PROTECTING THE PROTECTORS: A CALL FOR FAIR WORKING CONDITIONS FOR HOME HEALTH CARE WORKERS

Julia Lippitt

The elderly often require additional assistance and care. In the past such care has often taken place in a nursing home; however, long-term care increasingly takes place in the homes of elderly individuals themselves, because it is more cost-effective and comfortable. Now that America's aging baby boomers are beginning to require long-term assistance and care, the need to address adequately the working and compensation conditions of those who provide such care is more pressing than ever. Although home health care workers – encompassing both home care aides and home health aides – provide essential and difficult services, they are low-paid and exempt from the wage and hour regulations of the Fair Labor Standards Act (FLSA) due to the companionship exemption and its corresponding regulations. In this Note, Ms. Lippitt focuses on the injustice of this policy and argues for sweeping change to offer these workers the same labor protections as other Americans, protect the elderly, keep costs down, and effectuate the true Congressional intent of the FLSA as amended in 1974. Ms. Lippitt describes the many important and time consuming functions that home health care workers provide with little compensation. Next, Ms. Lippitt goes on to chart the statutory and regulatory history of the companionship exemption to the FLSA, including the landmark case Long Island Care at Home, Ltd. v. Coke,

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the attempts to modify regulations regarding the application of the companionship exemption to those employed by third parties, and other efforts to amend the FLSA. There have been numerous suggestions on how to remedy this crisis, such as extending home health care workers' FLSA protections, revising Department of Labor regulations, working through unions, and implementing innovative policies in the states. However, Ms. Lippitt argues that these solutions inadequately address the breadth of the crisis. Ms. Lippitt concludes that a broad sweeping policy that revises the FLSA and its regulations; establishes an industry standard wage; allocates more federal funds to support home health service, training, and job opportunities; and requires states to establish public authorities that exercise oversight of home health care is necessary to ensure proper treatment of home health care workers and the elderly.

I. Introduction

Provision of long-term elder care is increasingly taking place in the elderly individual's home instead of in a traditional institutional setting such as a nursing home.[1] The spiraling financial costs associated with institutional long-term care for the elderly and the recognition that elder care may be more effective in the comfort and familiarity of one's home have caused a major shift in the way long-term care is provided.[2] Today, approximately 7.5 million individuals receive long-term care in their homes, compared with 1.5 million individuals in nursing facilities and 1.1 million individuals in assisted living facilities.[3] This shift and the aging of the baby boomers have increased the demand for home health care workers.[4] In 2008,

1. *See* Jon Pynoos et al., *Aging in Place, Housing, and the Law*, 16 ELDER L.J. 77, 78 (2008) (discussing the recent changes in federal policy leading to increasing numbers of the elderly being cared for at home and the barriers they face in attempting to do so). In 2000, the Department of Health and Human Services reported that 7,178,964 individuals received home care services in that year. *See* NAT'L ASS'N FOR HOME CARE & HOSPICE, BASIC STATISTICS ABOUT HOME CARE 8 tbl.8 (2004), *available at* http://www.nahc.org/04HC_stats.pdf.

2. Application of the Fair Labor Standards Act to Domestic Service, 66 Fed. Reg. 5481, 5483 (proposed Jan. 19, 2001).

3. *Study Examines Long Term Home Health Care Utilization*, AM. ASS'N FOR LONG-TERM CARE INS. (Dec. 10, 2009), http://www.aaltci.org/news/long-term-care-news/study-examines-long-term-home-health-care-utilization.

4. INST. OF MED. OF THE NAT'L ACADS., NAT'L ACADS. PRESS, RETOOLING FOR AN AGING AMERICA 203 (2008) [hereinafter RETOOLING AGING AMERICA], *available at* http://www.nap.edu/openbook.php?record_id=12089&page=R1; FED. INTERAGENCY FORUM ON AGING-RELATED STATISTICS, OLDER AMERICANS 2010: KEY INDICATORS OF WELL-BEING, at XIV (2010) (estimating that the number of people over the age of sixty-five will increase from thirty-five million to seventy-two million between 2000 and 2030), *available at* http://www.agingstats.gov/agingstatsdotnet/Main_Site/Data/2010_Documents/Docs/OA_2010.pdf.

about 1.7 million people worked as either home care aides or home health aides.[5] Between 2008 and 2018, the number of people working as home care aides is expected to increase by forty-six percent, to nearly 1.2 million, and the number of people working as home health aides is expected to increase by fifty percent, to nearly 1.4 million, increasing the total number of home care jobs by over 800,000, to over 2.5 million.[6]

The Department of Labor divides home health care workers into two distinct categories: home health aides and personal and home care aides.[7] Home health aides generally work for a certified home health agency under the supervision of a licensed nurse and provide basic health-related services, such as administering medications and simple physical exercises, in addition to other caregiving tasks.[8] Personal and home care aides also often work for a home health agency but are not required to work under the supervision of a medical professional.[9] They also assist with clients' daily living activities and perform other caregiving tasks.[10] The authorities cited in this Note describe these workers in various and sometimes inconsistent ways. For the purpose of this Note, "home health care worker" will refer to home health aides and home care workers collectively. "Home health aide" and "home care aide" will refer to the subsets of home health care workers described above by the Department of Labor.

Generally, home health care workers perform a wide variety of services, including cleaning, cooking, laundry, bathing, grooming, dressing, running errands, administering medications, and helping with prescribed exercises.[11] Despite the emotionally and physically

5. U.S. DEP'T OF LABOR, OCCUPATIONAL OUTLOOK HANDBOOK: HOME HEALTH AIDES AND PERSONAL AND HOME CARE AIDES 2 (2010–11) [hereinafter OCCUPATIONAL OUTLOOK], *available at* http://www.bls.gov/oco/pdf/ocos326.pdf.

6. *Id.* at 2–3 (explaining that the projected increase in jobs will be from 1.7 million to over 2.5 million, encompassing both home health aides and home care aides).

7. *Id.* at 1.

8. *Id.*

9. *Id.*

10. *Id.*

11. *The Fair Home Health Act: Hearing on H.R. 3582 Before the Subcomm. on Workforce Prot. of the H. Comm. on Educ. and Labor*, 110th Cong. 43 (2007) [hereinafter *Hearing on H.R. 3582*] (statement of William Dombi, Vice-President for Law, National Association for Home Care & Hospice, Inc.) (explaining that home health care workers are considered the "heroes" of home care); RETOOLING AGING AMERICA, *supra* note 4, at 201–03.

demanding nature of these services and their essential role in the daily life of many elderly persons, home health care workers endure low pay, lack of overtime payments, long hours, and lack of most employee benefits (including health insurance).[12] These workers are forced to live with such poor conditions in large part because they are excluded from federal wage and hour regulations mandated by the Fair Labor Standards Act (FLSA) due to the companionship services exemption.[13] As a result, they are denied basic labor protections afforded to most employees in the United States.

Home health care workers are often required to work long shifts, sometimes for up to twenty-four hours, without formal breaks or adequate compensation for all the time spent caring for their elderly or disabled clients.[14] These conditions take a toll on the health and well-being of these workers and affect the quality of care being delivered to the client. For example, Normita Lajos, a home health worker in Los Angeles, developed a sleeping disorder and suffered two miscarriages as a result of poor working conditions.[15] She was required to be on call for twenty-four hour shifts; lifted and carried clients to and from their wheelchairs; and cooked, cleaned, and assisted the clients' use of the bathroom, all for fifty dollars per day.[16]

Home health care workers provide essential services to the most vulnerable members of society; yet, they are subject to working conditions that frequently put them in positions of social and financial vulnerability. For example, Deborah Hibbler, another home health care worker in California, drives thirty minutes to and from her client's home every day to perform two hours of work that pays ten dollars an

12. *See* Peggie Smith, *Protecting Home Care Workers Under the Fair Labor Standards Act*, DIRECT CARE ALLIANCE, INC., 2–4 (June 2009), http://blog.directcarealliance.org/wp-content/uploads/2009/06/6709-dca_policybrief_2final.pdf. Peggie Smith is a law professor who has written and published extensively on the subject of home-based care and labor and employment law. *Faculty Profiles*, WASH. U. L., http://law.wustl.edu/faculty_profiles/profiles.aspx?id=7971 (last visited Mar. 1, 2011).

13. *See* Smith, *supra* note 12, at 2.

14. *See* Iryll Sue Umel, Comment, *Cultivating Strength: The Role of the Filipino Workers' Center COURAGE Campaign in Addressing Labor Violations Committed Against Filipinos in the Los Angeles Private Home Care Industry*, 12 ASIAN PAC. AM. L.J. 35, 39 (2007) (discussing the challenges confronted by minority and immigrant home health workers).

15. *Id.* at 35.

16. *Id.*

hour.[17] She does not receive health insurance or benefits and is not compensated for gasoline.[18] Over a nine-year period working for a previous client, Hibbler took no vacation or days off.[19] She explained, "[I]f I take days off, I don't get paid. If I don't get paid, I don't eat. I can't pay my bills."[20]

The earnings of home health care workers are among the "lowest in the service industry."[21] In 2008, the median hourly wage for home health aides was $9.84 and $9.22 for home care aides.[22] Meanwhile, the median wage for all U.S. workers was $15.57.[23] In that same year, the median annual income for home care aides was $12,000, well below the national median annual income level of $35,400.[24] A disproportionate number of home health care workers are female, single mothers, and minorities.[25] Many home health care workers live in poverty,[26] and they are twice as likely as the general workforce to rely on public assistance to meet their living needs.[27] As a result, they re-

17. Li Lou, *Budget Cuts Squeeze Home Health Care Workers*, SACRAMENTO BEE, July 26, 2009, at 1D, *available at* http://www.sacbee.com/392/story/2054581.html.

18. *Id.*

19. *Id.*

20. *Id.*

21. Smith, *supra* note 12, at 2. For example, on average, home health care workers earn less per hour than office clerks and janitors. Press Release, Bureau of Labor Statistics, U.S. Dep't of Labor, Occupational Employment and Wages – May 2009 (May 14, 2010), *available at* http://www.bls.gov/news.release/pdf/ocwage.pdf.

22. OCCUPATIONAL OUTLOOK, *supra* note 5, at 3.

23. *See* U.S. BUREAU OF LABOR STATISTICS, U.S. DEP'T OF LABOR, OCCUPATIONAL EMPLOYMENT AND WAGES, 2008, at 5 fig.4 (2009), *available at* http://www.bls.gov/oes/2008/may/chartbook.pdf.

