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29 CFR Part 552

Application of the Fair Labor Standards Act to Domestic Service; Proposed Rule

DEPARTMENT OF LABOR

Wage and Hour Division

29 CFR Part 552

RIN 1235–AA05

Application of the Fair Labor Standards Act to Domestic Service

AGENCY: Wage and Hour Division, Department of Labor.

ACTION: Notice of proposed rulemaking.

SUMMARY: The Department of Labor (the Department or DOL) proposes to revise the current Fair Labor Standards Act (FLSA or the Act) regulations pertaining to the exemption for companionship services and live-in domestic services. Section 13(a)(15) of the FLSA exempts from its minimum wage and overtime provisions domestic service employees employed ''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).'' Section 13(b)(21) of the FLSA exempts from the overtime provision any employee employed ''in domestic service in a household and who resides in such household.''

These exemptions were enacted in 1974 at the same time that Congress amended the FLSA to extend coverage to domestic service employees employed by private households. The regulations governing these exemptions have been substantively unchanged since they were promulgated in 1975. Due to significant changes in the home health care industry over the last 35 years, workers who today provide in-home care to individuals are performing duties and working in circumstances that were not envisioned when the companionship services regulations were promulgated. The number of workers providing these services has also greatly increased, and a significant number of these workers are being excluded from the minimum wage and overtime protections of the FLSA under the companionship services exemption. The Department has re-examined the regulations and determined that the regulations, as currently written, have expanded the scope of the exemption beyond those employees whom Congress intended to exempt when it enacted §§ 13(a)(15) and 13(b)(21) of the FLSA. Therefore, the Department proposes to amend the regulations to revise the definitions of ''domestic service employment'' and ''companionship services.'' The Department also proposes to clarify the type of activities and duties that may be considered ''incidental'' to the provision of companionship services. In addition, the Department proposes to amend the record-keeping requirements for live-in domestic workers. Finally, the Department proposes to amend the regulation pertaining to employment by a third party of companions and live-in domestic workers. This change would continue to allow the individual, family, or household employing the worker's services to apply the companionship and live-in exemptions and would deny all third party employers the use of such exemptions.

DATES: Comments must be received on or before February 27, 2012.

ADDRESSES: You may submit comments identified by RIN 1235–AA05, by either one of the following methods: Electronic comments, through the Federal eRulemaking Portal: *http://www.regulations.gov.* Follow the instructions for submitting comments. Mail: Address all written submissions to Mary Ziegler, Director, Division of Regulations, Legislation, and Interpretation, Wage and Hour Division, U.S. Department of Labor, Room S–3502, 200 Constitution Avenue NW., Washington, DC 20210.

Instructions: Please submit one copy of your comments by only one method. All submissions must include the agency name and Regulatory Information Number (RIN) 1235–AA05. Please be advised that comments received will be posted without change to *http://www.regulations.gov,* including any personal information provided. Because we continue to experience delays in receiving mail in the Washington, DC area, commenters are strongly encouraged to transmit their comments electronically via the Federal eRulemaking Portal at *http://www.regulations.gov* or to submit them by mail early. For additional information on submitting comments and the rulemaking process, see the ''Public Participation'' heading of the **SUPPLEMENTARY INFORMATION** section of this document.

Docket: For access to the docket to read background documents or comments received, go to the Federal eRulemaking Portal at *http://www.regulations.gov.*

FOR FURTHER INFORMATION CONTACT: Mary Ziegler, Director, Division of Regulations, Legislation, and Interpretation, U.S. Department of Labor, Wage and Hour Division, 200 Constitution Avenue NW., Room S–3502, FP Building, Washington, DC 20210; telephone: (202) 693–0406 (this is not a toll-free number). Copies of this proposed rule may be obtained in alternative formats (Large Print, Braille, Audio Tape, or Disc), upon request, by calling (202) 693–0675 (not a toll-free number). TTY/TTD callers may dial toll-free (877) 889–5627 to obtain information or request materials in alternative formats.

Questions of interpretation and/or enforcement of the agency's current regulations may be directed to the nearest Wage and Hour Division (WHD) District Office. Locate the nearest office by calling the Wage and Hour Division's toll-free help line at (866) 4US–WAGE (866) 487–9243 between 8 a.m. and 5 p.m. in your local time zone, or log onto the Wage and Hour Division's Web site for a nationwide listing of Wage and Hour District and Area Offices at: *http://www.dol.gov/whd/america2.htm.*

SUPPLEMENTARY INFORMATION:

I. Electronic Access and Filing Comments

Public Participation: This notice of proposed rulemaking is available through the **Federal Register** and the *http://www.regulations.gov* Web site. You may also access this document via the Wage and Hour Division's home page at *http://www.wagehour.dol.gov.* To comment electronically on Federal rulemakings, go to the Federal eRulemaking Portal at *http://www.regulations.gov,* which will allow you to find, review and submit comments on documents that are open for comment and published in the **Federal Register**. Please identify all comments submitted in electronic form by the RIN docket number (1235–AA05). Because of delays in receiving mail in the Washington, DC area, commenters should transmit their comments electronically via the Federal eRulemaking Portal at *http://www.regulations.gov,* or submit them by mail early to ensure timely receipt prior to the close of the comment period. Submit one copy of your comments by one method only.

II. Background

Congress extended FLSA coverage to ''domestic service'' workers in 1974, amending the law to apply to employees performing services of a household nature in or about the private home of the person by whom they are employed. *See* 29 U.S.C. 202(a), 206(f), 207(l). Domestic service workers were made subject to the FLSA even though they worked for a private household and not for a covered enterprise. Domestic service workers include, for example, employees employed as cooks, butlers, valets, maids, housekeepers, governesses, janitors, laundresses, caretakers, handymen, gardeners, and family chauffeurs. Senate Report No. 93–690, 93rd Cong., 2d Sess. p. 20

(1974). The 1974 Amendments also created an exemption from both the minimum wage and overtime pay requirements of the Act for casual babysitters and persons ''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).'' 29 U.S.C. 213(a)(15). Congress also created a more limited exemption from the overtime pay requirement for domestic service employees who reside in the household where they work. 29 U.S.C. 213(b)(21).

