who will most likely use it, families are set up for failure.

In San Francisco, nearly three-quarters (71 percent) of respondents felt that the application process was an obstacle to obtaining care. In addition, many felt overwhelmed by the amount of documentation required, with no formal support or guidance to navigate what is needed. One woman, Madhia, stated that she found it difficult to get a doctor to sign documents and struggled in “just figuring out what to do.”

In Sacramento, nearly 30 percent of respondents felt the application process was an obstacle. Danita, a Black woman, explained that even the medical personnel – the ones who are supposed to have deep knowledge about the process – were “confused about who would complete the paperwork or what paperwork to use to provide me with the leave.” Andrea had a similar experience, but for her the confusion came from her human resources department. She said, “even with one-on-one help from HR, I still couldn’t understand how to apply and access the different leaves I was eligible for.”
LONG TERM SERVICES & SUPPORTS

KEY TAKEAWAYS

Care workers are paid low wages with inadequate benefits. The median wage for direct care workers in California is $13.18. Home health care workers would need a 61 percent wage increase, to $22.26 per hour, to have a reasonable average wage, according to guidance by the Economic Policy Institute.

Many Californians struggle to find workers to support them for the hours that they have been allotted, leaving them without the care that they need.

POPULATION & COST SIMULATION

The estimate assumes the following benefit design:

- **PRIMARY RESIDENCE**: Long-term care recipients residing in cities of Los Angeles, San Francisco, or Sacramento.

- **AGE OF ELIGIBILITY**: Age of eligibility: 18+ years

- **QUALIFYING DISABILITY**: Individuals qualify for the program based on either meeting the HIPAA definition of disability or having difficulty with one or more activities of daily living (ADLs). A person has a qualifying disability if they are certified by a licensed health care practitioner as: (1) “being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living for a period of at least 90 days to a loss of functional capacity”; or (2) “requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment.” Also included are people who experience one ADL limitation.

- **EXCLUSIONS**: People who use Medicaid for LTSS services are ineligible for this program. Hospice care is not included in the model as it is typically covered by health insurance.

- **SUBSIDY AMOUNT**: 100% of current market cost.

- **ANNUAL OR LIFETIME CAPS**: There are no caps on total benefits or years receiving the LTC subsidy.
• **TYPES OF LONG-TERM CARE COVERED**: Long-term care covered in this program includes in-home care (such as homemakers services and home health aides), community and assisted living (adult day health care and assisted living facility), and nursing home care (semi-private rooms and private rooms).

Researchers at GCPI estimated the number of people who would have been eligible, expected to participate, and the total costs of benefits (including administration costs) of those expected to have participated in a hypothetical fully-implemented, city-wide, universal, and voluntary LTSS program in 2019.

The process involved estimating the number of people eligible for LTSS. Then, researchers estimated the number of people projected to participate in LTSS. They estimated the number of days of LTSS institutional services consumed by participants and the average daily cost of care per participant. Next, they estimated the annual cost per enrollee of home and community-based LTSS services based on Medicaid HCBS spending.27 Next, GCPI estimated the total subsidy costs by multiplying LTSS participation and use estimates by average daily or annual cost of care in the LTSS sector. Finally, administrative costs were estimated.

### GCPI LONG TERM SUPPORT SERVICES POPULATION & COST SIMULATION

<table>
<thead>
<tr>
<th>CITY</th>
<th>ELIGIBILITY</th>
<th>NUMBER OF PARTICIPANTS</th>
<th>PROJECTED TOTAL COSTS (2020 DOLLARS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Los Angeles</td>
<td>18+ years old</td>
<td>78,000</td>
<td>$2.29 billion</td>
</tr>
<tr>
<td>San Francisco</td>
<td></td>
<td>20,000</td>
<td>$601.0 million</td>
</tr>
<tr>
<td>Sacramento</td>
<td></td>
<td>10,000</td>
<td>$290.7 million</td>
</tr>
</tbody>
</table>

### FEEDBACK FROM CAREGIVER SURVEY AND INTERVIEWS

**1. THE HIGH COSTS OF LTSS PROHIBITS ACCESS**

Across cities, feedback regarding LTSS exposed the limits of the current system to provide affordable care – even when some of it is covered by insurance. Across each city, 33 percent or more participants reported cost as an obstacle to care (33% in San Francisco, 44% in Sacramento, and 44% in Los Angeles).