24. PARAPROFESSIONAL HEALTHCARE INST., WHO ARE DIRECT-CARE WORKERS? 5 (2010), *available at* http://www.directcareclearinghouse.org/download/NCDCW%20Fact%20Sheet-1.pdf. The $12,000 figure accounts for home care aides who worked part-time hours. *Id.* In 2008, forty-three percent of home care aides were employed part-time or worked full-time for only part of the year. *Id.* at 2.

25. *See* RETOOLING AGING AMERICA, *supra* note 4, at 205 tbl.5-3. Female home health aides are much more likely to be black, Hispanic, foreign born, or a single mother than females in the general labor pool. *Id.* For example, twenty-four percent of female home health aides are black, compared with thirteen percent of women in the general labor pool. *Id.*

26. *See* PARAPROFESSIONAL HEALTHCARE INST., DIRECT-CARE HEALTH WORKERS: THE UNNECESSARY CRISIS IN LONG-TERM CARE 12 (2001), *available at* http://www.directcareclearinghouse.org/download/Aspen.pdf.

27. Smith, *supra* note 12, at 3. A large proportion of direct-care workers, including home health care workers, rely on public aid to meet their basic needs. U.S. DEP'T OF HEALTH & HUMAN SERVS., NURSING AIDES, HOME HEALTH AIDES, AND RELATED HEALTH CARE OCCUPATIONS – NATIONAL AND LOCAL WORKFORCE SHORTAGES AND ASSOCIATED DATA NEEDS 20 (2004) [hereinafter NATIONAL AND

port low quality of working conditions and have high rates of work-related injuries or illness.[28]

Inadequate pay and other poor working conditions lead to high turnover rates among home health care workers, with estimates ranging from twelve to sixty percent.[29] High turnover jeopardizes the quality of care provided by home health care workers, because clients may experience a disruption in care or have difficulties adapting to a new worker.[30] In some circumstances, this may lead to hospitalization or may prematurely force the elderly person into an institutional setting.[31]

Part II of this Note explores the statutory and regulatory history of the companionship exemption to the FLSA, as well as the 2007 United States Supreme Court decision to uphold this exemption in *Long Island Care at Home, Ltd. v. Coke*. Part III argues that statutory and regulatory modifications excluding home health care workers from the companionship services exemption are necessary, but not adequate, to ensure that home health care workers are fairly compensated and capable of providing quality care to some of the nation's most vulnerable citizens. Part IV presents additional recommendations for protecting home health care workers beyond revising the statute and regulations and argues that federal and state investment in home health care services is necessary and will ultimately result in health care cost savings for the aging population.

II. Background of the FLSA Companionship Exemption

The Fair Labor Standards Act was enacted in 1938 to eliminate "conditions detrimental to the maintenance of the minimum standard of living necessary for health, efficiency, and general well-being of workers."[32] It provides for "minimum wage, overtime pay, record-

LOCAL WORKFORCE SHORTAGES], *available at* http://www.directcareclearinghouse.org/download/RNandHomeAides.pdf. Thirty-six percent of all home health aides live in families with annual incomes of less than $20,000 and are twice as likely to receive food stamps. *Id.*

28. *See* RETOOLING AGING AMERICA, *supra* note 4, at 200.

29. *See Hearing on H.R. 3582*, *supra* note 11, at 15 (statement of Craig Becker, Associate General Counsel, AFL-CIO and Service Employees International Union).

30. *Id.*; Smith, *supra* note 12, at 4.

31. *See Hearing on H.R. 3582*, *supra* note 11, at 15 (statement of Craig Becker); *see also id.* at 2 (statement of Rep. Lynn C. Woolsey, Chairwoman of the Subcomm. on Workforce Protection).

32. Fair Labor Standards Act of 1938, 29 U.S.C. § 202(a) (2006).

keeping and child labor standards for full-time and part-time workers in the private and public sectors."[33] At the time of its enactment, the FLSA wage and hour protections did not extend to domestic service employment, reflecting the ideological separation between the home and the workplace and the view that domestic labor had a "special" status in private family life.[34]

A. 1974 FLSA Domestic Service Amendments

Between 1938 and 1974, domestic service workers were excluded from FLSA protections, because this kind of work was considered intimate family work and, thus, was not subject to regulation by the government.[35] The home was within the sphere of one's private life, not a workplace to be governed by economic transactions.[36] This landscape shifted in 1974 when Congress amended the FLSA to extend wage and hour protections to individuals who worked in private homes and performed domestic service work.[37]

The question of wage and hour protection for domestic service workers stirred debate among lawmakers leading up to the Amendments' adoption. Lawmakers opposing the 1974 Amendments argued that domestic workers could not be covered under the FLSA because, by working in the private home, their employment relationships had large personal components to them.[38] They considered caregiving and other household tasks performed by domestic workers to be enjoyable work that did not require regulation. Such work was merely an extension of, or substitution for, the woman's labor in the home and, thus, was not "real work" rising to a level that necessitated government regulation.[39]

33. Joseph E. Tilson & Bradford A. LeHew, *FLSA Cases: The New Wave of Employment Litigation*, 682 PRACTISING L. INST. 395, 403 (2002), *available at* Westlaw 682 PLI/Lit 395, 403.

34. Molly Biklen, Note, *Healthcare in the Home: Reexamining the Companionship Services Exemption to the Fair Labor Standards Act*, 35 COLUM. HUM. RTS. L. REV. 113, 113–14 (2003).

35. *Id.* at 117 (explaining that both the proponents and opponents of the 1974 Amendments believed that "intimate care is the responsibility of the family").

36. Peggie Smith, *Aging and Caring in the Home: Regulating Paid Domesticity in the Twenty-First Century*, 92 IOWA L. REV. 1835, 1857–58 (2007).

37. Fair Labor Standards Amendments of 1974, Pub. L. No. 93-259, 88 Stat. 55 (codified at 29 U.S.C. §§ 206(f), 207(l) (2006)).

38. *See* Biklen, *supra* note 34, at 117–18 (explaining that "domestics" were often excluded from federal laws because of the nature of the private home).

39. *Id.* at 120–22.

Proponents of the 1974 Amendments argued that extending FLSA coverage was necessary even though the work was performed in private homes, because domestic workers were subject to poor working conditions and demeaning treatment, the exact types of conditions the FLSA was enacted to prevent.[40] They further argued that modernizing the concept of domestic workers by removing them from the category of domestic relations was necessary in order to protect the civil rights of these workers, many of whom were African-American women forced into low-wage domestic service employment during the Jim Crow era.[41]

Despite these ideological differences, both sides agreed that the 1974 Amendments providing FLSA protections to domestic service workers would continue to exempt workers who provided "companionship services" from wage and labor protections.[42] Congress believed that a companion was someone acting as a babysitter or filling in as a substitute for a member of the family to watch an elderly person or a child when that family member had to run errands or go to work.[43] Such temporary work, Congress reasoned, fulfilled a function that fell in the private family sphere and was not subject to regulation.[44] Lawmakers believed that companion services were easy services performed occasionally on a casual, non-commercial basis that provide "reciprocal benefits of fellowship for the caregiver and the client."[45] The legislature did not envision companionship services as

40. *See id.* at 123.

41. *Id.* at 124. During the time the 1974 FLSA Amendments were being debated, two-thirds of domestic workers were African-American and ninety-seven percent were women. *Id.* Many African-American women were forced to work as domestic workers for low pay and under bad conditions during the Jim Crow era when other employment opportunities were closed to them. *Id.* It was thought that extending the FLSA to include domestic workers would help level the playing field by ensuring these workers the opportunity to make a decent wage. *See id.*

42. *Id.* at 126–30. The statute provides an exemption for anyone working on a "casual basis in domestic service employment to provide babysitting services or any employee employed in domestic service employment to provide companionship services for individuals who (because of age or infirmity) are unable to care for themselves (as such terms are defined and delimited by regulations of the Secretary)." Fair Labor Standards Amendments of 1974, Pub. L. No. 93-259, 88 Stat. 55 (codified at 29 U.S.C. § 213(a)(15) (2006)).

43. Biklen, *supra* note 34, at 128–29.

44. *See id.* at 128.

45. *Id.* at 130. Senator Dominick read from a constituent's letter that described the woman she employed to take care of her mother. *Id.* at 126. This letter described the employee watching television, eating, and relaxing while engaging in a small amount of work. *Id.*

encompassing non-casual services performed on a daily basis as part of a worker's vocation, such as the types of services provided by hundreds of thousands of home health care workers in the homes of elderly and infirm clients today.[46]

B. Department of Labor Companionship Regulations

The Department of Labor (DOL) promulgated regulations in 1975 that defined companionship services as "services which provide fellowship, care, and protection" to elderly or infirm persons.[47] Companionship services under section 552.6 of the regulations include "household work related to the care of the aged or infirm person" and general household work unrelated to the care of the client, as long as such work does not exceed twenty percent of the total weekly hours worked.[48] The interplay between the definition of companionship services provided in this regulation and agency-promulgated regulations subjecting "companionship services" employees employed by third parties to the companionship exemption has resulted in the broad application of the companionship exemption to domestic service workers who provide home health care services.[49] To determine whether the companionship services exemption applies, it is first necessary to determine whether one is a domestic service employee, as the exemption only applies to a domestic service employee.[50] Although the term is not defined in the FLSA, the DOL defines domestic service employment as "services of a household nature performed by an employee in or about a private home (permanent or temporary) of the person by whom he or she is employed."[51]

1. SECTION 552.109(A)—THIRD PARTY EMPLOYMENT

Under the DOL definition of domestic service employee, home health care workers employed by a third party should not be considered to be providing a domestic service, because they are employed

46. Smith, *supra* note 12, at 5.
47. 29 C.F.R. § 552.6 (2010).
48. *Id.*; Smith, *supra* note 12, at 5.
49. *See* 29 C.F.R. § 552.109 (2011); Biklen, *supra* note 34, at 136–39.
50. *See* Fair Labor Standards Amendments of 1974, Pub. L. No. 93-259, 88 Stat. 55 (codified at 29 U.S.C. § 213(a)(15) (2006) (indicating that the companionship exemption only applies to domestic service employment).
51. 29 C.F.R. § 552.3 (2011).

