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VIA Electronic Submission

Mary Ziegler
Director, Division of Regulations, Legislation, and Interpretation
Wage and Hour Division
U.S. Department of Labor
200 Constitution Avenue NW., Room S-3502
Washington, DC 20210

**Re: Comments on the Wage and Hour Division, Department of Labor's
Proposed Regulations Re: Application of the FLSA to Domestic Service, 78
Fed. Reg. 81190 Dec. 27, 2011
Regulatory Information Number 1235-AA05**

Dear Ms. Ziegler:

Thank you for the opportunity to comment on the Department of Labor's (DOL) proposed rule changes to the wage and hour regulation of domestic service employees. The Disability Rights Education and Defense Fund (DREDF) is a leading national law and policy center that advances the civil and human rights of people with disabilities through legal advocacy, training, education, and public policy and legislative development. Our comment on the proposed regulations pertain to their potential impact on personal assistance workers (PA workers) and people with disabilities who employ and rely on PA workers to live independently in the community.

Introduction

DREDF does not oppose wage protections for personal assistance workers, and we certainly recognize the economic, physical, and social vulnerability of all domestic workers who generally labor individually behind closed doors. Indeed, the majority of people with disabilities (PWD), and particularly those who have significant personal assistance needs, live lives that parallel those of their PA workers due to such factors as:

- Longstanding disproportionately high incidence of poverty among PWD, and a higher likelihood of experiencing long-term poverty (remaining in poverty > 36 months)¹;

¹ Using the official U.S. measure of poverty level, which is based primarily on the cost of minimum necessary food consumption, the 1997 poverty rates for those aged 25-61 ranged from 5% for those with no work limitation, to 23% for those who were unable to perform, or who needed assistance with, at least one life activity, and 32% for individuals prevented by a disability from working for all of 1997. Among individuals with long term work limitations of greater than 36 months, 51% who were in poverty for at least 12 months remained in poverty for over 36 months. Gina Livermore, *Poverty and Hardship Among Working-Age People with Disabilities*. Mathematica Policy Research, Inc. and Center for Studying Disability Policy. December 3, 2009. Available at: <http://www.google.com/url?sa=t&rct=j&q=mathematica%20livermore%20poverty%20and%20hardship%20among%20working->

- Substantial living expenses that are not covered by public programs or employment/private insurance (e.g., California's primarily Medicaid-funded In-Home Supportive Services Program does not reimburse PA workers for reading correspondence to individuals with visual disabilities, most private small group insurers in California impose an annual limit on DME coverage of approximately \$2000 which is thousands less than the cost of an electric wheelchair)²;
- Physical and social Isolation due to the limited accessibility of sidewalks, public transportation, and the built environment, as well as communication barriers and the acute social stigma and misunderstanding that still accrue to mental health disabilities, despite the advances brought about by the Americans with Disabilities Act of 1990;
- Personal physical, economic, and social risk due to the necessity of opening one's home, and personal and intimate details of one's life to relative strangers.

The above commonalities between employer and employee result in a natural desire in the disability community to support advances in the well-being of PA workers. In addition, there is the argument that has been advanced by many domestic worker organizations, that the lives and well-being of PWD and PA workers are intertwined, so that achieving better working conditions for workers accrues to the benefit of PWD who receive personal assistance. We agree with this proposition, and would like to take it one logical step further. Securing greater economic stability and enhanced home and community-based long-term supports and services for individuals with disabilities and seniors who are at risk of institutionalization accrues to the benefit of workers who provide personal assistance.

DOL has stated that this rule-making is simply intended to "close the gap" that exists between Congress' intentions in 1974, when the "companionship exemption" was first enacted for the benefit of those relatively few families who casually hired sitters as company for relatives who were older or had disabilities, and the current reality of a large PA workforce that is left out of the federal minimum wage and overtime (OT) protections afforded to all other wage and hour workers. It must be noted that the PA workforce has grown exponentially over the past several decades, and acquired higher levels of skill, because PWD have fought to return to and remain in their communities, despite long term supportive services systems that heavily favor institutional care. PWD, and their families, advocates, and lawmakers have created innovative financial, social, and employment arrangements, and entire state and local infrastructures over the years such as consumer-directed personal assistance, intended to support the needs of PWD as they live in and contribute to their communities. These are also

age%20&source=web&cd=1&ved=0CCgQFjAA&url=http%3A%2F%2Fwww.disabilitypolicyresearch.org%2FForums%2F20091203%2Flivermore.pdf&ei=XTdpT9q3GeSqiQK7moSEBw&usg=AFQjCnFmviAVD9KJGvIr-47km0s3zBAIHw&cad=rja