Congressional committee reports describe the bases for extending the minimum wage protections to domestics as ''so compelling and generally recognized as to make it hardly necessary to cite them.'' Senate Report No. 93–690, at p. 18. Private household work had been one of the least attractive fields of employment. Wages were low, work hours were highly irregular, and non-wage benefits were few. *Id.*

The U.S. House of Representatives Committee on Education and Labor stated its expectation ''that extending minimum wage and overtime protection to domestic service workers will not only raise the wages of these workers but will improve the sorry image of household employment. * * * Including domestic workers under the protection of the Act should help to raise the status and dignity of this work.'' House Report No. 93–913, 93rd Cong., 2d Sess., pp. 33–34 (1974). The legislative history explains that the 1974 Amendments were intended to include all employees whose vocation was domestic service, but to exempt from coverage babysitters and companions who were not regular bread-winners or responsible for their families' support. It was not intended to exclude trained personnel such as nurses, whether registered or practical, from the protections of the Act. *See* Senate Report No. 93–690, at p. 20. Senator Williams, Chairman of the Senate Subcommittee on Labor and the Senate floor manager of the 1974 Amendments to the FLSA, described companions as ''elder sitters'' whose main purpose is to watch over an elderly or infirm person in the same manner that a babysitter watches over children. 119 Cong. Rec. S24773, S24801 (daily ed. July 19, 1973). Senator Williams further noted that all other work, such as occasionally making a meal or washing clothes for the person, must be incidental to that primary purpose. *Id.*

On February 20, 1975, the Department issued regulations and interpretations in 29 CFR part 552 implementing the domestic service employment provisions *See* 40 FR 7404. Subpart A of the rule defined and delimited the terms ''domestic service employee,'' ''employee employed on a casual basis in domestic service employment to provide babysitting services,'' and ''employment to provide companionship services to individuals who (because of age or infirmity) are unable to care for themselves.'' Subpart B of the rule set out statements of general policy and interpretation concerning the application of the FLSA to domestic service employees. Section 552.109 contained the Department's position that the exemptions contained in § 13(a)(15) and § 13(b)(21) of the Act (exemptions for companions or live-in domestic service workers) were applicable to employees of a third party employer or agency.

On December 30, 1993, the Department published a notice of proposed rulemaking in the **Federal Register,** inviting public comments on a proposal to revise 29 CFR 552.109 to clarify that, in order for the exemptions under § 13(a)(15) and § 13(b)(21) of the FLSA to apply, employees engaged in companionship services and live-in domestic service who are employed by a third party employer or agency must be ''jointly'' employed by the family or household using their services. Other minor updating and technical corrections were included in the proposal. *See* 58 FR 69310. On September 8, 1995, the Department published a final rule revising the regulations to incorporate changes required by the recently enacted changes to Title II of the Social Security Act and making other updating and technical revisions. *See* 60 FR 46766. That same day, the Department published a proposed rule reopening and extending the comment period on the proposed changes to § 552.109 concerning third party employment. *See* 60 FR 46797. The Department did not finalize this proposed change.

On January 19, 2001, the Department published a notice of proposed rulemaking to amend the regulations to revise the definition of ''companionship services'' to more closely mirror Congressional intent. The Department also sought to clarify the criteria used to determine whether employees qualify as trained personnel and to amend the regulations concerning third party employment. On April 23, 2001, the Department published a proposed rule reopening and extending the comment period on the January 2001 proposed rule. *See* 66 FR 20411. This rulemaking was eventually withdrawn and terminated on April 8, 2002. *See* 67 FR 16668.

III. Need for Rulemaking

The home care industry has undergone a dramatic transformation since the Department published the implementing regulations in 1975. There has been a growing demand for long-term in-home care for persons of all ages, in part because of the rising cost of traditional institutional care, and because of the availability of funding assistance for in-home care under Medicare and Medicaid. The growing demand for long-term in-home care for persons is also partly due to the significant increase in our aging population.[1]

In response to the growing demand for long-term in-home care, the home health care services industry has grown. According to the National Association of Home Care (NAHC) publication, *Basic Statistics About Home Care* (March 2000), data from the Department of Health and Human Services' Health Care Financing Administration (HCFA) showed that the number of Medicare-certified home care agencies increased from 2,242 in 1975 to 7,747 in 1999. In the NAHC 2008 update, this number increased to 9,284 by the end of 2007. The number of for-profit agencies not associated with a hospital, rehabilitation facility, or skilled nursing facility, *i.e.,* freestanding agencies, increased more than any other category of agency from 47 in 1975 to 4,919 in 2006. These for-profit agencies grew from 2 percent of total Medicare-certified agencies in 1975 to 68 percent by 2006, and now represent the greatest percentage of certified agencies. Public health agencies, which constituted over one-half of the certified agencies in 1975, now represent only 15 percent.

Public funds pay the overwhelming majority of the cost for providing home care services. Medicaid payments represent nearly 40 percent of the industry's total revenues; other payment sources include Medicare, insurance plans, and direct pay. Based on data from the Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, National Health Care Expenditures Historical and Projections: 1965–2016, Medicare and Medicaid together paid over one-half of the funds to freestanding agencies (37 and 19 percent, respectively). State and local governments account for 20 percent, while private health insurance accounts for 12 percent. Out-of-pocket funds

[1] *See* Shrestha, Laura, *The Changing Demographic Profile of the United States,* Congressional Research Service p. 13–14 (2006).

account for 10 percent of agency revenues.

There has been a similar increase in the employment of home health aides and personal care aides in the private homes of individuals in need of assistance with basic daily living or health maintenance activities. Bureau of Labor Statistics' (BLS) national occupational employment and wage estimates from the Occupational Employment Statistics (OES) survey show that the number of workers in these jobs tripled during the decade between 1988 and 1998, and by 1998 there were 430,440 workers employed as home health aides and 255,960 workers employed as personal care aides. The combined occupations of personal care and home health aides constitute a rapidly growing occupational group. BLS statistics demonstrate that between 1998 and 2008, this occupational group has more than doubled with home health aides increasing to 955,220 and personal care aides increasing to 630,740. (*http://www.bls.gov/oes/current/oes399021.htm*).

The growth in demand for in-home care and in the home health care services industry has not resulted in growth in earnings for workers providing in-home care. The earnings of employees in the home health aide and personal care aide categories remain among the lowest in the service industry. Studies have shown that the low income of direct care workers including home care workers continues to impede efforts to improve both jobs and care.[2] Protecting domestic service workers under the Act is an important step in ensuring that the home health care industry attracts and retains qualified workers that the sector will need in the future. Moreover, the workers that are employed by home care staffing agencies are not the workers that Congress envisioned when it enacted the companionship exemption *i.e.,* neighbors performing elder sitting, but are instead professional caregivers entitled to FLSA protection. In view of the dramatic changes in the home health care sector in the 36 years since these regulations were first promulgated and the growing concern about the proper application of the FLSA minimum wage and overtime protections to domestic service employees, the Department believes it is appropriate to reconsider whether the scope of the regulations are now too broad and not in harmony with Congressional intent.

[2] *See* Brannon, Diane, *et al.,* ''Job Perceptions and Intent to Leave Among Direct Care Workers: Evidence From the Better Jobs Better Care Demonstrations'' *The Gerontologist,* Vol. 47, No. 6, p. 820–829 (2007).

IV. Proposed Regulatory Revisions

A. Domestic Service Employment (29 CFR 552.3)

Current § 552.3 states that ''As used in section 13(a)(15) of the Act, the term domestic service employment refers to 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.'' The current definition also lists various occupations which are considered ''domestic service employment.'' The Department proposes to update and clarify the § 552.3 definition of ''domestic service employment'' in order to reflect the changing workforce.