by an external third party, not the occupant of the private home in which they work.[52] Therefore, they should not fall under the companionship exemption, because they are not domestic service workers. The DOL, however, also promulgated a conflicting regulation regarding third-party employment of workers engaged in companionship services.[53] This regulation provides that "employees who are engaged in providing companionship services, as defined in section 552.6, and who are employed by an employer or agency other than the family or household using their services, are exempt from the Act's minimum wage and overtime pay requirements . . . ."[54]

Courts have dealt with this inconsistency by using the specific third-party employment regulation of section 552.109(a) to trump the domestic services regulation, holding that the companionship exemption does apply to home health care workers who are employed by third parties, because the third-party employment regulation is not "arbitrary, capricious, or manifestly contrary to the statute."[55] The result is that agencies that employ home health care workers are not required to meet federal minimum wage laws.[56] Judicial interpretation of these conflicting regulations has exempted a very significant portion of the home health care worker labor force from the FLSA, as approximately 1,325,000 home health care workers were employed in 2004.[57]

2. SECTION 552.109(B)—BABYSITTERS EXCLUDED FROM COMPANIONSHIP SERVICES EXEMPTION

Section 552.109 is itself inconsistent and contradictory on its face, as it appears to make an arbitrary distinction between elder sitters and

52. *See id.*; Biklen, *supra* note 34, at 136.
53. 29 C.F.R § 552.109(a) (2011).
54. *Id.*
55. Johnston v. Volunteers of Am., Inc., 213 F.3d 559, 562 (10th Cir. 2000) ("[T]he fact that the domestic service employees are not employed by the individual receiving care, does not alone exclude them from the exemption.").
56. WAGE & HOUR DIV., U.S. DEP'T OF LABOR, FACT SHEET #25: THE HOME HEALTH CARE INDUSTRY UNDER THE FAIR LABOR STANDARDS ACT (FLSA) (2008), http://www.dol.gov/whd/regs/compliance/whdfs25.pdf.
57. *See* Daniel E. Hecker, *Occupational Employment Projections to 2014*, MONTHLY LAB. REV., Nov. 2005, at 70, 75 tbl.2. There were 624,000 home health aides and 701,000 personal and home care aides employed in 2004. *Id.* These statistics likely represent the number of home health workers employed by third parties—few statistics are available for home health workers employed directly by families. *See* Smith, *supra* note 36, at 1846.

babysitters.[58] Section 552.109 governing third-party employers requires opposite outcomes for babysitters and elder sitters employed by third parties; employees who provide babysitting services and are employed by a third-party employer, instead of directly by the family to whom the employee is providing the services, are "not employed on a 'casual basis' for purposes of the section 13(a)(15) exemption."[59] Instead, babysitters employed by third parties are "engaged in this occupation as a vocation," and the companionship exemption does not apply to them.[60] Consequently, section 552.109 makes the distinction that babysitters who are employed through a third party are considered to be working on a non-casual basis as a vocation, while "elder sitters," often home health care workers performing similar caregiving work, who are employed through a third party are considered to be providing companionship services on a casual basis, despite the fact that, for many, home health care work for the elderly is a full-time vocation that requires formal training (although many current state programs are lacking in that area).[61]

Because Congress intended the 1974 FLSA Amendments to extend labor protections to all domestic service employees working formally as breadwinners and only to exclude work done informally (not in the pursuit or practice of a vocation), in 2001, the DOL proposed amending regulations to effectuate that intent during the final days of the Clinton administration.[62] Hope for the proposed regulations was short-lived, however, as the Bush administration withdrew the proposed changes in 2002.[63] It is difficult to imagine a true distinction between work as a babysitter employed by a third party and work as a home health care worker employed by a third party that warrants

58. *See* 29 C.F.R. § 552.109 (2011); Biklen, *supra* note 34, at 137.

59. 29 C.F.R. § 552.109(b).

60. *Id.*

61. *See* RETOOLING AGING AMERICA, *supra* note 4, at 204 (explaining that many current minimum training requirements are inadequate); ROBYN STONE & JOSHUA WIENER, WHO WILL CARE FOR US?: ADDRESSING THE LONG-TERM CARE WORKFORCE CRISIS 27–29 (2001) (detailing various state efforts to improve upon the training and education of home health care workers), *available at* http://aspe.hhs.gov/daltcp/reports/ltcwf.pdf .

62. Application of the Fair Labor Standards Act to Domestic Service, 66 Fed. Reg. 5481, 5482 (proposed Jan. 19, 2001). The proposed regulations would have changed the definition of "companionship services" and would have amended the regulations regarding third-party employment. *Id.*

63. Application of the Fair Labor Standards Act to Domestic Service, 67 Fed. Reg. 16,668, 16,668 (Apr. 8, 2002).

such preferential treatment for babysitters. This limited exception to the companionship services exemption for babysitters employed by third parties is contrary to Congress's intent to create a narrow exemption, and the regulations, as written, exempt more people than Congress intended with the companionship services exemption to the 1974 Amendments.[64]

3. SECTION 552.6—TRAINED PERSONNEL EXCEPTION

Another exception to the companionship services exemption that excludes "trained personnel" does not apply to most home health care workers. Section 552.6 of the DOL regulations allows an exception to the companionship services exemption for "services relating to the care and protection of the aged or infirm which require and are performed by trained personnel, such as a registered or practical nurse."[65] Although services performed by "trained personnel" are not considered companionship services, courts have limited the trained personnel exception to employees who have the same level of training as a registered or practical nurse.[66] This interpretation of "trained personnel" means that licensed certified nursing assistants (CNAs), who comprise much of the home health care aide workforce, are not included in the trained personnel exception.[67] This is increasingly problematic, as the advances in medical technology that enable people to live longer and require more home health care services mean that CNAs likely will be responsible for providing or assisting in medical services to a greater extent in future years.[68]

The exclusion of CNAs from the definition of "trained personnel" is difficult to reconcile with the reality of the training and responsibilities of nursing assistants who provide home health care services today. Every nursing assistant who works for an employer receiving Medicare or Medicaid funding must pass a competency test as a condition of employment.[69] Federal law suggests that states should re-

64. Application of the Fair Labor Standards Act to Domestic Service, 66 Fed. Reg. at 5482.

65. 29 C.F.R. § 552.6 (2011).

66. *See* Cox v. Acme Health Servs., Inc., 55 F.3d 1304, 1309–10 (7th Cir. 1995); McCune v. Oregon Senior Servs. Div., 894 F.2d 1107, 1110–11 (9th Cir. 1990); Sandt v. Holden, 698 F. Supp. 64, 68 (M.D. Pa. 1988).

67. Application of the Fair Labor Standards Act to Domestic Service, 66 Fed. Reg. at 5484–85; Biklen, *supra* note 34, at 140–41.

68. *See* STONE & WIENER, *supra* note 61, at 15–16.

69. *See* RETOOLING AGING AMERICA, *supra* note 4, at 207.

quire home health aides to complete seventy-five hours of training under the supervision of a registered nurse,[70] and some states have adopted training programs that meet these suggested requirements.[71] Home health care workers perform a wide variety of vital medical tasks that require training by their nursing supervisors, including assisting with ventilators, catheters, and feeding tubes.[72] These workers may also be required to undergo more formal training in some states.[73] Some states, including California, Maine, and Oregon, require at least 150 hours of training.[74] By limiting "trained personnel" to registered and practical nurses, the courts fail to recognize the sophisticated work performed by home health aides, denying many trained home health care workers FLSA protections.

C. *Long Island Care at Home, Ltd. v. Coke*

In 2007, the Supreme Court confirmed in *Long Island Care at Home, Ltd. v. Coke* that workers employed by third-party health care agencies are subject to the companionship exemption.[75] In *Coke,* the Court unanimously decided to defer to the DOL's regulation in section 552.109(a), applying the companionship services exemption to home health care workers employed by third parties.[76] In *Coke*, plaintiff Evelyn Coke brought suit against her former employer for failing to pay her the overtime and minimum wages to which she argued she was entitled under New York law and the FLSA.[77] Coke was employed by Long Island Care at Home as a domestic worker who provided at-home companionship services to elderly persons.[78] She spent twenty years at Long Island Care at Home, often spending the night in her clients' homes while working twenty-four-hour shifts.[79] She ar-

70. *Id.* The competency test and suggested training requirements only apply to home health aides. *Id.* Personal and home care aides do not have any federal requirements, because they are not covered under Medicare or Medicaid. *Id.*

71. *See id.* at 206.

72. Biklen, *supra* note 34, at 141.

73. STONE & WIENER, *supra* note 61, at 27. However, more formal, quality training for all is necessary to ensure a competent home health care workforce and to improve retention rates. *See* RETOOLING AGING AMERICA, *supra* note 4, at 215.

74. STONE & WIENER, *supra* note 61, at 27.

75. Long Island Care at Home, Ltd. v. Coke, 551 U.S. 158, 162 (2007).

76. *Id.*

77. *Id.* at 164.

78. *Id.*

79. *Hearing on H.R. 3582*, *supra* note 11, at 2 (statement of Craig Becker).

gued that the DOL regulation—stating that workers who are employed by third parties to provide companionship services are subject to the companionship exemption[80]—was unenforceable because the regulation went beyond the power delegated by Congress, was inconsistent with another regulation, was an "interpretive" regulation (therefore, not subject to judicial deference), and was improperly promulgated.[81]

In an opinion greatly disappointing to Ms. Coke's supporters, who favored allowing home health care workers FLSA protections, the Supreme Court reversed the Second Circuit's finding that the regulation was unenforceable and instead deferred to the DOL's regulatory power.[82] Narrowing the coverage of FLSA protections, the Court's decision was contrary to Congress's intent to expand FLSA coverage through the 1974 Amendments.[83] The Court found that the legislature had expressly left the definitions of the broad terms "domestic service employment" and "companionship services" for the DOL to clarify and that the regulation, therefore, was within the agency's purview.[84] Although the Court conceded that the two regulations were inconsistent, it held that the DOL's interpretation of 29 C.F.R § 552.109(a) as controlling was not "plainly erroneous or inconsistent with the regulations being interpreted."[85] On the question of whether the regulation was "interpretive" and, therefore, not subject to *Chevron* deference,[86] the Court stated:

> Where an agency rule sets forth important individual rights and duties, where the agency focuses fully and directly upon the issue, where the agency uses full-notice and comment procedures to promulgate a rule, where the resulting rule falls within the statutory grant of authority, and where the rule itself is reasonable,

80. *See* 29 C.F.R. § 552.109(a) (2011).

81. *Long Island Care at Home*, 551 U.S. at 165–66.