² Those with no functional limitations reported hardships such as food security and/or the inability to meet expenses, pay rent or mortgage, pay utility bills, or get needed medical care or dental care at an annual income level of \$10,160. Individuals with disability work limitations of over 12 months had an equal probability of reporting these hardships at an income level of \$34,239 when other factors were held constant. G. Livermore, from She and Livermore (2007) using the 1996-1998 survey of Income and Program Participation.

developments that senior communities are learning about and embracing as the median age of Americans increases.

All of this has come to pass, and continues to develop, in an existing regulatory context. While much relevant regulation has a negative impact on deinstitutionalization, such as the Medicare “homebound” rules around certain benefits, some regulations have been interpreted helpfully at times including the companionship exemption and certain tax credit and deduction provisions concerning medical expenses. Equally important, public programs such as Medicaid are under extreme stress in light of record federal and state budget deficits, and PWD are threatened by reduced home and community-based services (HCBS).

Moreover, even as one arm of the federal government considers this “simple” rule change, another arm is actively engaged in negotiating fundamental structural and financial changes to the way in which Medicare and Medicaid-eligible beneficiaries (“dual eligibles”) receive services.³ The approximately 9 million dual eligibles in the country include many of the poorest and most medically complex PWD. The CMS Medicare-Medicaid Coordination Office⁴ is literally receiving project proposals daily from states on “person-centered approaches to coordinate care across primary, acute, behavioral health and *long-term supports and services* for dual eligible individuals” with the goal of identifying integrated service delivery and financial models that could be tested and replicated in other states. (Emphasis added) Many of these models involve managed care entities, which would add yet another potential “employment” layer in PA services for the DOL to consider. Advocates and states have been actively discussing “maintenance of effort” provisions in these proposals as a consumer protection that would hold the amount of funds spent on in-home supportive services provided to PWD through the first couple of years of the transition. In theory this would protect PWD from managed care entities immediately cutting down on the amount of PA hours received by PWD. At least in California, the Director of Health Care Services, in response to a direct question from DREDF, stated that the state’s maintenance of effort clause is not taking into account any additional costs that would be associated with minimum wage and O/T⁵ provisions under an amended FLSA. We cannot overstate how dynamic health care for PWD is right now, and how much risk and opportunity exists for fostering and disseminating innovative ways to provide HCBS, including critical personal assistance services

It is not a simple matter of turning back the clock. It is not enough for DOL to try to capture what Congress intended almost 40 years ago when the vast majority of PWD with high PA needs were institutionalized. Congress must consider, in light of all the

³ For more information, see http://www.cms.gov/medicare-medicaid-coordination/04_StateDemonstrationsToIntegrateCareForDualEligibleIndividuals.asp#TopOfPage.

⁴ The Medicare-Medicaid Coordination Office was established pursuant to Section 2602 of the Affordable Care Act.

⁵ The DOL analysis of state law indicated that California’s approximately 367,000 county-employed In-Home Supportive Services (IHSS) workers do receive minimum wage and “may also receive overtime” under their union contracts. That is incorrect. California’s IHSS workers are not currently entitled to O/T, and the latest version of AB 889, the California Bill that proposes a Domestic Worker Bill of Rights including O/T, actually exempts IHSS workers.

complex factors mentioned above, how to preserve and further encourage the deinstitutionalization gains made by PWD while considering how best to provide wage protections for PA workers. Ultimately, we cannot support the proposed rule change because of the possible unintended consequences to PWD and their families, both those who rely on public programs and those who are just getting by on fixed or middle class incomes and paying privately, when the rule change fails to even identify, much less mitigate, those consequences in our present context.

The Proposed Rule Change Places PWD at Risk

If DOL simply passes the rule change now, without in-depth consideration of the impact on PWD, and consultation with the disability community and other federal and state agencies involved in public personal assistance programs, individuals with the most serious chronic conditions and the highest levels of functional impairments will be at increased risk of institutionalization. The impact will be felt among PWD who are below poverty level, low-income PWD, and PWD who on paper make a good income, but who spend very significant percentages of that income on PA services. The 3 biggest areas of concern raised by the proposed rule changes fall into (1) concerns about budget deficits and who is the employer for PWD on Public Programs, (2) Income limitations for PWD paying privately, and (3) what the exemption covers.