The Department proposes to remove the qualifying introductory language ''[A]s used in section 13(a)(15) of the Act'' because the definition of domestic service employment has broader context than simply those employed to provide babysitting services on a casual basis and those performing companionship services. The proposed definition also removes the language that the domestic service work be performed in or about the home ''of the person by whom he or she is employed.'' This language has been part of the regulations since first implemented in 1975; however, the Department believes the definition may be confusing and may be misread as impermissibly narrowing coverage of domestic service employees under the FLSA. The Senate Committee responsible for the 1974 Amendments looked at regulations issued under the Social Security Act for defining domestic service. The Department borrowed this language from the Social Security regulations without discussion or elaboration, and has consistently maintained that the phrase is extraneous vestige. *See Long Island Care at Home, Ltd.* v. *Coke,* 551 U.S. 158, 169–70 (2007) (concluding that § 552.3 does not answer the question on third party employment and that the Department's third party regulation at § 552.109 controls). Moreover, the legislative history states that Congress intended to extend FLSA coverage to all employees whose ''vocation'' was domestic service, but to exempt from coverage casual babysitters and companions who were not regular breadwinners or responsible for their families' support. *See* House Report No. 93–913, p. 36. Removal of this extraneous language more accurately reflects Congressional intent and clarifies coverage of these workers.

Congress considered domestic service workers to include, for example, employees working as cooks, butlers, valets, maids, housekeepers, governesses, janitors, laundresses, caretakers, handymen, gardeners, and family chauffeurs. *See* Senate Report No. 93–690, p. 20. The Department included these occupations in § 552.3 as illustrative of domestic service workers. The Department proposes to delete the more outdated occupations in the list, such as governesses, footmen, and grooms, and to add additional modern day occupations such as nannies, home health aides, and personal care aides. The Department also proposes to include babysitters and companions to the list of domestic service workers, as workers in those occupations are domestic service workers, however, workers in those occupations may be exempt under FLSA § 13(a)(15) or § 13(b)(21). The list continues to be illustrative, not exhaustive.

B. Duties of a Companion (29 CFR 552.6)

The Department proposes to revise § 552.6, the regulation pertaining to companionship services for the aged and infirm. Current § 552.6 defines ''companionship services'' including ''fellowship, care, and protection'' provided to a person who, because of advanced age or physical or mental infirmity, can not care for his or her own needs. This regulation defines exempt services as including household work related to the person's care (such as meal preparation, bed making, washing of clothes, and other similar services). Under the current regulation, a companion may also perform additional general household work within the exemption if it is ''incidental'' and comprised of no more than 20 percent of the total weekly hours worked. This regulation further explains that the term ''companionship services'' does not include 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.

1. Companionship Services

In 1974 Congress amended the FLSA specifically to include domestic service workers (such as maids, cooks, valets and laundresses) as among those to be covered by the Act. Congress simultaneously created a narrow exemption for casual babysitters and those providing companionship to the elderly or infirm. The Senate debate of the companionship services exemption provides insight into the type of work Congress sought to exempt:

Senator Burdick: I am not concerned about the professional domestic who does this as a daily living. But we have situations in which young people, a widow, a divorcee, or a family of low income, of necessity, must have someone sit with their children while they are at work.

We have another category of people who might have an aged father, an aged mother, an infirm father, an infirm mother, and a neighbor comes in and sits with them.

This, of course, entails some work, such as perhaps making lunch for the children, or making lunch for the infirm person, and may even require throwing some diapers in the automatic washing machine for the baby. This would be incidental to the main purpose of the employment.

The Senator has used the word ''companion'' in the exception. When the Senator uses the word ''companion,'' the Senator does not mean that in the ordinarily accepted sense, that they are there to make them feel good. They are there to take care of them, he means, when he uses the word ''companion.'' Is that correct?

Senator Williams: We use the situation in which people are in a household not to do household work but are there, first, as babysitters. I think we all have the full meaning in mind of what a babysitter is there for—to watch the youngsters.

''Companion,'' as we mean it, is in the same role—to be there and to watch an older person, in a sense.

Senator Burdick: In other words, an elder sitter.

Senator Williams: Exactly.

119 Cong. Rec. at S24801.

The House Report offers further insight into Congressional intent with respect to those employees providing ''companionship services'' stating:

It is the intent of the committee to include within the coverage of the Act all employees whose vocation is domestic service. However, the exemption reflects the intent of the committee to exclude from coverage babysitters for whom domestic service is a casual form of employment and companions for individuals who are unable because of age or infirmity to care for themselves. But it is not intended that trained personnel such as nurses, whether registered or practical, shall be excluded. People who will be employed in the excluded categories are not regular bread-winners or responsible for their families support. The fact that persons performing casual services as babysitters or services as companions do some incidental household work does not keep them from being casual babysitters or companions for purposes of this exclusion.

House Report No. 93–913, p. 36.

This legislative history indicates that Congress intended to remove from minimum wage and overtime pay protection only those domestic service workers for whom domestic service was not their vocation and whose actual purpose was to provide casual babysitting or companionship services. Congress also intended that a limited amount of incidental work, such as making a meal or washing diapers for the person being cared for, would not remove the worker from the exemption.

In addition to the legislative history, the dictionary definition of ''companionship'' is instructive in understanding the scope of a companion as originally intended in the legislative history, that is, someone in the home primarily to watch over and care for the elderly or infirm person. The dictionary defines companionship as the ''relationship of companions; fellowship,'' and the term ''companion'' is defined as a ''person who associates with or accompanies another or others; associate; comrade'' and as a ''person employed to live with or travel with another.'' *See* Webster's New World Dictionary, p. 288 (2d College Ed. 1972). It further defines ''fellowship'' as including ''a mutual sharing, as of experience, activity, interest, *etc.'' Id.* at 514.

The Department is concerned that the current regulatory definition of ''companionship services'' allows for the denial of minimum wage and overtime pay protection to workers who work in private homes and routinely perform general household work or provide medical care, and who may also provide fellowship and protection as an incidental activity to the household work or medical care. The current regulatory language places inappropriate emphasis on the ''household work related to the person's care,'' such as meal preparation, bed making, washing of clothes, and other similar services. These activities, particularly when combined with the current 20 percent tolerance for general household work, exempt workers for whom providing ''fellowship and protection'' is incidental to their employment as cooks, waiters, butlers, valets, maids, housekeepers, nannies, nurses, janitors, laundresses, caretakers, handymen, gardeners, home health aides, personal care aides, and chauffeurs of automobiles for family use. Therefore, the Department proposes to revise § 552.6 to clarify the tasks an exempt companion may perform and to more closely align the regulation with Congressional intent.

The Department proposes to divide § 552.6 into four paragraphs. Proposed paragraphs (a), (b) and (c) will clarify what duties and activities may be considered ''companionship services'' and ''incidental'' to companionship services. Proposed paragraph (d) explains and clarifies that the companionship exemption is not applicable to medical care typically provided by personnel with specialized training.