82. *See id.* at 173–75; Michael Selmi, *The Supreme Court's 2006–2007 Term Employment Law Cases: A Quiet but Revealing Term*, 11 EMP. RTS. & EMP. POL'Y J. 219, 238 (2007).

83. Smith, *supra* note 36, at 1866 (explaining that the Second Circuit held that section 552.109(a) was in conflict with Congress's intent as expressed in the 1974 FLSA Amendments).

84. *Long Island Care at Home*, 551 U.S. at 167.

85. *Id.* at 170–71.

86. *See* Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc., 467 U.S. 837, 843–44 (1984) ("The 'power of an administrative agency to administer a congressionally created . . . program necessarily requires the formulation of policy and the making of rules to fill any gap left, implicitly or explicitly, by Congress.'") (quoting Morton v. Ruiz, 415 U.S. 199, 231 (1974)).

> then a court ordinarily assumes that Congress intended it to defer to the agency's determination.[87]

The Supreme Court, likewise, rejected Coke's argument that the regulation was not properly promulgated, finding that the DOL had reasonably explained its decision not to adopt the proposal that would have allowed for special treatment of employees employed by certain enterprises.[88]

The Court's decision to give deference to the Department of Labor was likely influenced by the political history of the issue of whether home health care workers employed by third parties were properly excluded from the companionship services exemption.[89] The Clinton administration had proposed modifying the regulation by removing the third-party exclusion in 1993, but this attempt failed.[90] It revived the proposal in 2001, but the proposal "was later withdrawn by the Bush administration."[91] In the years leading up to the Supreme Court's decision, FLSA protections for home health care workers became even more of a "hot topic" due to the dramatic growth of the home health care industry and the corresponding aging of the population.[92] The Court may have based its complete reliance on *Chevron* deference to avoid making a political decision.[93]

III. Analysis

Several approaches have been proposed to address the home health care worker crisis, but all approaches fall short of the kind of reform that is necessary to protect the home health care workforce and ensure quality care for elderly and disabled home care patients. It is necessary to revise the companionship exemption statute and regulations to include the burgeoning home health care workforce as a recognized part of the labor force,[94] but further measures are necessary to

87. *Long Island Care at Home*, 551 U.S. at 173–74.
88. *Id.* at 174–75.
89. *See* Selmi, *supra* note 82, at 240.
90. *Id.*
91. *Id.*
92. *See id.* at 238–39; *see also supra* note 62 and accompanying text.
93. Selmi, *supra* note 82 at 245.
94. *See Hearing on H.R. 3582*, *supra* note 11, at 12–14 (statement of Craig Becker). Total expenditures for home health care were projected to be more than $57 billion in 2007. NAT'L ASS'N FOR HOME CARE & HOSPICE, BASIC STATISTICS ABOUT HOME CARE 1 (2008) [hereinafter BASIC STATISTICS 2008], *available at* http://www.nahc.org/facts/08HC_stats.pdf.

bring home care working conditions up to a level that will sustain a quality home care workforce.

A. Impact of the Companionship Exemption Today

The companionship services exemption applies today to services and employees in ways that were not envisioned when the FLSA Amendments were passed in 1974.[95] Home health care workers provide extensive and comprehensive services analogous to those provided by nursing aides in nursing homes and other institutions; they provide custodial care, observe changes in condition, and provide medical assistance.[96] Home health care is often the primary vocation of workers employed by third-party agencies, and workers provide services to several clients.[97] This work differs from the kind of services that Congress intended to exclude from FLSA coverage with the companionship exemption; instead, lawmakers at the time of the 1974 Amendments envisioned the exclusion of companions who spent time sitting and conversing with a single friend or relative.[98]

The duties of home health care workers are often stressful and physically and emotionally taxing. "The home care aide is generally considered to have the toughest job in home care as she must respond to a myriad of personal care needs of her patients ranging from simple bathing to managing incontinent, non-ambulatory elderly patients with Alzheimer's Disease."[99] As more elderly persons decide to stay at home rather than go to a nursing facility, fewer family members are available to provide care, and as the population ages, home health

95. Application of the Fair Labor Standards Act to Domestic Service, 66 Fed. Reg. 5481, 5482 (proposed Jan. 19, 2001). *See* Smith, *supra* note 36, at 1869–70. The Second Circuit's 2004 holding in *Coke* recognized "that extending the companionship-services exemption to home-care workers employed by third-party employers is inconsistent with congressional intent." *Id.* at 1870.

96. *See* Brief for AARP & Older Women's League as Amici Curiae Supporting Respondent at 5, Long Island Care at Home, Ltd. v. Coke, 551 U.S. 158 (2007) (No. 06-593), 2007 WL 922217 at *5–6 [hereinafter AARP Brief]. By "providing the vast majority of face-to-face contact with long term care patients, direct care workers are considered the lifeblood of the long term [sic] care industry." *Id.* at *6.

97. Brief for Alliance for Retired Americans et al. as Amici Curiae Supporting Respondent at 7, Long Island Care at Home, Ltd. v. Coke, 551 U.S. 158 (2007) (No. 06-593), 2007 WL 951137 at *7 [hereinafter Retired Americans Brief].

98. *Id.* at *8.

99. *Hearing on H.R. 3582*, *supra* note 11, at 43 (statement of William Dombi).

care workers are increasingly becoming primary caregivers performing a vital role for society.[100]

As previously noted in Part I, the trend is for the elderly and infirm to receive care at home rather than stay in an institutionalized setting.[101] Not only is home care more cost-effective, it also preserves the independence and dignity of elderly persons, two major quality of life factors that are often lost in an institutionalized setting.[102] The Supreme Court, in its decision in *Olmstead v. L.C. ex rel Zimring*, affirmed the preference for non-institutionalized settings when it held that institutionalizing someone unnecessarily is unlawful.[103] "*Olmstead* and subsequent cases have moved state Medicaid programs away from a bias in favor of nursing home care and toward more home and community-based care."[104] The executive branch also demonstrated its preference for home-based care with Executive Order 13217, Community-Based Alternatives for People with Disabilities, in June 2001.[105]

Despite the increased demand for in-home care resulting from this preference for home care, many home health care workers earn less than $15,000 per year, hardly enough to keep good workers, let alone attract them.[106] The basic rationale for denying home health care workers wage and hour protections through the companionship exemption is to keep health care costs low so that more people will be

100. *See generally* PARAPROFESSIONAL HEALTHCARE INST., OCCUPATIONAL PROJECTIONS FOR DIRECT-CARE WORKERS 2006–2016, *available at* http://www.directcareclearinghouse.org/download/BLSfactSheet4-10-08.pdf (providing statistics reflecting the growing direct care workforce, top ten fastest growing occupations, occupations expected to add the most positions, shifts in employment settings, and demand for home health services).

101. *Id.* at 3 (estimating that the number of direct care workers working in the home will increase by ten percent—from fifty-four percent to sixty-four percent—between 2002 and 2016).

102. BASIC STATISTICS 2008, *supra* note 94, at 13. One study found that clients receiving home care often had more favorable health outcomes. *Id.* at 7–8.

103. *See* Olmstead v. L.C. *ex rel* Zimring, 527 U.S. 581, 600, 607 (1999) (holding that keeping individuals isolated or segregated through unjustified institutionalization violates Title II of the ADA).

104. AARP Brief, *supra* note 96, at *7.

105. *Hearing on H.R. 3582*, *supra* note 11, at 43 (statement of William Dombi). Executive Order 13217 requires the federal government to help states quickly implement the decision in *Olmstead* by revising state policies and programs to provide wider access to home- and community-based care. Exec. Order No. 13217, 66 Fed. Reg. 33155 (June 18, 2001).

106. *See H.R. 3582 The Fair Home Health Care Act: An Analysis*, PARAPROF. HEALTHCARE INST., 1, http://www.directcareclearinghouse.org/download/PHI_FairHHCActAnalysis.pdf (last visited Mar. 1, 2011).

able to afford them.[107] Shortchanging workers to keep health care costs low, however, is unacceptable for many people on principle.[108] As Professor Michael Selmi, of The George Washington University School of Law noted, "[N]o one can reasonably defend a policy that keeps costs low by paying workers on a scale that is different from most of the rest of the workforce."[109]

Proponents of excluding home health care workers from the companionship exemption to the FLSA[110] argue that home health care workers must be afforded FLSA protections to bridge the gap between the home health care workforce and the number of people requiring their services.[111] The AARP and Older Women's League argue that better pay for home health care workers results in a higher quality of care for home care clients and that the failure to provide better compensation and benefits will cause "severe disruption" in care for the elderly because there will be a shortage of workers.[112] Moreover, the Paraprofessional Healthcare Institute reports that the costs of increasing wages will be offset by large savings from reduced worker turnover.[113] It is estimated that the cost of replacing a direct care worker is between $3500 and $5000.[114]

The lack of home health care workers has consistently been attributed to poor wages and working conditions; providing such workers with overtime and minimum-wage protections is likely to in-

107. Selmi, *supra* note 82, at 246.
108. *See, e.g.*, *id.*
109. *Id.*
110. Proponents include the Alliance for Retired Americans, an assortment of law professors and historians, and the AARP, among others. *See generally* Retired Americans Brief, *supra* note 97; AARP Brief, *supra* note 96; Brief of Law Professors & Historians as Amici Curiae Supporting Respondent, Long Island Care at Home, Ltd. v. Coke, 551 U.S. 158 (2007) (No. 06-593), 2007 WL 950947 [hereinafter Law Professors Brief]; Brief for the Urban Justice Center et al. as Amici Curiae Supporting Respondent, Long Island Care at Home, Ltd. v. Coke, 551 U.S. 158 (2007) (No. 06-593), 2007 WL 950948.
111. *E.g.*, AARP Brief, *supra* note 96, at *3. In its brief, the AARP argued that "the exclusion is inconsistent with the purposes of the FLSA, which sought to provide workers with needed protection *and* ensure an adequate supply of domestic workers." *Id.* at *4 (emphasis in the original).
112. *Id.* at *5–6.
113. *See* PARAPROFESSIONAL HEALTHCARE INST., *supra* note 24, at 20.
114. BARBARA W. FRANK ET AL., MASS. HEALTH POLICY FORUM, HEALTH CARE WORKFORCE ISSUES IN MASSACHUSETTS, ISSUE BRIEF 13 (2000) [hereinafter WORKFORCE ISSUES], *available at* http://masshealthpolicyforum.brandeis.edu/publications/pdfs/09-Jun00/IBHealthWorkfrcIssues%209.pdf.