PWD on Public Programs

While the DOL analysis accompanying the rule change spent little time on consumer-directed assistance services, they are a central and unique feature of California's Medi-Cal program, and a growing trend throughout the country. In California, the state/local government entity that administers the In-Home Supportive Services (IHSS) program remains the employer of record, while the individual with a disability is in control of attendant hiring, firing, training, and supervision. Since these PA workers are employed by the county, they would not fall within the companionship exemption, and IHSS would also not be entitled to claim the "live-in" exemption with regard to O/T. The county and the state would therefore be subject to the minimum wage and O/T provisions. IHSS workers already receive at least minimum wage, but given the state of California's budget, and projected cuts to the federal Medicaid budget, it is highly unrealistic to assume that the state and local governments would be willing to pay O/T. It is far more likely that IHSS would simply cap individual workers' hours at 40 hours/week.

This would have a particularly devastating impact in those situations where a family member chooses, because of a personal relationship with a PWD, to work as that person's PA worker. These are generally low income families given Medi-Cal eligibility. An individual with a disability can qualify for up to a maximum of 283 hours a month, which works out to approximately 65 hours a week. IHSS currently would pay the family member attendant an hourly rate for all 65 hours without O/T. For these families, the family member's work as an assistant serves the double purpose of enabling family members to care for one another as a natural extension of an existing relationship, and also allows the family unit to earn an income that helps to make up for the lost

opportunity to work outside of the home. Capping the family member's hours at 40 hours/week would result in the loss of up to 38% of that member's income, and the family unit would have to hire, train, supervise, and keep employment records for another individual who would receive that lost income from IHSS.

There would also likely be a negative impact in rural and other areas of California where there is already an existing shortage of qualified PA workers. If IHSS capped individual worker hours at 40/week, it could be very difficult for PWD to find sufficient replacement workers, and the rural PA worker would have to take on more individual clients and increased travel time to make up for income that had previously been received through working for one individual with whom they have already established a relationship.⁶

The IHSS program in California is one type of consumer directed community based long-term supports and services program that has developed over many years. Throughout the country, however, the deinstitutionalization trends of the last few decades have led to a number of innovative models that may have complicated legal and financial arrangements among the public state and/or local government Medicaid entity, third party non-profit service or care management organizations, and individual PWD. The PA workers in these situations may well have an official third-party employer, including arrangements where the PA assistant also lives or forms a household with the person with a disability. As a consequence, all of these innovative arrangements may fall outside of the companionship exemption and the "live-in" exemption from O/T, and are all put at risk by a public payer's unwillingness to pay O/T. Moreover, there is the inevitable chilling effect that will be experienced because public payers around the country will be far less willing to experiment with sorely-needed flexible ways of providing consumer-directed in-home supports and services when they may wind up liable for O/T.

Following are just a few additional concrete illustrations of the interpretive difficulties that the proposed FLSA rule will raise in California for a Californian with a disability who qualifies for the maximum 283 hours/month.

- 1) A person with a disability is Medi-Cal eligible and has 3 non-live-in attendants a week who come 3 days, 2 days, and 2 days respectively. IHSS counts time according to work done on specific tasks, not according to the amount of time spent physically in the home or with a person with a disability. Would these 3 attendants automatically be incurring weekly O/T because FLSA rules apply so that the 3 day/week person is actually working all of the 72 hours (or, if the person does get a minimum of 5 hrs/night of uninterrupted sleep, would that person be working 58 hours/week?) Or would FLSA count hours in accordance with IHSS rules?

⁶ There are approximately 28,600 Californians who live with a family member caregiver funded through the IHSS program to provide more than forty hours a week of care. Declaration of Eileen Carroll, Deputy Director, Adult Programs Division, California Department of Social Services (Dec. 23, 2011), ¶¶ 4, 5, in *Oster v. Lightbourne*, No. C 09-4668 CW (Mar. 2, 2012) (Docket No. 506); IHSS Providers: Characteristics, *supra*. As IHSS is the employer of record, the minimum wage and O/T requirements would apply to these family/friend PA workers.

- 2) In the above scenario, IHSS pays for most of the attendant's time, but assume that the individual and his family pay those same regular attendants for some additional tasks that are not reimbursed by IHSS. Is it clear that these additional hours would not trigger the FLSA O/T requirements unless they separately tallied more than 40 hrs/week?