Current § 552.6 defines the term ''companionship services.'' Proposed § 552.6(a) also defines ''companionship services'' as ''the provision of fellowship and protection for a person who, because of advanced age or physical or mental infirmity, is unable to care for themselves'' and adds language that defines the terms ''fellowship'' and ''protection.'' The legislative history describes a companion as someone who ''sits with [an infirm parent];'' provides ''constant attendance;'' and renders services similar to a babysitter, *i.e.,* ''someone to be there and watch an older person,'' an ''elder sitter.'' Such duties fall under the umbrella of fellowship and protection. Examples of activities that fall within fellowship and protection may include playing cards, watching television together, visiting with friends and neighbors, taking walks or engaging in hobbies. In addition, a companion may provide assistance with mobility and transfers. In the Department's view, ''mobility'' includes assistance with ambulation, including the use of a wheelchair or walker, and ''transfers'' include assisting the recipient in moving from one seating or reclining area to another. The Department believes that such tasks are consistent with what a babysitter or elder sitter would perform as contemplated by Senator Burdick in his explanation of the bill. The Department believes this expanded paragraph clarifies what is meant by ''companionship services,'' ''fellowship,'' and ''protection.''

Proposed § 552.6(b) explains that ''companionship services'' may include the intimate personal care services that the Secretary considers ''incidental'' to the provision of fellowship and protection. The proposed regulation limits a companion's duties to fellowship and protection with some allowance for certain incidental work, provided the incidental duties are performed concurrent with fellowship and protection of the individual and exclusively for that individual. The discussion of companionship duties in the legislative history allows incidental work, such as ''making lunch for the infirm person'' and ''some incidental household work.'' *See* 119 Cong. Rec. at S24801. However, such incidental services must be performed attendant to and in conjunction with the provision of fellowship and protection and in close physical proximity to the aged or infirm individual. Proposed paragraph (b) makes clear that such intimate personal care services that are incidental to the provision of fellowship and protection

must not exceed 20 percent of the total hours worked in the workweek. Should the provision of these incidental services exceed 20 percent of the total hours worked in any workweek, then the exemption may not be claimed for that week and workers must be paid minimum wage and overtime.

Proposed paragraph (b) also provides an illustrative list of permissible incidental services that may be provided by an exempt companion. In proposed § 552.6(b)(1), the Department proposes to include assistance with occasional dressing of the elderly or infirm person as an incidental activity. The Department believes that allowing assistance with dressing is consistent with Congressional intent, as assistance with dressing is something that would normally be contemplated by a babysitter or elder sitter. For example, a companion may assist an elderly or infirm person in laying down or arising from a nap which may either be preceded by shedding of some clothing or applying some clothing. Adjustments in weather may also require either the addition or subtraction of certain clothing or footwear, or the elderly or infirm person may, on occasion, need assistance in dressing after soiling their clothing by spilling food on their blouse or shirt during a meal, for example. This type of occasional dressing is permissible; however, the Department does not envision this task as being a regular and recurring part of the companion's duties. Further, the Department does not consider the application of special appliances or medical wraps (that require specialized training to apply) as part of assistance with dressing.

In proposed § 552.6(b)(2), the Department proposes that an exempt companion be allowed to assist with occasional grooming, including combing and brushing hair, assistance with brushing teeth, application of deodorant, or cleansing of the person's face and hands, such as following a meal. The Department recognizes that occasional grooming of the aged or infirm person is consistent with the Department's goal of providing incidental intimate personal care services attendant to and in conjunction with the provision of fellowship and protection for the aged or infirm person.

In proposed § 552.6(b)(3), the Department has included assistance with toileting, including assistance with transfers, mobility, positioning, use of toileting equipment and supplies (such as toilet paper, wipes, and elevated toilet seats or safety frames), diaper changing, and related personal cleansing. In the Department's view, assistance with toileting is carried out attendant to and in conjunction with the provision of fellowship and protection of the aged or infirm person. Because toileting is a basic human need and not a function that can be scheduled, the Department proposes to include it in the list of incidental tasks that may be performed by the exempt companion. The Department specifically invites comment on the inclusion of occasional toileting and diaper changing to the list of incidental activities performed by the exempt companion.

Proposed § 552.6(b)(4) suggests that an exempt companion may occasionally drive the aged or infirm individual to appointments, errands, and social events. The Department believes there is some justification for a companion who provides ''fellowship and protection'' to accompany an aged or infirm person to certain appointments. There is, however, some concern that providing transportation may be more akin to the duties of a chauffeur than to the duties of a companion. The Department is mindful that drivers and chauffeurs were expressly considered by Congress as among those they intended to be covered by the Act. The Department is also concerned about issues such as extra costs for the domestic worker and/or their employer with respect to insurance coverage levels, for example. The Department proposes that occasional driving can be a component of incidental duties; however, with the cap on incidental duties at 20 percent, the Department anticipates that only a limited amount of time will be spent driving the aged or infirm person to appointments, errands and social events. The Department notes that while it seeks to limit the time an exempt companion spends driving the aged or infirm individual, the Department considers time spent accompanying an aged or infirm individual to appointments, errands or social events (*e.g.,* traveling via a taxi cab or using public transportation) to be providing fellowship and protection. The Department explicitly invites comment on the proposal to include driving among the incidental activities an exempt companion may perform.

Proposed § 552.6(b)(5) provides that an exempt companion may provide occasional assistance with feeding the aged or infirm person, including food preparation and clean-up associated with feeding; however, the Department considers feeding through or assistance with a feeding tube to be medical care (that is typically provided by personnel with specialized training) that is excluded from the definition of ''companionship services.'' The Department notes that Senator Burdick stated in his floor speech that companionship was meant to include, ''some work, such as perhaps making lunch for the children, or making lunch for the infirm person * * *.'' 119 Cong. Rec. at S24801. The Department proposes to require that in order for food preparation to be considered as an incidental activity, the food prepared by the companion must be eaten by the aged or infirm person while the companion is present. The Department believes that this is consistent with the goal that incidental intimate personal care services be provided attendant to and in conjunction with the provision of fellowship and protection of the aged or infirm person. However, it is not the Department's intent that an exempt companion will be permitted to cook a week's worth of food while the aged or infirm individual is engaged in other activities, for example, because that would not be attendant to and in conjunction with providing fellowship and protection.

Proposed § 552.6(b)(6) provides that an exempt companion may occasionally place clothing worn by the person in the hamper, deposit the aged or infirm person's clothing into the washing machine or dryer, and assist with hanging, folding, and putting away the aged or infirm person's clothing. The Department's review of the legislative history indicates that occasional, light laundry was contemplated by Congress in consideration of the casual babysitter and companionship exemptions. In their exchange, Senators Williams and Burdick indicated that one ''may even require throwing some diapers in the automatic washing machine for the baby. This would be incidental to the main purpose of the employment.'' 119 Cong. Rec. at S24801.