crease the retention rate.[115] The AARP and Older Women's League note that many home health care workers lack health insurance, despite having one of the highest rates of work-related injury and illness.[116] Because of the high turnover rate, many patients fail to establish trusting relationships with their home health care workers and constantly have to reinstruct them as to their needs and preferences.[117] This leads to a decreased quality of care, including additional mental strain for home care recipients already struggling with other medical challenges.[118]

On the other hand, those who oppose extending FLSA protections, including many third-party employers, argue that requiring a minimum-wage standard for home health care workers would only exacerbate the health care cost problem.[119] Many home health care agencies continually lose money, because they are reliant on government payments through Medicaid that do not cover their operating costs.[120] Agencies that are struggling to survive worry that they would be forced to reduce the number of hours worked by their employees if home health care workers were subject to wage and hour protections, resulting in home health care clients experiencing reduced hours of service.[121] Alternatively, opponents, such as the city of New York, have argued that agencies would incur additional expenses, because they would have to hire more nurse supervisors to handle more home health care workers working fewer hours, and they would have to train additional workers.[122]

In its amicus brief, Continuing Care Coalition, Inc. argued that increasing the cost of home health care affects hospitals, which may be forced to retain patients for longer periods of time until home health

115. RETOOLING AGING AMERICA, *supra* note 4, at 214–15.
116. AARP Brief, *supra* note 96, at *9.
117. *Id.* at *10.
118. *Id.*
119. WILLIAM G. WHITTAKER, CONG. RESEARCH SERV., THE FAIR LABOR STANDARDS ACT: CONTINUING ISSUES IN THE DEBATE 8 (2008), http://digitalcommons.ilr.cornell.edu/key_workplace/519/.
120. Brief for Continuing Care Leadership Coalition, Inc., et al. as Amici Curiae Supporting Petitioners at 11, Long Island Care at Home, Ltd. v. Coke, 551 U.S. 158 (2007) (No. 06-593), 2007 WL 549106 at *11 [hereinafter Continuing Care Brief].
121. *Id.* at *12 (explaining what occurred in New York after the Second Circuit's decision in *Coke*).
122. Brief for City of New York and New York State Association of Counties as Amici Curiae Supporting Petitioners at 23, Long Island Care at Home, Ltd. v. Coke, 551 U.S. 158 (2007) (No. 06-593), 2007 WL 460416 at *23.

care is available.[123] It is estimated that an increase of one day in the average stay for patients in New York hospitals would cost ninety-six million dollars.[124] Thus, opponents argue, removing the application of the companionship exemption to home health care workers would frustrate the purpose of the companionship exemption and Congress's policy goal of "mak[ing] reasonable accommodations to enable disabled individuals to receive services in the least restrictive setting under Title II of the Americans with Disabilities Act" by making it more difficult for elderly and disabled persons to receive non-institutionalized care at home.[125] These opponents fail to note, however, that even if the cost of providing home health care for patients upon their release from a hospital increases overall, that cost would still be less than the cost of keeping the patient in the hospital.[126]

B. Amending the FLSA—The Fair Home Health Care Act of 2007 and the Direct Care Worker Empowerment Act of 2010

Revisions to the FLSA companionship exemption have been proposed periodically throughout the past few decades, but none have been successful. In 2007, Senator Tom Harkin proposed the Fair Home Health Care Act (FHHCA) of 2007 in the Senate.[127] Although the bill ultimately died in committee, it sought two promising changes to the FLSA that would have limited the FLSA's companionship exemption as applied to home health care workers.[128] First, the FHHCA would have amended the companionship exemption so that it applied only to home health care workers employed on a "casual basis."[129]

123. Continuing Care Brief, *supra* note 120, at *13.
124. *Id.*
125. *Id.* at *14.
126. *See id.* at *13. Staying in a hospital is actually more expensive. *Id.*
127. Fair Home Health Care Act of 2007, S. 2061, 110th Cong. (2007).
128. *Id.* at § 2(a)–(b); *S.2061: Fair Home Health Care Act of 2007*, GOVTRACK.US, http://www.govtrack.us/congress/bill.xpd?bill=s110-2061 (last visited Apr. 17, 2011).
129. S. 2061, § 2(a). The act would amend the language of 29 U.S.C. § 213(a)(15) to include:

> Any employee employed on a casual basis in domestic service employment to provide baby-sitting services or any employee employed on a casual basis in domestic service employment to provide companionship services for individuals who (because of age or infirmity) are unable to care for themselves (as such terms are defined and delimited by regulations of the Secretary).

Id.

This change would be consistent with other federal employment laws, including the Social Security Act, the National Labor Relations Act, and the Occupational Safety and Health Act, which interpret "domestic service employment" as excluding third-party employers and only applying to domestic workers "employed on a personal basis."[130] Second, it would have added a definition of "casual basis" to the FLSA, defining it as intermittent or irregular (not exceeding twenty hours per week) employment performed by someone whose vocation is not providing such services and who is not employed by a third party.[131]

In her statements before the U.S. House of Representatives in support of the FHHCA, Dorie Seavey, Director of Policy Research at the Paraprofessional Healthcare Institute, argued that the FLSA amendments were necessary from a labor market perspective, because the companionship exemption created "distortions and artificial segmentation of caregiver labor markets across the entire system," resulting in a depressed supply of labor and distorted demand for services.[132] Ms. Seavey noted that home care workers perform essentially the same services as aides in a nursing home; yet, they are not afforded the same labor protections, and, in many cases, around a third of workers are not provided health insurance.[133] In contrast, health care workers in institutionalized settings such as nursing homes receive these protections and benefits; these institutions, therefore, are able to attract more workers.[134]

The proposed amendments would effectively remove the majority of home health care workers from the companionship exemption,

130. Law Professors Brief, *supra* note 110, at *13.

131. S. 2061, § 2(b). The Act would amend 29 U.S.C. § 203 (2006) by adding the following definition:

> 'Casual basis' means employment which is irregular or intermittent, and which is not performed by an individual whose vocation is the provision of babysitting or companionship services or an individual employed by an employer or agency other than the family or household using their services. Employment is not on a casual basis, whether performed for one or more family or household employers, if such employment for all such employers exceeds 20 hours per week in the aggregate.

Id.

132. *See Hearing on H.R. 3582*, *supra* note 11, at 23 (statement of Dorie Seavey, Director of Policy Research, Paraprofessional Healthcare Institute).

133. *Id.*

134. *See id.* at 23–24.

providing them with the basic FLSA protections and "bring[ing] the FLSA into alignment with ever evolving industry conditions."[135] Such changes are not likely to significantly increase the costs of home care, thereby causing decreased access to care nationwide. First, in her hearing testimony, Seavey points out that "virtually all" home health care workers receive at least the federal minimum wage.[136] Second, she also testifies that the "vast majority" of home health care workers do not work more than forty hours per week.[137] If this is the case, it suggests that, while amending the FLSA would afford home health care workers the same protections as other low-wage workers, it would not have the dire financial impact predicted by the Act's opponents.[138] Amending the FLSA by itself would make home health care work a more desirable occupation by ensuring protections—including paid time for travel—to all workers, without dire service interruptions.[139]

It is necessary to bring the FLSA up to date with labor changes and improve working conditions, but amending the FLSA in isolation to achieve better working conditions for home health care workers is a limited solution. There are some financial considerations that must be addressed. As William Dombi, Vice-President of the National Association for Home Care & Hospice (NAHC), noted during his testimony before the U.S. House of Representatives, the majority of funding for home health care services comes from public programs, such as Medi-

135. *Id.* at 26.

136. *Id.* at 24. The majority of home health care workers make less than ten dollars per hour. *PHI National Policy Agenda: Wages and Benefits*, PARAPROFESSIONAL HEALTHCARE INST., 1, http://phinational.org/wp-content/uploads/2008/02/policyagendawages2.pdf (last visited Mar. 1, 2011). The federal minimum wage prior to July 29, 2007 was $5.15 per hour; as of July 24, 2009, the federal minimum wage is $7.25 per hour. *What Is the Minimum Wage*, U.S. DEP'T OF LABOR, http://www.dol.gov/elaws/faq/esa/flsa/001.htm (last visited Mar. 1, 2011).

137. *Hearing on H.R. 3582*, *supra* note 11, at 24 (statement of Dorie Seavey).

138. *See id.* (arguing that there should instead be an adjustment in state reimbursement methods).

139. *See id.* Although a nationwide service disruption caused by increased costs of employing home health care workers is unlikely, amending the FLSA could affect individual states differently, and so the implications of providing wage and labor protections to home health care workers should be examined on a state-by-state basis. *See id.* at 23. Any perceived deficiencies in a state's ability to avoid service disruptions could be cured through improving management and scheduling practices. *Id.*

caid, Medicare, the Administration on Aging, and TRICARE.[140] Because these programs reimburse home health care agencies through a prospective payment system, they will not be able to respond quickly to any increased cost of care, possibly forcing employers to restrict employee hours or lower wages until budget years change and rates can catch up with the legislation.[141]

Even if a limited number of home health care workers are eligible for overtime compensation, the additional financial strain could have a substantial negative impact on the employer.[142] Additionally, many Medicaid programs operate around a "standard of cost effectiveness."[143] Therefore, if the cost of in-home care exceeds the cost of institutionalized care, consumers may be forced into nursing homes.[144] Thus, the FLSA amendments by themselves, without changes in the way long-term care is financed, will do little to alleviate the crisis.

The potential for increased costs to home health care arising from granting minimum-wage and overtime protections, however, cannot justify denying this vulnerable class of workers fair labor protections. This same argument was raised by opponents to the 1974 Amendments to the FLSA on the grounds that providing domestic workers with minimum labor protections would make the services too costly and decrease their demand.[145] Congress rejected this argument, electing to provide domestic workers with the same protections afforded other workers in the general labor force.[146]

The most recent legislative attempt to exclude home health care workers from the companionship exemption was the Direct Care Workforce Empowerment Act (DCWEA), introduced by Congresswoman Linda Sanchez (D-CA) in the House on July 28, 2010.[147] The

140. *Hearing on H.R. 3582*, *supra* note 11, at 42 (statement of William Dombi). Indeed, as Dombi points out, in 2006, Medicare spent $3.1 million of its total $13.2 billion on providing home health services. *Id.* In 2000, Medicaid expenditures on home care were $24.3 billion "of which $11.6 billion was spent on personal support services." *Id.*

141. *See id.* at 44.