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27 Estimated service costs reflect increased wages for LTSS workers.
Marlene, from Los Angeles, explained her struggle to afford care for her grandmother. She shared, “I care for and live with my grandmother because she needs around-the-clock care. She doesn’t qualify for medical services, so there is no money to help hire another person.” She continued, “24/7 care is virtually impossible for any working class/middle class family.”

Doreen, an Asian woman from Sacramento, described a similar difficulty in affording care. She remarked that, “finding reliable, trustworthy caregivers that were affordable,” was a challenge. She continued that, “some agencies were extremely expensive, charging $600 for overnight stay. The caregivers I interviewed who were NOT with an agency did not appear trustworthy during my interview with them.”

Dana from Sacramento described her trouble with Medicare when she said, “most long-term care agencies do not take Medicare and other insurances. Did not make enough money to afford the program – unable to access services.”

2. THE SUPPLY OF LTSS PROVIDERS DOES NOT MATCH DEMAND

Respondents across cities consistently pointed out that there are not enough providers. For example, in San Francisco, 39 percent of respondents reported that waitlists were obstacles to obtaining LTSS. Kalia said that, “Everything in San Francisco has a waitlist, so I just give up and don’t try to get on a list.”

Liciana from Sacramento shared the impact that long waitlists have on poorer families. “Most lower income based locations have waitlists over three years. The waitlist affects the possibility of finding care for a loved one that is in need,” she said. Tien, an Asian woman, echoed these sentiments when she said, “Usually when you need long term services you need it NOW, not in the future. With a waitlist you never know when an opening will occur.”

In addition, the turnover rate for LTSS providers is high. Also, when accessing respite care providers and general care providers, duration of care is often not long enough to match need and the cost is too expensive to pay out-of-pocket.

3. LOCATION OF LTSS FACILITIES MAKES CARE INACCESSIBLE

Location matters to families making care arrangements for their loved ones while balancing other priorities, like work. It also matters for families who have little economic choice and freedom to move to other, more expensive neighborhoods. While a minority of respondents in Los Angeles (15%) reported location as an issue, the problem was more widespread in San Francisco (34%) and Sacramento (31%).
Arianna, a Hispanic woman from San Francisco, described her trouble finding doctors in her area. She explained, “The program does not have available doctors that are close to me. I have not had appointments with specialists for more than a year.”

One caregiver, Mariah, told a heartbreaking story of a client who was stuck in an inaccessible living situation because he wasn’t offered an alternative housing placement near his family. Mariah said, “Through the mayor’s office and family help, my client was offered a place to live in the Tenderloin. My client refused because he wanted to stay closer to his friends, son, and family where he is now. At least they can reach him easier than if he was downtown and needed them.” She continues, “As a result, my client has opted for 17 stairs to get up to get to his front door with a wheelchair and currently hasn’t been able to manage his living space, being in and out of the hospital for the last year. Now he can’t access his room and has no heat or electricity in his room. The rental is not wheelchair accessible in any way, from the curb to the inside of the unit, kitchen, or bathroom.”

Location can place burdens on caregivers as well as on the people receiving care. In Los Angeles, Donna described the problem that her mother’s caregivers live far away from her mom who needs care. In addition, she mentioned, “caregivers having transportation, caregivers taking public transportation...there should be a van to drive caregivers to the elderly people they care for.”
HOW WE PAY FOR CARE: REVENUE RAISING OPTIONS FOR ECCE, PFML, AND LTSS
OVERVIEW

The Institute on Taxation and Economic Policy (ITEP) designed and modeled different funding mechanisms as “pay-fors” to support the fully phased-in costs of the Caring Across Generations UFC Pilot in Los Angeles, San Francisco, and Sacramento. This includes a Universal Long-Term Care subsidy, Universal Early Child Care subsidy, and Universal Paid Medical and Family Leave. The funding mechanisms include a mix of state- and local-level options.

COST TARGETS

When designing the funding mechanisms, ITEP determined the low and high ends of the range of revenue that would need to be raised to fund these programs. The estimates below were based on the participation rates provided by GCPI.