PWD Who Pay Privately – Context and Personal Assistance Issues

Everything we know about people who are not on Medicaid and who have difficulty performing activities of daily living (ADL) so that they need, or are at risk of needing, PA services is that they are disproportionately poor compared to the general population and more likely to incur out-of-pocket healthcare expenses.⁷

Data from the 2009 American Community Survey (ACS) indicates that 5.1% of Californians, or 1.8 million, have limitations in performing ADL. Not everyone who has difficulty performing ADL requires actual assistance with ADL, but those who need PAS fall within this group, as do those who would potentially benefit from or need PAS in the future.⁸ Within this group, income levels are as follows:

- 18.9% below Federal Poverty Thresholds (FPT)⁹
- 28.2% between 100-199% FPT
- 17.2% between 200% and 299% FPT
- 35.7% between at or > 300% FPT

Crossing the ACS data with estimates for people who need help with ADL, derived from the Survey of Income and Program Participation (SIPP), it is estimated that approximately two-thirds of people who have limitations in performing ADL actually need the assistance of another person. This works out to 1.2 million Californians who need assistance with ADL. The median household income for Californians needing help with ADL is \$38,400/year. Californians who live alone and need help with ADL have a median income of \$17,000/year. For purposes of comparison, the 2008 median California household income was \$61,017.¹⁰ Taking approximate Federal and California income tax payments into account, the median disposable income¹¹ for Californians needing assistance with ADL is \$27,700/year, and \$15,400/year for those living alone. Approximately 700,000 out of the 1.2 million in this group are not covered by Medicaid.¹² Purely for purposes of comparison, Californians with disabilities who are on Medi-Cal because they receive Supplemental Security Income (SSI) are eligible to receive a maximum federal and state combined

⁷ For example, a wheelchair user who requires assistance with self-help and household activities will also likely incur healthcare expenses related to high co-pays, annual private insurance caps on durable medical equipment, and the purchase of necessary items that not covered by insurance such as lifts, bath seats, and support stockings.

⁸ (Source: PAS Center website:

http://www.pascenter.org/state_based_stats/disability_stats/acs_prevalence.php?state=california).

⁹ The FPL in 2009 ranged from \$10,956 for an individual to \$21,954 for a family of 4 persons. See

<http://www.census.gov/hhes/www/poverty/data/threshld/thresh09.html>.

¹⁰ See <http://quickfacts.census.gov/qfd/states/06000.html>.

¹¹ Adjusted for inflation in 2011 dollars.

¹² Source: Center for Personal Assistance Services at UCSF [PAS Center], unpublished tabulations.

monthly payment of \$845,000,¹³ and generally have few out-of-pocket healthcare expenses, though this is likely to change depending on the ongoing crisis with California's state budget.

SIPP data from 2005¹⁴ establishes that some Californians with disabilities shoulder very significant out-of-pocket expenses for PAS and for healthcare expenses. 10% of Californians who need help with ADL pay out-of-pocket, and 21% of those living alone and needing PA services pay out-of-pocket. The median out-of-pocket expenditure is approximately \$1,500 per year, but 25% of those paying out-of-pocket spend more than \$5,300/year on PA services. Put another way, the median spent out-of-pocket on PA services is 4.6% of disposable income, and one-quarter of this groups spends more than 13.7% of their disposable income on PAS. Within this same group of Californians who are not on Medicaid and therefore paying out-of-pocket for needed PAS, the median amount spent out-of-pocket on healthcare expenses (including health insurance premiums, if any) is \$1,400 per year, with 25% paying more than \$4,300 per year.¹⁵ Even those who qualify for Medicaid and/or California's In Home Supportive Services (IHSS) program can be paying out-of-pocket for needed personal assistance services and/or healthcare expenditures that are not covered because of restrictions in the IHSS or Medicaid programs. The real income levels for people with disabilities needing assistance with ADL who are low income, but earn too much to be eligible for SSI, places them in much the same income bracket as their PA workers.

The picture we get from the above data is that while a number of Californians with disabilities who need assistance with ADL appear to get by spending relatively small amounts on PA services, there is clearly a group that pays substantial out-of-pocket amounts for PA services, and for additional healthcare expenditures. The additional costs associated with the proposed wage protections may be flatly unaffordable. This group also likely comprises individuals with significant disabilities and/or chronic complex health conditions, who require more PA services for longer periods of time, which then also potentially raises the additional costs mandated by the overtime provisions in the bill. As well, we must consider the likely negative impact on the physical and mental well-being of some PWD who require 24-hour care and who may have difficulty forming trusting relations with multiple attendants coming in and out of the home (e.g., individuals with dementia or mental health impairments).