142. *See id.* Home health care employers relying on federal reimbursement cannot raise their reimbursement rate if costs increase. *Id.*

143. *Id.*

144. *See id.* at 44–45.

145. *See, e.g.*, S. REP. NO. 93-300, at 121 (1973).

146. *See id.* at 70 (amending the definition of the term "employee" to include any individual employed in domestic service, except babysitters).

147. Direct Care Workforce Empowerment Act, H.R. 5902, 111th Cong. (2010).

Direct Care Workforce Empowerment Act, which was substantially similar to the Fair Home Health Care Act, proposed amending section 13(a)(15) of the FLSA by limiting the companionship exemption to "any employee employed on a *casual basis* in domestic service employment to provide companionship services for individuals . . . ."[148] The bill defined casual basis to mean work performed by an individual whose vocation is not babysitting or companionship services, who is not employed by a third party, and who provides less than twenty hours per week of companionship services.[149] By limiting the exemption to companionship services provided on a truly casual basis, enactment of the DCWEA would narrow the companionship exemption to conform to the congressional intent that existed at the time the 1974 Amendments created the companionship services exemption.[150]

The DCWEA contained provisions aimed at better data collection, workforce monitoring, and improved worker recruitment and retention.[151] The DCWEA also called for the creation of a federal direct care workforce monitoring program that would collect data and promote the sharing of data and best practices among the states, in addition to the creation of a National Advisory Council on the Direct Care Workforce in conjunction with the Department of Labor.[152] The bill provided for grants of $100,000 to states to develop direct care workforce plans and to improve training programs, worker retention, and state data collection.[153] These proposed measures reflect the need for an integrative approach that goes beyond amending the FLSA to achieve better working conditions for home health care workers. However, the DCWEA never became law.[154]

C. Revised DOL Regulations

In January 2001, with only a few remaining days in power, the Clinton administration proposed revising the DOL regulations, seeking to narrow the companionship regulation that defined companion-

148. *Compare* H.R. 5902 § 3, *with* Fair Home Health Care Act of 2007, S. 2061 § 2, 110th Cong. (2007).
149. H.R. 5902 § 3(b).
150. *See supra* notes 46, 62 and accompanying text.
151. H.R. 5902 §§ 4–5.
152. *Id.* at § 4.
153. *Id.* at § 5.
154. *H.R. 5902: Direct Care Workforce Empowerment Act*, GOVTRACK.US, http://www.govtrack.us/congress/bill.xpd?bill=h111-5902 (last visited Mar. 1, 2011).

ship services and seeking to reverse the third-party agency rule.[155] Mr. Becker of the Services Employees International Union stated that these proposals were never adopted because the Bush administration withdrew them without much comment or analysis.[156] Some commentators determined that the "economic impact of the new regulations was too great to warrant change."[157] Recently, the Obama administration has renewed interest in the regulations, and Labor Secretary Hilda Solis has said that she will consider making changes to the DOL regulations.[158] Lawmakers have also been pressuring Solis to revise the regulations, with members of both houses sending letters requesting review.[159] In the spring of 2010, the DOL added revising FLSA Companionship Services Regulations to its agenda, though no new rules had been proposed as of January 2011.[160]

The 2001 revisions to the companionship services exemption proposed three alternatives to the current regulation.[161] Under the first alternative, the companionship exemption would only apply if fellowship duties were a "significant part" of the services provided by the employee, but the revisions did not define "significant part."[162] With the second alternative, the companionship services exemption would apply only if fellowship was the "primary" duty of the em-

155. *Hearing on H.R. 3582*, *supra* note 11, at 15 (statement of Craig Becker). Mr. Becker argued on behalf of Ms. Coke in the U.S. Supreme Court. *Id.* at 12.

156. *Id.* at 15. *See supra* notes 62–63 and accompanying text.

157. Tilson & LeHew, *supra* note 33, at 435.

158. Sam Hananel, *Labor Secretary Ponders Oversight of Home Workers*, WASH. POST, June 12, 2009, *available at* http://www.just-pay.org/news/article.256448-Labor_Secretary_ponders_oversight_of_home_workers. Labor Secretary Solis said, "As [S]ecretary of [L]abor, I intend to fulfill the [D]epartment's mandate to protect America's workers, including home health care aides, who work demanding work schedules and receive low wages." *Id.*

159. Opinion, *Fair Pay for Caregivers*, N.Y. TIMES, July 9, 2009, at A30, *available at* http://www.nytimes.com/2009/07/09/opinion/09thur2.html. In June, fifteen senators sent letters to Solis asking that the regulations be revised, and in May there was a letter from thirty-seven House representatives, "but beyond a statement from Ms. Solis expressing concern and pledging to look into the matter, there has been no progress." *Id.*

160. *Spring Regulatory Agenda 2010, Amendments to the Fair Labor Standards Act (FLSA) Companionship Services Regulations*, U.S. DEP'T OF LABOR, http://www.dol.gov/regulations/factsheets/whd-fs-flsa-companionship.htm (last visited Mar. 1, 2011).

161. Application of the Fair Labor Standards Act to Domestic Service, 66 Fed. Reg. 5481, 5484 (proposed Jan. 19, 2001).

162. *Id.* Fellowship duties are duties that involve the home care worker and client interacting on a "close personal basis" while performing activities such as playing games, talking about the client's family life, reading books and newspapers, or going for a walk. *Id.*

ployee, meaning that the employee spent more than fifty percent of his or her time engaged in fellowship duties.[163] Under the third, broadest alternative, the companionship exemption would only apply if fellowship services were the "sole" duty of the employee, meaning that the employee spent at least eighty percent of his or her time on fellowship services.[164] The third alternative would provide the most coverage to home health care workers, because it would not include intimate caregiving tasks as a fellowship service—fellowship would have to be the core duty of the employee for the exemption to apply.[165]

The DOL should use the third alternative in its revision, because Congress did not intend for the companionship services exemption to apply to formal caregiving situations.[166] Revising the DOL's regulations presents the best opportunity for protecting home health care workers under the FLSA, because passing the Direct Care Workforce Empowerment Act will likely be difficult, especially in the current economic and political climate.[167] Revising the DOL regulations could result in FLSA coverage for home health care workers in much the same way that passing the Direct Care Workforce Empowerment Act would provide coverage.[168] However, the benefits of providing overtime and minimum-wage protections to home health care workers are very limited in isolation. Further measures are necessary to protect home health care workers and improve the quality of care provided.

D. Reliance on Unions

Union action is another approach to improving the working conditions of home health care workers. Professor Selmi cites legislative and executive inaction as reasons for concluding that union organization is the only route to securing fair wages for home health

163. *Id.*
164. *Id.*
165. *See* Smith, *supra* note 12, at 5.
166. *Id.*
167. *See id.* at 5–6. Professor Smith was concerned about the passage of the Fair Home Health Act. *Id.* at 6. Both the Fair Home Health Act and the Direct Care Workforce Empowerment Act stalled in Congress. *See supra* notes 128, 154 and accompanying text.
168. Ilyse Schuman, *Bill Would Apply Minimum Wage, Overtime to Home Care Workers*, EMP. L. UPDATE (July 30, 2010), http://www.dcemploymentlawupdate.com/2010/07/articles/employment-wage-and-hour-law/bill-would-apply-minimum-wage-overtime-to-home-care-workers/.

care workers.[169] Despite the fact that many home health care workers are considered "independent contractors" and work in isolated, private settings, they proved their ability to organize in 1999 when 74,000 workers joined the Service Employees International Union (SEIU) in Los Angeles, California.[170]

Unionizing home care workers is challenging and requires a convergence of a number of factors, including a favorable political climate and a mutuality of interest between home health care workers and consumers.[171] Workers who are employed by agencies that rely on public funding are independent contractors for purposes of their relationship with the state, despite the fact that they are compensated by the state for their services.[172] However, such workers in several states now possess collective bargaining rights and have organized to win extended labor protections.[173] This has resulted in tangible benefits for such home health care workers, including increased wages, health benefits, and paid leave.[174]

Despite the benefits associated with union membership, it "has been on a steady decline for the last twenty years."[175] Also, attempts at change through the unionization of home health care workers have not been as successful in states where the political climate has been less favorable.[176] Unions lack substantial bargaining power against many home health care employers who have limited ability to yield to the union's demands because of government rules and fixed Medicare

169. Selmi, *supra* note 82, at 246.

170. Peggie Smith, *The Publicization of Home-Based Care Work in State Labor Law*, 92 MINN. L. REV. 1390, 1390–91 (2008).

171. *Id.* at 1398.

172. *Id.* at 1403. Courts have routinely rejected workers' claims that they are employees of the government agencies that fund the care they provide. *See, e.g.*, Serv. Emps. Int'l Union, Local 434 v. County of Los Angeles, 275 Cal. Rptr. 508, 515 (Cal. Ct. App. 1990).

173. Smith, *supra* note 170, at 1403–04. States where unions have been successful in winning labor law protections include California, Illinois, Iowa, Massachusetts, Michigan, Ohio, Oregon, Washington, and Wisconsin. *Id.* at 1404.

174. *Id.* at 1413. In Illinois, wages were increased by thirty-four percent; in Michigan, they went up by close to twenty percent. *Id.*

175. Kristin J. Gerrick, *An Inquiry into Unionizing Home Healthcare Workers: Benefits for Workers and Patients*, 29 AM. J.L. & MED. 117, 131 (2003).

176. *See* Smith, *supra* note 170, at 1414. In New Jersey, a bill to extend labor protections to home health care workers died in committee when confronted by the strong for-profit home care market. *Id.* It is necessary for labor unions to consider the strong local for-profit market forces to better strategize in negotiating better working conditions. *See id.*

and Medicaid reimbursement rates.[177] While unions could try to force increases in reimbursement levels by striking, this tactic proved unsuccessful in nursing home strikes in Connecticut in 2001.[178] A home health care strike may compromise the patient care of home health care consumers who rely on the assistance of home health care workers. Furthermore, a strike may increase the overall costs of home health care services if replacement workers are required to be brought in or patients are required to move to an institutionalized setting.[179]

Although unionization has achieved better working conditions for some home health care workers, including increased wages and health care benefits, unions have limited ability to create universal and comprehensive change. In order to ensure quality jobs and quality care, change is required at a higher level that could produce far-reaching improvements to a broader number of home health care workers.[180]

E. State Responses

Responses to these serious home health care issues have varied among the states. In some states, such as Massachusetts, policy analysts have introduced recommendations designed to recruit and retain more home health care workers.[181] Goals include targeting immigrants and people transitioning from welfare-to-work programs with assistance to support their entry into the home health care field.[182] In addition, Massachusetts is seeking to increase wages and benefits, provide greater opportunities for advancement, and improve health management strategies to more effectively use home health care workers for service delivery.[183] It is also seeking to create a health

177. Gerrick, *supra* note 175, at 132.

178. *Id.* at 132–33. In Connecticut, nursing home employees were successful in garnering a raise in Medicaid reimbursement levels when they threatened to strike. *Id.* However, when they subsequently went on strike in March and May of 2001, the Governor responded by allowing the nursing homes to hire out-of-state workers as replacements. *Id.*

179. *See id.* at 133.