<table>
<thead>
<tr>
<th>CITY</th>
<th>LOW-END ESTIMATE</th>
<th>HIGH-END ESTIMATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Los Angeles</td>
<td>$5.24 billion</td>
<td>$5.47 billion</td>
</tr>
<tr>
<td>San Francisco</td>
<td>$1.12 billion</td>
<td>$1.22 billion</td>
</tr>
<tr>
<td>Sacramento</td>
<td>$737 million</td>
<td>$830 million</td>
</tr>
</tbody>
</table>

TYPES OF REVENUE OPTIONS AVAILABLE

MILLIONAIRE SURCHARGE

An additional tax on income over $1 million, earmarked for funding the UFC program. This can be done at the state and local level.²⁸

- **PROS:** California could meet the low-cost and high-cost target annually by adding a surcharge of 0.304-2.255 percent (depending on the city) on all personal taxable income above the highest income bracket ($1 million for single filers). ITEP estimates this would raise the funding annually and only impact taxpayers

²⁸ Technically it could be done at the local level, but California only currently has income taxes at the state level and that is the only level at which ITEP modeled it.
in the top 1 percent of incomes in the state. It is a highly progressive revenue raising option.

- **CONS**: California levies the highest marginal income tax rates in the nation, so an additional surcharge may face stiff opposition. There is already a 1 percent surcharge that is levied on incomes over $1 million to help pay for mental health programming initiatives.

### PROGRESSIVE PAYROLL TAX

A tax withheld on earnings (including wage, salary, unearned, and pass-through income) above the Social Security and Medicare tax threshold ($137,000 in 2020). This can be done at the state and local level.

- **PROS**: Such a tax would improve tax fairness because it would only apply to income that is not currently subject to federal payroll taxes at all, and would only affect upper-income households in the top 20 percent of incomes. It is a very progressive option.

- **CONS**: This option works best at the statewide level or in relatively affluent cities; cities with fewer high-income households could not fully fund the revenue targets without very high tax rates.

### TRADITIONAL PAYROLL TAX

A local tax on all wages and salaries, similar to the existing federal taxes that fund Social Security and Medicare.

- **PROS**: A traditional payroll tax is a more universal funding mechanism, resulting in a tax increase that spans the income spectrum. Funding goals can be met with relatively low rates—1.91 - 6.32 percent, depending on the city—because the tax base includes all wages and salaries.

- **CONS**: It also is a regressive tax in its impact. The tax increase as a share of income is higher for taxpayers with low and moderate incomes compared to those with the highest incomes.

### STATEWIDE SALES TAX INCREASE

An increase in the tax paid on the sale of certain goods. This can be done at the state and local level.

- **PROS**: The policy design can build in a refundable credit that can offset the impact of the sales tax increase for households in the bottom 40 percent of incomes. Sales taxes are also relatively stable because they apply to a very broad base of consumer purchases.
• **CONS**: California also has the highest state-levied general sales tax rate at 7.25 percent. Sales taxes are among the most regressive tax types, which means they make up a higher share of income from lower- and moderate-income households than the wealthiest. Without a refundable credit, this is a very regressive option.

**LOCAL SALES TAX**

An increase in the tax paid on the sale of certain goods in SF and LA.

• **PROS**: Sales taxes are relatively stable over time because they apply to a very broad base of purchases. They are also familiar to policymakers and consumers.

• **CONS**: State and local sales taxes are highly regressive. As a share of income, households in the bottom income quintile in California pay taxes seven times as high that paid by households in the top 1 percent.
RECENT POLICY CHANGES AT THE STATE AND FEDERAL LEVEL
Since the inception of the idea for universal family care, the COVID pandemic led to unexpected and significant federal investments to support families, with more potentially on the horizon. California has utilized those federal investments to expand supports across the care infrastructure.

**EARLY CHILD CARE AND EDUCATION (ECCE)**

**FEDERAL LEVEL**

On March 11, 2021, President Biden signed into law the American Rescue Plan. The plan specifies $23.975 Billion in Child Care Stabilization Funds for states, and $14.9 billion in CCDBG funds. California received $2.3 billion in Child Care Stabilization Funds and $1.4 Billion for CCDBG. Child Care Stabilization Funds are to be used as subgrants to child care providers, regardless of whether they are paid with child care subsidies or receive other federal assistance. The CCDBG funds can be used in accordance with the state’s plan for CCDF. They may also be used to provide care for essential workers, even if they do not meet CCDBG eligibility requirements.

**STATE LEVEL**

- The governor signed into law SB 130, which enacts the $2.7 billion universal transitional kindergarten program. The program will be gradually phased in over the next five years, until all of California’s 4-year-olds are included by the 2025-26 school year.