There is limited data concerning the work schedules of PA workers, but according to the 2004 Work Schedule Supplement of the Current Population Survey, 37% of PA workers¹⁶ nationally work shifts lasting over 8 hours. Without further data and study, it cannot and should not be assumed that longer personal assistance shifts can be easily avoided through employer education and increased supplies of qualified PA workers. In rural areas, where it can be especially difficult for a person needing assistance with ADL to find enough qualified personal attendants, longer shifts can be dictated by insufficient worker availability

¹³ See <http://www.ssa.gov/pubs/11125.html>. The actual monthly payments will vary somewhat depending on factors related in the recipient's independent living status, marital status, and whether the recipient is blind.

¹⁴ Adjusted for inflation in 2011 dollars.

¹⁵ (Source: Center for Personal Assistance Services at UCSF [PAS Center], unpublished tabulations.)

¹⁶ People who described themselves as "personal care attendants," "home health aides," nursing aides working in homes," etc.

as well as long commute distances for staff; a 90 or 120 minute one-way commute is easier to both employer and employee to justify for longer or even multiple day shifts, but figuring in overtime will make that option unaffordable. Even in urban areas, there is very little information about the ready availability of greater numbers of qualified attendants to fill the higher number of shorter shifts that anyone using potentially 24-hour assistance would need to avoid paying overtime. In competitive urban areas, qualified PA workers may demand considerably higher than minimum wage, but may employer and employee may freely enter into a separate agreement concerning how hours are accounted for or how O/T is or is not paid. Moreover, the proposed FLSA amendments fail to account for the economic and logistical difficulty of avoiding the incursion of O/T in myriad life situations such as long-distance travel, and having to meet overlapping work and social engagements in different locations when one's personal assistance worker is also one's driver.

Even for those Californians who are currently not spending large amounts on PA services, we have no indication of why this is so (e.g., we do not know whether an individual's current need for assistance is fully satisfied or already cannot be afforded). We also have very little data on the how the need for PAS increases over time for those who have difficulty performing ADL as, for example, age interacts with a disability or chronic health condition. Additional costs will force individuals who are just managing to afford or get by on a certain level of assistance to make terrible choices. Will they maintain their current level of personal assistance and cut back on medications? Will they maintain current levels and sacrifice the independence of their own apartment or room rental to save money by moving in with a relative (for those who even have that option)? Will they cut back on personal assistance hours or reduce the risk of incurring overtime by giving up all social activities? Must they open their homes and the most intimate details of their personal lives to a revolving door of PA workers? These questions are further complicated by considerations of the additional transportation and housing costs that are often incurred by those with significant disabilities and chronic complex conditions, thus making further inroads into the limited or fixed disposable incomes of many people with disabilities and seniors.

Narrow Definition of Companionship Services

DOL has stated its understanding that the FLSA amendment's definition of "companionship services" merely codifies the original intent behind the companionship exemption. Unfortunately, the proposed definition fails to capture the work performed by many PA workers today, which consistently includes assistance with myriad personal care services such as dressing, bathing, grooming, driving, and feeding, as well as paramedical services such as turning and repositioning, catheter and ostomy care, injections, tube feeding, and determining the need for medication. These latter paramedical functions are explicitly referred to in the proposed regulations as "medical care," which is excluded from companionship services and necessarily included as "domestic service" when performed in or about a private household. The mismatch between the codification of and the reality of PA services means that many PWD across the country who employ a PA worker would be unable to use the amended companionship exemption because it entrenches a highly outmoded definition of "companionship" that bears little resemblance to the actual work performed by PA workers today.

Once again, DOL cannot simply codify the intentions of Congress in 1974, because Congress could not at that time have ever envisioned the full development of disability civil rights and the blossoming of deinstitutionalization as PWD with multiple functional impairments and conditions reclaim their lives in their communities. This narrow codification entrenches the “medical model” of care needed by PWD in the community, and minimizes the capacity of trained, but non-medical, PA workers to work together with PWD in a way that guards the well-being of PWD and respects their dignity of choice. Even worse, the explicit limitation that “incidental intimate personal care services must not exceed 20 percent of the total hours worked in the workweek” at this time may well cause problems now and down the road for many PWD currently living in the community who have not historically had to parse out or justify what percentage of time has been spent on intimate personal care and what percent has been spent in other assistance work.