180. *Id.* at 138. "Quality Jobs / Quality Care" is the slogan used by the Paraprofessional Healthcare Institute, the leader in home health care reform. PARAPROFESSIONAL HEALTHCARE INST., RECRUITING QUALITY HEALTH CARE PARAPROFESSIONALS 3 (2000), *available at* http://www.directcareclearinghouse.org/download/PHIRecruitOvrvw.pdf.

181. WORKFORCE ISSUES, *supra* note 114, at 2.

182. *Id.*

183. *Id.*

care workforce commission sponsored by the legislature that will monitor health care employment needs and make further assessments and recommendations.[184] The downside of these goals is that they are dependent upon state funding and are vulnerable to a changing political climate.[185] These uncertainties provide little guarantee that these workers' rights will be protected in the future.

Other states, such as Rhode Island, have developed pay-for-performance incentives to encourage and reward high-quality care.[186] In Rhode Island, home care reimbursement rates increase with an increase in the quality of care.[187] Performance evaluations are based on several factors, including client and worker satisfaction, level of client's disability, provider's accreditation, and the level of care continuity.[188] While programs similar to Rhode Island's are a step toward increasing payment for home health care services, they can be difficult to implement, because comparing quality of care among home health agencies is a difficult, imprecise task.[189]

In New York, uninsured home care workers are provided health insurance through state funds under New York's Health Care Reform Act of 2000.[190] This Act is limited, however, because it only covers home care workers in New York City or Long Island.[191] Again, this is a step in the right direction, but it does not provide health insurance for all home health care workers in the state. Several states' labor statutes, modeled after or offering protections similar to the FLSA, do not have a companionship services exemption at all or have defined their companionship exemption in a way that would not include most home health care workers.[192] Yet, in these states, doomsday predictions of disruption in continuity of care and reduced services to clients

184. *Id.*
185. *See generally id.* (explaining that change will require industry, policymakers, and consumers to work together).
186. STONE & WIENER, *supra* note 61, at 26.
187. *Id.*
188. *Id.*
189. *See id.* (indicating that measuring these factors may be difficult to accomplish).
190. *Id.*
191. *Id.*
192. Retired Americans Brief, *supra* note 97, at 14–15, n.39. Some of the states without a companionship services exemption or with a narrowly defined one include Illinois, Kansas, Minnesota, Maryland, New Jersey, West Virginia, and Massachusetts. *Id.*

have not come to fruition.[193] Home health care agencies have not experienced financial ruin, nor have they had to drastically reduce the services they are able to provide.[194]

Moreover, several states have created public authorities that oversee state-subsidized home health care workers in response to pressures from the labor movement to increase labor rights for these workers.[195] For example, Oregon's Home Care Commission has the responsibility of "ensuring high quality care for consumers, providing training opportunities for workers, establishing worker qualifications, and maintaining a registry of qualified workers for the benefit of consumers searching for caregivers."[196] A main focus of the commission is consumer protection; a majority of the commission's board members are required to be consumers.[197] The commission was created when Oregon citizens elected to amend the State Constitution to establish a public authority to supervise home health care that is funded by public money.[198]

The Oregon Home Care Commission and similar programs in other states have been successful both in the protection of home care clients and in improving home health care worker benefits.[199] Although these kinds of commissions can serve as useful guides in creating broader home health care reform from a state perspective and are instructive in determining the positives and negatives of certain public authority structures, their success is limited because their authority does not extend beyond state lines and not all states are required to have these kinds of commissions. All home health care workers deserve to have labor protections, and all home health care recipients deserve quality care ensured by oversight and regulation of the labor force. A federal mandate that requires the creation of a home care

193. *Id.*
194. *Id.* at 15–16.
195. Smith, *supra* note 170, at 1412 (explaining that public authorities are charged "with ensuring the quality of home care services").
196. *See* OR. CONST. art. XV, § 11(2)(a) (LEXIS through 2009); Smith, *supra* note 170, at 1412.
197. OR. CONST. art. XV, § 11(2)(a) (LEXIS through 2009).
198. *Resources for Seniors and People with Disabilities*: *Oregon Home Care Commission*, OREGON DEP'T OF HUMAN SERVICES, http://www.oregon.gov/DHS/spd/adv/hcc/ (last visited Mar. 1, 2011).
199. *See* Stu Schneider, *Victories for Home Health Care Workers*, DOLLARS & SENSE, Sept.–Oct. 2003, at 25, 26–27, *available at* http://www.directcareclearinghouse.org/download/homehealthcare.pdf.

commission in each state would better protect both workers and consumers.

Without a federal mandate that requires states to form home care commissions to ensure these protections, state-created protections are at the mercy of the changing political and economic climate of that particular state. For example, although California is one of the states that has provided its home health care workers increased wage protections, recent state budget cuts have led the legislature to try to reduce the maximum amount the state is required to contribute to the In-Home Supportive Services (IHSS) program.[200] The California legislature's efforts to reduce IHSS worker wages has faced stiff opposition—it has been blocked in two federal courts and will be heard by the U.S. Supreme Court in 2011.[201] California is already facing many of the issues that arise when home health care workers are undercompensated, including labor shortages.[202]

Deborah Hibbler, an IHSS employee remarked, "I am preserving someone's life, preserving somebody's integrity. Yet, they don't appreciate what I do. They are not paying what I am worth."[203] Despite the fact that these workers are considered part of California's social services "backbone," California is trying to cut its contribution to home health care worker paychecks to "balance its budget."[204] The suggested cuts would limit the amount of services that IHSS employees could provide and disincentivize others from joining the home health care workforce.[205] A limited supply of home health care providers means that more clients in California would be forced into nursing homes, at an estimated cost of $55,000 annually, compared with $13,000 for in-home care.[206] Individual state protection plans are

200. *See* Lou, *supra* note 17.

201. *IHSS Worker Wages to Be Decided in Supreme Court*, UNITED DOMESTIC WORKERS ASS'N (Jan. 18, 2011), http://www.udwa.org/2011/01/ihss-worker-wages-to-be-heard-in-us-supreme-court/.

202. Lou, *supra* note 17.

203. *Id.*

204. *Id.* Governor Schwarzenegger argued that the cuts were to decrease fraud in the program, though the paper could find no evidence to support the Governor's claim that twenty-five percent of claims were fraudulent. *Id.* As the article points out, however, even if fraud was a problem within the program, dealing with it by cutting the wages of the majority of workers who are honest and hard-working is unfair and counterproductive. *See id.*

205. *See id.*

206. *Id.*

not adequate to guarantee a reasonable wage for all home health workers.

IV. Recommendation

A broader and more sweeping policy is required to fix the home health care industry. Home health workers need higher wages, more training opportunities,[207] greater opportunities for advancement, overtime compensation, health insurance, and other standard employee benefits afforded to employees in most occupations. These goals cannot be accomplished simply through FLSA amendments or revisions to the DOL regulations. While these changes should be made, Congress should not stop there. Unions have managed to accomplish some of these goals, but they cannot be relied on to bring about the change necessary to protect and honor the elderly by ensuring them quality care in their final years.

A federal mandate is needed that requires states to establish a public authority that can provide oversight to the home health care industry and ensure quality of care, much like the Oregon Home Care Commission.[208] Greater regulation of the home health care industry is necessary, just as the hospital and nursing home industries are regulated. In addition to the minimum-wage protections proposed in the Direct Care Workforce Empowerment Act, there should be an industry minimum-wage standard of at least twelve dollars per hour[209] to

207. *See* Joan Fitzgerald, *Getting Serious About Good Jobs; We Need to Link Training, Job Structuring, and Economic Development*, AM. PROSPECT, Oct. 22, 2006, at 33, *available at* http://www.prospect.org/cs/articles?article=getting_serious_about_good_jobs. In line with this, DOL Secretary Solis recently recognized the need for a trained direct care workforce in her remarks to the 2009 National Network of Sector Partners. *Id.* Solis "emphasized the importance of a large, adequately trained direct-care workforce that is capable of meeting the long-term care needs of our nation's elders and returning veterans." *Id.* She suggested training for home health workers through apprenticeships and adult vocational training. *Labor Secretary Solis Gives Nod to Building a Trained Direct-Care Workforce*, PHI BLOG (Nov. 18, 2009), http://phinational.org/archives/labor-secretary-solis-gives-nod-to-building-a-trained-direct-care-workforce/.

208. *See* Smith, *supra* note 170, at 1412–13.

209. As of 2008, the median hourly wage for home care aides was $9.22, with the middle fifty percent earning between $7.81 and $10.98, while the median hourly wage of home health aides was $9.84, with the middle fifty percent earning between $8.52 and $11.69. OCCUPATIONAL OUTLOOK, *supra* note 5, at 3. This is above the federal minimum wage. *See* Fair Minimum Wage Act of 2007, Pub. L. No. 110-28, § 8102(a)(1)(C), 121 Stat. 188, 188 (2007). Ideally, a fair wage would be closer to fifteen dollars an hour. *See supra* note 23 and accompanying text.

ensure fair compensation for the vital but challenging services provided by home health care workers. A decent wage is essential to attract these workers to such demanding and difficult work and to make self-support possible.[210] Some home health care workers are forced to work more than one job to provide for their families.[211] In 1998, a single parent of a young child in Massachusetts required an hourly wage of $15.28 just to meet the family's basic needs.[212]

As of 2008, a majority (about seventy-nine percent) of funding for home health services comes from the government through Medicare or Medicaid.[213] Therefore, if increased costs from a rise in workers' wages were to threaten the solvency of home care agencies, the government could avoid any potential disruption of services by increasing the Medicare and Medicaid reimbursement rates.