- Effective as of January 2022, a new law, AB 1365, requires quality indicators for preschool program activities and services that meet the cultural and linguistic needs of children and families to support their home language and English. The superintendent must develop procedures to identify and report data on dual language learners in preschool, including data on home languages and the language composition of the program staff.

- SB 393, also effective this year, aligns the funding stream for the Migrant Child Care Alternative (AP) program with other voucher-based programs. The shift in funding structures will allow more families, particularly families of migrant workers, to access public funds earmarked for essential workers.
• AB 1294, or the Subsidy Pilot Program Extension, signed into law in 2021, authorizes Santa Clara County to continue its individualized county child care subsidy program until July 1, 2023. This program seeks to make child care more accessible for families with the fewest resources living in high-cost Santa Clara County. The bill also requires the California Department of Education and California Department of Social Services to review and report to the state legislature on existing child care subsidy pilot programs in the counties of Alameda, Contra Costa, Fresno, Marin, Monterey, San Benito, San Diego, Santa Cruz, Solano, and Sonoma.

• In December 2020, the California Health and Human Services Agency, along with a team of researchers led by WestEd, published the “Master Plan for Early Learning and Care,” which provides direction for building a better system over time—one that partners with families, takes a whole child approach to ensure the best child outcomes, and supports the advancement of early learning and care professionals so that every family has access to quality care and learning supports.29

PAID LEAVE

FEDERAL LEVEL

In March of 2020, President Biden signed into law the Families First Coronavirus Response Act (FFCRA), which provided up to two weeks of paid sick leave to all employees of employers of 500 employees or less for specified reasons related to COVID-19. The FFCRA expired on December 31, 2020.

STATE LEVEL

• SB 114, COVID-19 Supplemental Paid Sick Leave, makes various statutory changes to extend COVID-19 supplemental paid sick leave provisions that were included in SB 95 but expired on September 30, 2021. This bill reinstates supplemental sick leave benefits for most California workers, providing up to two weeks of paid time off for COVID-19 related illnesses and absences. These benefits are available with retroactive payment between January 1, 2022 and September 30, 2022. The policy does not apply to small employers with 25 or fewer workers, leaving one in four workers with only three paid sick days. It was signed into law in February 2022.

29 Master Plan for Early Learning and Care: Making California For All Kids (California Health and Human Services Agency, Dec 2020).
• SB 95, which was signed by the governor last year, established the COVID-19 Supplemental Paid Sick Leave, and COVID-19 Food Sector Supplemental Paid Sick Leave, which provided up to two weeks of supplemental sick leave at employers with 500 workers or more. Employees may take this leave if they are subject to quarantine or isolation due to COVID-19 or prohibited from working due to concerns related to potential transmission of COVID-19. These provisions were retroactively applied to either March 4, 2020, or April 16, 2020, as specified, and were set to expire on December 31, 2020, or upon expiration of any federal extension of the Emergency Paid Sick Leave Law as established by the Families First Coronavirus Response Act (FFCRA).

• SB 1383, which was signed into law in 2020, expanded the law requiring large employers to grant 12 weeks of unpaid leave to include any employer with at least five workers.

• AB 123, which was vetoed by the governor last year, would have increased the wage replacement rate from 70% to 90% of a worker’s highest quarterly earnings in the past 12 months. Under current law, California’s paid family leave is often being used by those who can more easily afford going without full pay. The wage replacement of at least 90% was also advocated for in a December 2020 report from the California Health and Human Services Agency outlining a revamp of the state’s early learning and child care system.30

LONG TERM SERVICES AND SUPPORTS (LTSS)/HOME AND COMMUNITY-BASED SERVICES (HCBS)

FEDERAL LEVEL

The California Health and Human Services HCBS spending plan, funded by the Federal American Rescue Plan Act (ARPA), allocated $3 billion in enhanced federal funding for the quarters from April 2021 through March 2022. The initiatives identified by the state include funding to: eliminate assisted living waiver waitlists, create In-Home Supportive Services (IHSS) career pathways, create programs for direct care workforce (non-IHSS) training and stipends, make non-IHSS HCBS care economy payments, cre-
ate coordinated family support services, invest in adult family homes for older adults, and ensure LTSS data transparency.