Conclusion and Recommendations

DREDF has no disagreement with the motivation behind DOL’s proposed rule change in so far as it relates to improving the lives of PA workers. We do take issue with the attempt to enact a codification of an almost 40 year old Congressional intention in a vacuum, as if PWD living in the community, and especially those with severe functional impairments and multiple chronic conditions, has never occurred. Rightly or wrongly, the companionship exemption has, in conjunction with the evolution of the American disability rights movement, the profound determination of PWD to escape institutionalization, and myriad landmark legal and policy developments such as the Supreme Court *Olmstead*¹⁷ decision and “Money Follows the Person” initiatives, been part of a landscape that has enabled PWD to remain in and return to their communities. For the vast majority of PWD, the right to live independently in the community remains practically precarious, dependent upon shifting public policies and social supports constantly undermined by budget cuts, limited resources, and fixed incomes. Shifting one card in this balancing act, however well-intentioned and justified, **will** shift the entire structure, placing people with disabilities, their families, and their personal assistance workers, at risk of losing the gains of the past four decades.

We note that Congressional minimum wage increases in the past have often been accompanied by various measures, such as tax breaks for small businesses, designed to mitigate the impact of the increase on the class of entity that will be most negatively impacted.¹⁸ If this were a Congressional action, and not an agency rule change, then such sorely needed mitigating measures could be applied to PWD. For instance, there could be greater and more appropriate tax deductions and credits for PA costs, as well

¹⁷ See *Olmstead v. L.C.*, 527 U.S. 581 (1999).

¹⁸ For example, Congress approved the Fair Minimum Wage Act of 2007 that increased the minimum wage in three installments, reaching \$7.25 an hour for covered workers on July 24, 2009. This was accompanied by small business relief measures such as an extension of the Work Opportunity Tax Credit and an increase of Section 179 small business expensing limits to \$125,000.00 a year from \$100,000.00 for capital investments through 2010. U.S. Chamber of Commerce site at: <http://www.uschamber.com/issues/labor/minimum-wage>.

as other medically necessary expenses incurred by PWD.¹⁹ As another example, a thoughtful, time limited exception could potentially be crafted for those individuals who are eligible for more than 40 hours of personal assistance where there is clear evidence that a PA worker has financial, social, and/or personal reasons for working more than 40 hours a week and has freely entered an agreement to do so without the accrual of O/T (e.g., live-in family members or friends who are paid Medicaid through the state/local government employer).

A much better alternative is to place this entire matter squarely before federal legislators who will be charged with (i) extending wage protections to PA workers; (ii) validating and protecting the full scope and proportions of work that are currently safely performed by such workers; (iii) ensuring appropriate funding for Medicaid and home and community-based services and supports; and (iv) developing, disseminating, and mandating the use of a disability-adjusted, geographically specific real income standard that will take into account the minimum income needed by a person with disabilities to cover his or her basic expenses – housing, food, medical care and attendant needs, transportation.²⁰ Both PA workers and PWD deserve this consideration from lawmakers so that the extension of fundamental wage protections to PA workers does not come at the cost of deinstitutionalization gains in the disability community. At this point, we regretfully cannot support the immediate implementation of the proposed rule change without much more additional study and consultation with the disability community, and the full involvement of Congress.

Yours Truly,



Susan Henderson,
Executive Director

¹⁹ See Steven Mendelsohn, J.D., William N. Myhill, M.Ed., J.D.*, and Michael Morris, J.D., *Tax subsidization of personal assistance services*, Disability and Health Journal 5 (2012) 75-86.

²⁰ The UCLA Center for Health Policy Research, the Insight Center for Community Economic Development, and the organization Wider Opportunities for Women, have collaborated on the development of an Elder Economic Security Index that is calculated for all 58 California Counties as well as a statewide average. The California Elder Economic Planning Act of 2011 has mandated use of the Elder Economic Security Index as the new standard for all state aging agencies to assess how many seniors in any county can or cannot make ends meet. In and of itself, the new law does not require new spending or impose new regulatory requirements, but it does pave the way for state agencies to receive more accurate data concerning consumer needs and more efficiently prioritize the allocation of existing resources. See Susan E. Smith, *New Cal Law Could be Game-Changer on Elder Poverty*, New American Media at <http://newamericamedia.org/2011/10/new-cal-law-could-be-game-changer-on-elder-poverty.php>.