Proposed § 552.6(b)(7), allows for occasional assistance with bathing the aged or infirm person. The Department does not consider bathing to be part of the regular duties of the exempt companion; however, the Department believes that in certain exigent circumstances, a companion may need to provide assistance with bathing to the elderly or infirm person. An example of exigent circumstances would be when the elderly or infirm person has an unexpected toileting accident requiring the need for bathing. Generally, the Department believes that bathing is something that can be scheduled to not coincide with the companion's duty hours, but proposes to allow reasonable but limited exceptions that more closely align to an imminent need to assist the elderly or infirm person with cleansing.

The Department specifically invites comments with respect to the 20 percent threshold for incidental care services, and whether this percentage is an appropriate figure. Further, the Department invites comments on the list of services, whether additional services should be included or certain services should be excluded, whether the list should be an exclusive list of permitted incidental services, and whether the requirement that such services must be performed attendant to and in conjunction with the provision of fellowship and protection to the elderly or infirm person should be adopted.

Proposed § 552.6(c), makes clear that work benefiting other members of the household, such as preparing meals for the household, performing housekeeping or laundry for the other members of the household does not fall within incidental duties for an exempt companion. Similarly, general household services not otherwise allowed in § 552.6(b) and (d), are not considered ''companionship services.'' The Department's proposal includes a change from the current regulation that allows the companionship services exemption to apply when the worker spends up to 20 percent of his or her time performing general household work which is unrelated to the care of the person. General household work that is not allowed under proposed § 552.6(b), such as vacuuming, washing windows, and dusting, is the sort of work that Congress sought to cover when it amended the Act in 1974 to reach domestic service workers such as maids and housekeepers, and therefore, companions are precluded from performing such tasks in order for the exemption to apply. The Department believes the proposed revisions to the definition strike a balance that implements Congress' twin goals of extending FLSA coverage to domestic service workers generally while exempting companions, by recognizing that the fellowship and protection provided by a companion are very different from the household chores performed by a maid or cook or laundress. Further, the proposed regulations also reflect that coverage under the FLSA is construed broadly and the exemptions are construed narrowly to effectuate the Act's remedial purposes.

Thus, the performance of duties that are not for fellowship and protection of the aged or infirm person, or incidental to the provision of fellowship and protection, are not ''companionship duties,'' and therefore, any performance of general household work would result in the loss of the exemption for the week. The Department believes that the combination of proposed § 552.6(b) and (c) results in the narrow slice of the workforce that Congress intended to exempt under the companionship exemption.

2. Medical Care

Proposed paragraph § 552.6(d) excludes from the definition of ''companionship services'' medical care that is typically provided by personnel with specialized training. The Department proposes in § 552.6(d) to continue to make clear that ''companionship services'' does not include care that is typically provided by personnel with specialized training and provides an illustrative and non-exhaustive list of examples of the type of care that is not considered ''companionship services.''

The Department proposes to maintain the exclusion of medical care from the definition of ''companionship services,'' but proposes to clarify that companionship services do not include the performance of medically-related tasks for which training is typically a prerequisite. The Department's experience indicates that many workers for whom the companionship exemption is claimed are categorized as personal care aides or home health aides. The Department understands that these workers often visit a care recipient for the purpose of providing wound care such as changing bandages, taking the care recipients vital signs, evaluating the care recipient's health and performing other diagnostic or medically-related tasks. While some personal care or home health aides may be engaged to perform companionship services, the Department is concerned that many such workers are primarily performing medically-related or personal-care-related tasks rather than providing fellowship and protection, and are being denied minimum wage and overtime pay protections through misapplication of the companionship services exemption.

The Department proposes to exclude from the definition of companionship services medically-related duties such as medication management, the taking of vital signs (pulse, respiration, blood sugar screening, and temperature), routine foot, skin, and back care, and assistance with physical therapy. This list is illustrative, not exhaustive. Similarly, determining whether prescription medication needs to be taken would remove the domestic service worker from the companionship exemption.

However, the Department notes that reminders of medical appointments or a predetermined medicinal schedule would be encompassed within companionship duties. For example, where the companion is provided clear instructions to remind the aged or infirm person to take medication that has been provided in a daily pillbox at a prescribed time and the companion exercises no discretion as to the amount or when the care recipient takes the medication, such work generally would be intimate personal care activities considered by the Secretary to be incidental to the provision of fellowship and protection. The Department believes, however, that Congress did not intend the companionship services exemption to apply to employees who perform medically-related duties, such as registered or licensed nurses, certified nursing assistants, or certified nursing aides. Tasks being performed by these workers that typically require medical training and are beyond what Congress envisioned when it stated that persons providing companionship services are present in the home, as a neighbor might be, to watch over an elderly person the way a babysitter watches over a child.

The Department specifically seeks comment on whether the proposed rule appropriately reflects medical care tasks currently performed by home health aides or personal care aides which require training in order to perform. The Department also seeks comment on whether the rule should list additional examples of minor health-related actions that do not require training and could be included within companionship services, such as applying a band aid to a minor cut or helping an elderly person take over-the-counter medication.

It is important to note that workers providing healthcare in homes are already subject to minimum wage and overtime protections. However, the Department invites comment on the potential effects of the proposed changes as discussed above on the delivery of companionship services and whether unique circumstances exist that impact the provision of companionship services in the context of the broader healthcare system.

C. Third Party Employment (29 CFR 552.109)

The Department also proposes to revise § 552.109, the regulation pertaining to third party employment. Current § 552.109 provides that employees who are employed by an employer or agency other than the family or household using the companionship services may be subject to the FLSA exemption from minimum

wage and overtime pay for companions under § 13(a)(15). The current regulation also provides that live-in workers who are employed by a third party may be subject to an overtime exemption under § 13(b)(21) of the FLSA.

Upon further consideration and analysis, the Department believes that these two exemptions from the minimum wage and overtime protections of the FLSA should not be applicable to employees of third party employers. The Department proposes to revise § 552.109 to limit the application of these exemptions to the individual, family or household employing the companion or live-in domestic worker, regardless of whether the family member employing the companion or live-in domestic worker resides in the home where the services are performed. The Department believes this proposed change better reflects the understanding of Congress when it created these exemptions. In addition, the Department believes amending this regulation is necessary to address the changes that have taken place in the home health care industry since this regulation was first promulgated.

As noted by the Supreme Court, the Department has ''struggled with the third party employment question.'' *Long Island Care at Home, Ltd.* v. *Coke,* 551 U.S. 158, 171 (2007). In 1974, the Department proposed a regulation that would have denied the exemptions in §§ 13(a)(15) and 13(b)(21) of the Act to employees who, although providing companionship or live-in domestic services, were employed by an employer or agency other than the family or household using their services. *See* 39 FR 35383. However, in the final regulation, promulgated in 1975, the Department concluded that the exemption could be applicable to employees providing companionship or live-in domestic services employed by such third party employers. *See* 40 FR 7404. In 1993, 1995, and 2001, the Department revisited this regulation specifically, proposing amendments that would have curtailed the applicability of these exemptions to the employees of third party employers.