**STATE LEVEL**

- The state level Master Plan for Aging (MPA) blueprint outlines five bold goals and 23 strategies to build a California for All Ages by 2030. This initiative also includes a data dashboard on aging to measure progress, and a local playbook to drive partnerships. The annual MPA progress report will include: developing options to include family caregivers in home and community assessments, expanding respite care for family caregivers, convening a Direct Care Workforce Solutions Table to address workforce supply challenges and opportunities in skilled nursing facilities, considering expanding online training platforms for direct care workers – including opportunities for dementia training for IHSS family caregivers and more, and diversifying the pipeline for direct care workers in home and community settings by testing and scaling emerging models to meet need as funding allows.

- Additionally, from November 2019 to January 2020, Milliman, a national actuarial firm, consulted with the state and a number of stakeholders in California to gather information, priorities, and feedback for the Long-Term Services and Supports Feasibility Study. The final report provides background, stakeholder findings, a list of policy options and fiscal estimates, and actuarial analysis of the policy options. The interim report was prepared and distributed in June 2020. There are some real limitations to this report and it leaves out several populations, including people with disabilities, and those who have not worked, including family caregivers from accessing a new public LTSS program.

- In 2019, Governor Newsom signed into law AB 567, which created the Long Term Care Insurance Task Force within the California Department of Insurance to explore the feasibility of developing and implementing a culturally competent statewide insurance program for long-term care services and supports. The Task Force shall recommend options for establishing a statewide long-term care insurance program and comment on the respective degrees of feasibility of those options in a report submitted to the commissioner, the governor, and the legislature on or before January 1, 2023. After the completion of the feasibility report, the department will, no later than January 1, 2024, produce an actuarial report of the recommendations made by the task force and submitted to the legislature.

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31 Master Plan: 5 Bold Goals (California Department of Aging).
32 Long-Term Services and Supports Feasibility Study (California Department of Health Care Services).
33 Long Term Care Insurance Task Force (California Department of Insurance).
NOW IS THE TIME: CALIFORNIA CARE CAN’T WAIT
Californians need a strong, equitable care infrastructure that addresses their needs at every stage of life. The pandemic highlighted the fragility of the care systems that so many Californians rely on, and that many cannot access. That, in combination with our local data collection and the strong advocacy work of groups on the ground, demonstrated a consistent need in all areas of the state, across each of the care pillars. This led us to the conclusion that a statewide policy solution would be the most impactful towards creating accessible and affordable family care for all. Given the momentum of an infusion of resources from the federal government, and a newfound awareness in the general public about our need to collectively support care and caregivers across generation and ability, the time for bold action is now.

As California moves toward universal solutions, we will work in the context of existing programs to expand access to affordable quality care for all who need it, in the way that best fits their needs. And we will look for every opportunity to improve supports for family caregivers, as well as wages and job quality for professional care workers.

Every Californian will be a paid or unpaid caregiver or need care in their lifetime. A fresh, holistic and effective approach to caregiving is needed in California. A California Care Can’t Wait state level policy framework with strong programs for Early Childhood Care and Education, Paid Family and Medical Leave, and Long Term Supports and Services, with a focus on Home and Community Based Services, is more than a possibility – it’s what Californians need now.

Together, we can transform caregiving in California.
METHODOLOGY

Surveys and Interviews were conducted online between June 2021 and November 2021. Caring Across coordinated with California Care Partners on the ground in the three cities to help develop the survey and distribute it to locate potential participants. Data was collected from online surveys with 125 caregivers across three areas of care: ECCE, PFML, and LTSS. Interviews were conducted with 11 caregivers. Quantitative and qualitative analyses were then used to identify and characterize major themes and trends within and across cities. Multiple-case study design (Yin, 2003) was used to explore both formal and informal caregiver’s experiences, and the broader context in which they exist. Online surveys were developed to generate insights into the obstacles to and shortcomings of current care services across California. Caregiver interviews probed for insights about challenges and successes related to the acquisition, utilization of care services.

The survey was translated into Amharic, Hmong, Korean, Russian, Spanish, Tagalog, Traditional Chinese, and Vietnamese and programmed into Qualtrics online survey software and disseminated via email. Eligible respondents included caregivers 18 and older who provided either formal or informal care services in one of the respective cities at the time of survey. Respondents were given a $100 e-gift card as a token of appreciation for their time.

The online survey was broken into six main sections: Eligibility and General Care, ECCE, PFML, LTSS, Self-Care, and Background. Respondents who had indicated having had experiences with ECE, PFML, LTSS were asked about those experiences, respectively.

For more information about how the Population & Cost Simulation and Revenue Options are calculated, please follow the hyperlink on their respective sections above.

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