Whether the Direct Care Worker Empowerment Act, if enacted, is actually able to provide any benefit to home health care workers and the elderly population they serve largely depends upon the willingness of the government to increase funding and support to these vital services. There is no "trust fund" for health care that is going to run out—Medicare is funded in part by payroll taxes.[214] Congress can choose to appropriate more money for home health care services if it desires.[215] Congress can, and should, set wage floors for home health care workers employed by Medicare- and Medicaid-licensed agencies.

Additionally, federal funds should be used to provide training opportunities for workers through state Home Care Commissions.

210. *See* STONE & WIENER, *supra* note 61, at 12 (explaining that there are many home care workers below the poverty level).

211. *Id.*

212. WORKFORCE ISSUES, *supra* note 114, at 11.

213. CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP'T OF HEALTH & HUMAN SERVS., NATIONAL HEALTH EXPENDITURES BY TYPE OF SERVICE AND SOURCE OF FUNDS: CY 1960–2009 (2011), *available at* http://www.cms.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp (follow "National Health Expenditures by type of service and source of funds, CY 1960–2009 (ZIP, 3KB)" hyperlink). Of the approximately $62 billion spent nationally on home health care services in 2008, forty-three percent (about $27 billion) was paid by Medicare, and thirty-six percent (about $22 billion) was paid by Medicaid. *Id.*

214. *See* Richard L. Kaplan, *Taking Medicare Seriously*, 1998 U. ILL. L. REV. 777, 781–82 (1999).

215. *Id.* Kaplan notes that for Medicare, there is no particular fund that is going to run out. *Id.* For example, the government has found money to finance the war in Iraq without concerns that the "fund" will run out. Jan Dennis, *Gloomy Reports on Social Security Rooted in Myth*, ILL. NEWS BUREAU (Mar. 27, 2008), http://news.illinois.edu/news/08/0327socialsecurity.html.

These opportunities should include training support for those who are new to the workforce to close the labor shortage gap. Given changes in demographics in the coming years, there will be a shortage of available female workers under the age of fifty-five to provide in-home health services.[216] To help fill this gap, several states have already proposed plans to recruit workers not already in the workforce, such as immigrants and workers coming off of welfare.[217] Funding should be allocated to training programs that support the entry of these people into the workforce. General training programs are also necessary, not only to improve skills, but also to promote respect and boost morale among home health care workers.[218]

Employers who use Medicare and Medicaid to fund their home health care agency should be required to ensure that health insurance is obtainable for each employee. Evelyn Coke, the face of the fair-pay-for-caregivers movement, died in 2009 of heart and kidney failure at age seventy-four.[219] She neglected her health for years because she did not have health insurance.[220] She spent her life tirelessly caring for others in their elder years and was unable to enjoy her own senior years because of the unjust working conditions she endured as a home health worker.[221] The health care reform legislation that passed in March 2010, if not repealed, will require almost every individual in the United States to purchase health insurance.[222] This mandate should improve access to health insurance through the creation of health exchanges and other measures, creating more opportunities for home health care workers to obtain affordable insurance.[223] If the

216. *See* STONE & WIENER, *supra* note 61, at 16 (explaining that the group of women aged twenty-five to fifty-four will increase by only seven percent in the next thirty years).

217. *Id.* at 5–6.

218. *Id.* at 32.

219. Renée Loth, Op-Ed., *A Labor of Love - and Low Pay*, BOSTON GLOBE, Oct. 23, 2009, at 15, *available at* http://www.boston.com/bostonglobe/editorial_opinion/oped/articles/2009/10/23/a_labor_of_love___and_low_pay/. *See* Editorial, *Lilly and Evelyn*, N.Y. TIMES, Jan. 29, 2010, at A26 (calling for the enactment of the "Evelyn Coke Fair Pay for Caregivers Act" in her honor), *available at* http://www.nytimes.com/2010/01/29/opinion/29fri3.html (calling for the enactment of the "Evelyn Coke Fair Pay for Caregivers Act" in her honor).

220. Loth, *supra* note 218, at 15.

221. *See id.*

222. *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

223. *See* Sarah Lueck et al., *Health Reform Package Represents Historic Chance to Expand Coverage, Improve Insurance Markets, Slow Cost Growth, and Reduce Deficits*,

reform is repealed, ensuring that home health care workers have access to affordable health care must be a priority for state and federal lawmakers.

A major part of improving working conditions is to ensure continued Medicare funding for home health care services and to create more opportunities for Medicare beneficiaries to receive home health care, despite pressures on Congress to cut these valuable programs.[224] Utilization of home health care services by Medicare beneficiaries decreases Medicare spending; it is estimated that Medicare could save $31.1 billion over ten years just by expanding opportunities for patients with chronic illnesses to receive these services.[225]

A 2009 study sponsored by the Alliance for Home Health Quality and Innovation and conducted by Avalere Health revealed that the use of home health care services by patients with a chronic disease immediately following a hospital stay saved Medicare $1.71 billion between 2005 and 2006, and it was estimated that an additional $1.77 billion could have been saved over the same time period if home health care services had been used by all beneficiaries similarly situated.[226] Beneficiaries who received early home care services were healthier and less likely to be readmitted to a hospital.[227] Only 8.9% of beneficiaries, however, use home health care services, because Medicare re-

CENTER ON BUDGET & POL'Y PRIORITIES (Mar. 19, 2010), http://www.cbpp.org/cms/index.cfm?fa=view&id=3126.

224. *See* Robert Pear, *Senate Vote Clears Way for Home Health Care Cuts*, N.Y. TIMES, Dec. 6, 2009, at A35, *available at* http://nytimes.com/2009/12/06/health/policy/06health.html.

225. Press Release, Alliance for Home Health Quality & Innovation, New Report: Home Health Care Saves Billions for Medicare (May 11, 2009) [hereinafter Alliance], *available at* http://www.ahhqi.org/download/File/Avalere_Study_Alliance_press_release_FINAL_051109.pdf.

226. AVALERE HEALTH, LLC, MEDICARE SPENDING AND REHOSPITALIZATION FOR CHRONICALLY ILL MEDICARE BENEFICIARIES: HOME HEALTH USE COMPARED TO OTHER POST-ACUTE SETTINGS 14 (2009), *available at* http://www.avalerehealth.net/research/docs/20090508_AHHQI_Project_Results.pdf. The study was limited to chronically ill patients (patients who had diabetes, congestive heart failure, or chronic obstructive pulmonary disease) and compared those who received post-acute care at home after a hospitalization with those who received post-acute care away from home. *Id.* at 17. The study suggests that the same methodology may be used to study the entire Medicare population. *Id.* at 15. In this study, "Early Home Health Users" were those that received post acute care in their home during the same quarter they were hospitalized. *Id.* at 17. These patients were compared with "Non-Home Health Users" who did not use any home health care services during the period following their hospitalizations. *Id.*

227. *See id.* at 14. Hospitalization readmissions decreased by 24,000, or 12.7% during the 2005–2006 period. *Id.*

quires beneficiaries to be home-bound in order to receive the home health benefit.[228]

Despite these findings, during the 2009 congressional debates on health care reform, Democrats supported cutting Medicare spending on home care by $43 billion over ten years to "eliminate waste and inefficiency in home care."[229] Home health care services comprised only 3.3% of Medicare's expenditures in 2007.[230] It is within the power of Congress to preserve and expand this essential Medicare benefit. This will be challenging in light of current economic circumstances, but it is an endeavor that is necessary to ensure high-quality care and protection of some of the nation's most vulnerable people.

Passing the Direct Care Worker Empowerment Act and revising the regulations must happen in tandem with a government commitment to adequately fund home health care programs through Medicare and Medicaid reimbursements. There must be statutory and regulatory protections for home health workers, as well as increased funding to allow employers to recruit and maintain a workforce that is growing not only in numbers, but also in importance. The way that the home health system is organized and funded must be reevaluated and changed to prepare for changes in age and workforce demographics. States must be required to create public authorities that can regulate the exploding home health care industry by developing and enforcing industry standards of care and providing more opportunities for training and professional advancement.

228. 42 U.S.C. §§ 1395f(a)(8), 1395f(a)(2)(C) (2006); Alliance, *supra* note 224, at 1. Home health benefits are limited to beneficiaries who have conditions that render them unable to leave the home without assistance of another or some aid device or if it is medically inadvisable. § 1395f(a)(8). They can still be considered homebound even if they leave the house to attend religious services or adult day care. *Id.* A less restrictive home health Medicare benefit that covers more beneficiaries would better promote cost savings through less reliance on hospitals. AVALERE HEALTH, LLC, *supra* note 226, at 14.

229. Pear, *supra* note 224.

230. BASIC STATISTICS 2008, *supra* note 94, at 12 fig.3. In 2007, only 3.3% of Medicare's expenditures were on home health services, compared with over thirty percent on hospitals, about twenty percent on managed care, and about twenty percent on other care. *Id.* The findings of this study suggest that increasing the amount of expenditures on home health care could decrease the amount of spending of hospitals and could decrease spending overall. *See id.* In fact, overall Medicare spending on home health services has decreased since 1997. *Id.* at 3. Furthermore, between 1998 and 2000, there was a 5.8% decrease in those who received formal home care, mainly because of a "reduction in patients receiving home health benefits from Medicare." *Id.* at 5. Home care is cost-effective. *Id.* at 7.

V. Conclusion

Long-term care is increasingly provided in the homes of the elderly and disabled instead of in institutionalized settings. The lack of appropriate working conditions for some of the most valuable members of the national workforce poses serious problems for the provision of long-term care. The resulting high turnover rates and troubling consequences for the quality of care provided to home health care consumers demands sweeping national change.

Due to the rapidly aging population over sixty-five, quick measures are necessary to ensure the improved retention rates of workers and to attract the additional 800,000 plus workers that will be necessary to meet the demand for in-home health care by 2018.[231] In order to achieve this goal, the federal government must step in, and in addition to passing the Direct Care Worker Empowerment Act and revising the DOL regulations, must require states to construct public authorities to regulate the provision of home health care. The government must increase Medicare and Medicaid reimbursement rates to ensure fair compensation for home health care workers. It is imperative that the federal government invest in the creation of a quality home care workforce to ensure that elderly Americans are able to live out the last years of their lives with dignity.

231. *See* OCCUPATIONAL OUTLOOK, *supra* note 5, at 2–3.