In revisiting the legislative history of the 1974 Amendments, the Department believes that Congress contemplated that individual family members, and not third party employers that already were covered by the FLSA, would be impacted by the extension of coverage to domestic service workers. ''I just cannot imagine the housewife struggling with the paper work which would be required.'' 120 Cong. Rec. S5269 (daily ed. Mar. 5, 1974) (statement of Sen. Fannin). ''The position of the committee in adding complete coverage for domestics and thus adding additional recordkeeping and other chores for the American housewife * * *'' 120 Cong. Rec. S5275 (statement of Sen. Dominick). Because Congress believed that private households would be impacted by the expansion of FLSA coverage, it is reasonable to conclude that Congress intended only private households to be entitled to the exemptions from FLSA protections for domestic service workers. Professional caregivers, such as those individuals employed by third party employers, are simply not the type of employment arrangements that Congress sought to exempt. In view of the professionalization and standardization of this growth industry that has taken place over the last three decades, it is the Department's position that employees providing companionship services who are employed in the vocation of caregiver by third parties should have the same minimum wage and overtime protections that other workers enjoy.

Statements in the Congressional Record made by supporters of the amendment also demonstrate that Congress considered the impact that the expansion of FLSA coverage would have on poor women, many of them women of color, employed as domestics. Senator Williams noted that ''the plain fact is that private household domestic workers are overwhelmingly female and members of minority groups,'' and ''[i]n failing to cover domestics under our basic wage and hour law we would be turning our backs on these people.'' 119 Cong. Rec. S24799 (statement of Senator Williams). Senator Williams further emphasized that ''[s]ince domestic employment is one of the prime sources of jobs for poor and unskilled workers, it is clear that there is an important national interest at stake in insuring that the wages received for such work do not fall below a minimal standard of decency.'' *Id.* at 24800. Such statements indicate that Congress intended broad FLSA coverage for domestic workers. Poor, minority women, many of them immigrants, continue to comprise the great majority of the companion workforce today. The fact that 70 percent of home health care workers are employed by third party agencies—and fall outside of FLSA coverage under the current third party regulation—is an important indication that what Congress intended to accomplish in amending the FLSA in 1974 remains unfinished.[3]

Moreover, under the 1974 Amendments, Congress explicitly extended FLSA coverage to domestic service employees who were not previously covered, *i.e.,* those who worked only for a private family or a small business and not for a covered enterprise. Prior to 1974, employees who had worked for a covered placement agency, but were assigned to work in someone's home were covered by the FLSA. 39 FR 35385. Congress did not intend for the 1974 Amendments, which sought to extend the reach of the FLSA, to exclude workers already covered by the Act. The focus of the floor debate concerned the extension of coverage to categories of domestic workers who were not already covered by the FLSA, specifically, those not employed by an enterprise-covered agency. *See, e.g.,* 119 Cong. Rec. at S24800 (''coverage of domestic employees is a vital step in the direction of insuring that *all* workers affecting interstate commerce are protected by the Fair Labor Standards Act''); *see also* Senate Report No. 93–690 at p. 20 (''The goal of the Amendments embodied in the committee bill is to update the level of the minimum wage and to continue the task initiated in 1961—and further implemented in 1966 and 1972—to *extend* the basic protection of the Fair Labor Standards Act to additional workers and to reduce to the extent practicable at this time the remaining exemptions.'') (emphasis added). Further, there is no indication that Congress considered limiting enterprise coverage for third party employers providing domestic services. The only expressions of concern by opponents of the amendment related to the new recordkeeping burdens on private households. Recognizing this intended expansion of the Act, the exemptions excluding employees from coverage must therefore be defined narrowly in the regulations to achieve the law's purpose of extending coverage broadly. This is consistent with the general principle that coverage under the FLSA is broadly construed so as to effect its remedial purposes, and exemptions are narrowly interpreted and limited in application to those who clearly are within the terms and spirit of the exemption. *See, e.g., A.H. Phillips, Inc.* v. *Walling,* 324 U.S. 490, 493 (1945). Upon further analysis, the Department acknowledges that the regulatory rollback of coverage for many workers that resulted from current § 552.109 was not in accord with Congress' purpose of expanding coverage.

[3] University of California San Francisco, Center for California Health Workforce Studies, *An Aging U.S. Population and the Healthcare Workforce: Factors Affecting the Need for Geriatric Care Workers at 30* (Feb. 2006).

In addition, 14 states already have statutes providing minimum wage and overtime protections to all or most third-party-employed home care workers who may otherwise fall under the federal companion exemption. These states are Colorado, Hawaii, Illinois, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Jersey, New York, Pennsylvania, Washington, and Wisconsin. Maine and California extend minimum wage and overtime protections to all companions employed by for-profit agencies. Five more states (Arizona, Nebraska, North Dakota, Ohio, and South Dakota) and the District of Columbia provide only minimum wage coverage only to home care workers, including companions, employed by third parties.

Significantly, several of the states have instituted these protections in the last several years. For example, in January 2010 Colorado extended minimum wage and overtime protection to home care workers not employed by private households; in October 2003 Michigan extended minimum wage and overtime protection to home care workers employed by an employer with 2 or more employees and in July 2003 California extended minimum wage coverage to all companions employed by third parties and overtime coverage to companions employed by for-profit agencies. The fact that these state statutes exist negates many of the objections raised in the past regarding the feasibility and expense of prohibiting third parties from claiming the companionship and live-in worker exemptions.

Members of Congress have also recently urged the Department to narrow the scope of these exemptions. In 2009, over 50 Members of Congress wrote to Secretary Solis, urging the Department to revise the companionship regulation because it ''interpreted a narrow exemption Congress provided for 'companionship services' to exclude all workers, including those employed by a third party, who provide in-home care for elderly or disabled people from the FLSA's wage and overtime protections.'' *See* Letter from Representative Sanchez *et al.* to Secretary Solis, May 18, 2009; Letter from Senator Harkin, *et al.,* to Secretary Solis, June 11, 2009. The Members also noted that most home care workers are women and often the sole bread winners for their families. The latter point is important because Congress stated that ''[p]eople who will be employed in the excluded categories are not regular bread winners or responsible for their families' support.'' Senate Report No. 93–690, at p. 20. The expanded coverage was needed to raise incomes for those workers who depended on domestic work as a ''daily living,'' which was the workforce that Rep. Shirley Chisholm described as the ''thousands of ladies who have the sole responsibility for taking care of their families and will not be able to adequately support their families.'' This situation continues today. One survey in New York City, for example, reported that 81 percent of home care workers served as the primary income earner for their family.[4]

In 2007, the Department's third party employment regulation was addressed by the Supreme Court. *See Coke,* 551 U.S. 158. In *Coke,* a home health care worker employed by a third party challenged the validity of the Department's regulation permitting employees of third parties to claim the companionship exemption. The Court acknowledged that the statutory text and legislative history do not provide an explicit answer to the third party employment question. *Id.* at 168. Rather, the FLSA leaves gaps as to the scope and definition of statutory terms such as ''domestic service employment'' and ''companionship services,'' and it provides the Department with the power to fill those gaps. *Id.* at 167. Further, when the Department fills statutory gaps with any reasonable interpretation, and in accordance with other applicable requirements, the courts accept the result as legally binding. *Id.* at 167–68. The Court noted that the 1974 Amendment ''expressly instructs the agency to work out the details of those broad definitions'' and explained that the regulation ''concerns a matter in respect to which the agency is expert,'' because whether the 1974 Amendment should extend protection to any third party companions turns ''upon the kind of thorough knowledge of the subject matter and ability to consult at length with affected parties that an agency, such as the Department of Labor, possesses.'' *Id.* at 167–68. The Court concluded that ''whether to include workers paid by third parties within the scope of the definitions is one of those details'' that Congress entrusted to the Department. *Id.* at 167.

In *Coke,* the Department argued that the third party regulation was an exercise of its expressly delegated legislative rulemaking authority, and as such, was legally binding and must be accorded the highest level of deference. The position taken by the Department in *Coke* concerning deference, as affirmed by a unanimous Supreme Court, remains relevant as the Department reconsiders the scope of these exemptions. By engaging in a new round of notice and comment rulemaking, the Department is again appropriately exercising its expressly delegated rulemaking authority. The Department's proposal to revise the third party regulation is in no way inconsistent with the Court's ruling. Rather, the Court recognized that the statutory text does not answer the question and affirmed the Department's broad authority to promulgate regulations that define the scope of the exemption. The Court explicitly recognized that the Department may interpret its ''regulations differently at different times in their history,'' and may make changes to its position, provided that the change creates no unfair surprise. *Id.* at 170–71. The Court also recognized that when the Department utilizes notice-and-comment rulemaking in an attempt to codify a new regulation, as it is doing now, such rulemaking makes surprise unlikely. *Id.* at 170.

It must be noted that the Department argued in *Coke,* as well as in Wage and Hour Advisory Memorandum (''WHAM'') 2005–1 (Dec. 1, 2005) (found at *http://www.dol.gov/whd/FieldBulletins/index.htm*), that the third party regulation, as currently written, was the Department's best reading of these statutory exemptions. However, upon further consideration of the purpose and objectives behind the 1974 Amendments, the Department is no longer convinced that our prior reading is the best one. The purpose behind the Amendments, confirmed by the legislative history, was to extend FLSA coverage to domestic workers who were not employed by covered enterprises. In recognition that it was expanding coverage to workers employed by private households, Congress created the narrow exemption for casual babysitters and companions whose vocation is not domestic service. In light of the purposes behind the amendment and the exemption, § 13(a)(15) of the FLSA cannot and should not necessarily be read to apply to third party employers, as we argued for in the WHAM. The Department erroneously focused on the phrase ''any employee,'' instead of focusing on the purpose and objective behind the 1974 Amendments, which was to expand minimum wage and overtime protections to workers employed by private households that did not otherwise meet the FLSA coverage requirements. The Supreme

[4] Gilbert, Lenora. *Home Care Workers: The New York City Experience,* Encyclopedia of Occupational Safety and Health, Vol. 3. (4th ed. International Labor Organization, 1998).

Court has ''stressed that in expounding a statute, we must not be guided by a single sentence or member of a sentence, but look to the provisions of the whole law, and to its object and policy.'' *U.S. Nat'l Bank of Oregon* v. *Indep. Ins. Agents of Am., Inc.,* 508 U.S. 439, 455 (1993) (internal quotation marks omitted). The Supreme Court concluded that ''the text of the FLSA does not expressly answer the third party employment question.'' *Coke,* 551 at 168. Thus, the statutory phrase ''any employee'' cannot, standing alone, answer the question at hand, and after considering the purpose and objectives of the Amendments as a whole, the Department believes that the companionship exemption was not intended to apply to third party employers.

Moreover, upon further reflection, the Department is no longer convinced that Congress' failure to limit the companionship exemption to employees of a particular employer is evidence of Congressional intent on this issue. WHAM at 2. In 1974, Congress understood that enterprises that employed domestic service workers to perform services in private homes were already covered employers under the Act and thus, their employees already received the protections of the FLSA even when they performed companionship services. There is no indication that Congress intended to narrow coverage of those employed by third party employers when this would be contrary to the intent and purpose of expanding coverage and protecting low-wage workers. By focusing on the impact that the 1974 Amendments would have upon private households during the debates, Congress presumably did not think it necessary to explicitly limit the narrowly created statutory exemptions to families and households who employ companions, causal babysitters and live-in domestics. Rather, Congress provided the Department with the power to fill these kinds of statutory gaps.

The WHAM noted the ambiguity and lack of clarity in the companionship regulations, stating that ''phrases in the [companionship regulations] could potentially be read to exclude third party employees from the definition of domestic service employment.'' WHAM at 3. This admitted lack of clarity is one of the reasons the Department has revisited these regulations, and, upon further consideration, proposes amending this regulation to state that employees of third party employers may not use these exemptions. This proposed amendment, as explained above, is based upon a closer examination of the legislative history and legislative intent, the manner in which the home health care industry has evolved, an attempt to better harmonize the regulations pertaining to companionship, 36 years of enforcement experience, and additional information provided by stakeholders, Members of Congress, and individual states.

Based on the foregoing reasons, the Department proposes to revise § 552.109(a) and (c) to apply the exemptions in §§ 13(a)(15) and 13(b)(21) of the FLSA only to workers employed by the individual, family or household using the worker's services. Further, to address concerns expressed in the legislative history that FLSA compliance would be a burden to the individual, family, or household, the Department believes it is consistent with the statute to maintain the §§ 13(a)(15) and 13(b)(21) exemptions for the individual, family, or household even if they engage the services of a third party employer. Therefore, if the individual, family, or household and the third party agency are joint employers, only the individual, family, or household is still entitled to assert the exemptions. However, regardless of whether a joint employment relationship exists, the exemptions are not available to the third party employer. Thus, all workers employed by a third party, whether solely or jointly, are entitled to the minimum wage and overtime protections of the Act. The Department further notes that if the employee fails to qualify as an exempt companion, such as if the employee performs incidental duties that exceed the 20 percent tolerance allowed under the proposed § 552.6(b), or the employee provides medical care for which training is a prerequisite, the individual, family or household member cannot assert the exemption and is jointly and severally liable for the violation. The proposed revision appropriately limits these exemptions to the scope Congress intended.

Finally, the proposed regulation refers to ''the individual or member of the family or household'' who employs the companion or live-in domestic worker. It is the Department's intent that ''member of the family or household'' be construed broadly, and no specific familial relationship is necessary. For example, a ''member of the family or household'' may include an individual who is a child, niece, guardian or authorized representative, housemate, or person acting *in loco parentis* to the elderly or infirm individual needing companionship or live-in services.

The Department invites comments on the proposed changes to the third party employment regulation, and specifically seeks feedback from home health care workers, organizations, and employers.

D. Live-in Domestic Service Employees (29 CFR 552.102 and 552.110)

The Department proposes revisions to the recordkeeping requirements in 29 CFR part 552 applicable to live-in domestic employees, in order to ensure that employers maintain an accurate record of hours worked by such workers and pay for all hours worked in accordance with the FLSA. Section 13(b)(21) of the Act, provides an overtime exemption for live-in domestic employees; however, such workers remain subject to the FLSA minimum wage protections. Current § 552.102 allows the employer and employee to enter into an agreement that excludes the amount of sleeping time, meal time, and other periods of complete freedom from duty when the employee may either leave the premises or stay on the premises for purely personal pursuits. Paragraph 552.102(a) makes clear that if the free time is interrupted by a call to duty, the interruption must be counted as hours worked. Paragraph 552.102(b) allows an employer and employee who have such an agreement to establish the employee's hours of work in lieu of maintaining precise records of the hours actually worked. The employer is to maintain a copy of the agreement and indicate that the employee's work time generally coincides with the agreement. If there is a significant deviation from the agreement, a separate record should be kept or a new agreement should be reached.

The Department is concerned that not all hours worked are actually captured by such agreement and paid, which may result in a minimum wage violation. The current regulations do not provide a sufficient basis to determine whether the employee has in fact received at least the minimum wage for all hours worked.

Proposed § 552.102(b) would no longer allow the employer of a live-in domestic employee to use the agreement as the basis to establish the actual hours of work in lieu of maintaining an actual record of such hours. Instead, the employer will be required to keep a record of the actual hours worked. Consequently, the language suggesting that a separate record of hours worked be kept when there is a significant deviation from the agreement is deleted. Nonetheless, proposed § 551.102(b) requires entering into a new written agreement whenever there is a significant deviation from the existing agreement.

The Department also proposes to amend § 552.110 with respect to the records kept for live-in domestic employees. Current § 552.110 specifies the recordkeeping requirements for domestic service employees. Paragraph 552.110(b) provides that records of actual hours worked are not required for live-in domestic employees; instead, the employer may maintain a copy of the agreement referred to in § 552.102. It also states that the more limited recordkeeping requirement in this section does not apply to third-party employers and that no records are required for casual babysitters. Paragraph 552.110(c) permits, when a domestic service employee works a fixed schedule, the employer to use the schedule that the employee normally works and either provide some notation that such hours were actually worked or, when more or less hours are actually worked, show the exact number of hours worked. Paragraph 552.110(d) permits an employer to require the domestic service employee to record the hours worked and submit the record to the employer.

For the reasons outlined above, proposed § 552.110(b) will no longer permit an employer to maintain a copy of the agreement as a substitution for recording actual hours worked by the live-in domestic employee. Instead, it requires that the employer maintain a copy of the agreement and maintain records showing the exact number of hours worked by the live-in domestic employee. Proposed § 552.110(b) also makes clear that the provisions of 29 CFR 516.2(c) do not apply to live-in domestic employees, which means that employers of such employees may not maintain a simplified set of records for live-in domestic employees who work a fixed schedule. As a result, § 552.110(c) is revised to clearly state that the provision does not apply to live-in domestic workers. The Department believes that the frequency of schedule changes simply makes reliance on a fixed schedule and noting exceptions too unreliable to ensure an accurate record of hours worked by these employees. In addition, the proposed changes to § 552.109 makes the reference in § 552.110(b) to third-party employers not being able to rely on the simplified recordkeeping requirements moot; consequently, it is removed from proposed § 552.110(b). The proposed regulations also revise § 552.110(d), thus no longer allowing the employer to require the live-in domestic service employee to record the hours worked and submit the record to the employer. As with other employees, the employer is responsible for making, keeping, and preserving records of hours worked and ensuring their accuracy. As is the case now, the Department does not require records for casual babysitters as defined by § 552.5; however, that provision is in a stand-alone paragraph, proposed 29 CFR 552.110(e).

V. Paperwork Reduction Act

The Paperwork Reduction Act of 1995 (PRA), 44 U.S.C. 3501 *et seq.,* and its attendant regulations, 5 CFR part 1320, requires that the Department consider the impact of paperwork and other information collection burdens imposed on the public. Under the PRA, an agency may not collect or sponsor the collection of information, nor may it impose an information collection requirement unless it displays a currently valid Office of Management and Budget (OMB) control number. *See* 5 CFR 1320.8(b)(3)(vi).

This action contains the following proposed amendments to the existing information collection requirements previously approved under OMB Control Number 1235–0018. As required by the Paperwork Reduction Act of 1995 (44 U.S.C. 3507(d), the Department has submitted these proposed information collection amendments to OMB for its review.

Summary: The Department seeks to minimize the paperwork burden for individuals, small businesses, educational and nonprofit institutions, Federal contractors, State, local, and tribal governments, and other persons resulting from the collection of information by or for the agency. The PRA typically requires an agency to provide notice and seek public comments on any proposed collection of information contained in a proposed rule. *See* 44 U.S.C. 3506(c)(2)(B); 5 CFR 1320.8.

The PRA requires all Federal agencies to analyze proposed regulations for potential time burdens on the regulated community created by provisions within the proposed regulations that require the submission of information. These information collection (IC) requirements must be submitted to OMB for approval. Persons are not required to respond to the information collection requirements as contained in this proposal unless and until they are approved by the OMB under the PRA at the final rule stage. This ''paperwork burden'' analysis estimates the burdens for the proposed regulations as drafted. The Department proposes to amend 29 CFR part 552 with respect to the records kept for live-in domestic employees. Proposed 29 CFR 552.102(b) would no longer allow the employer of a live-in domestic employee to use an agreement as the basis to establish hours worked in lieu of maintaining actual record of such hours. Instead, the employer will be required to keep a record of the actual hours worked. Concurrently, proposed 29 CFR 552.110(b) will no longer permit an employer to maintain a copy of an agreement as a substitute for keeping records of hours worked by the live-in domestic employee. Finally, the Department's proposed amendments to 29 CFR part 552 results in fewer employees being exempt from the minimum wage and overtime law. Employers must maintain records of hours worked for employees who are not exempt from minimum wage and overtime pay requirements. Therefore, the number of employees for whom an employer must maintain records of hours worked will increase under the proposed rule. This will increase the burden under 29 CFR part 516, the general recordkeeping regulation under the FLSA.

Circumstances Necessitating Collection: The Fair Labor Standards Act (FLSA), 29 U.S.C. 201 *et seq.,* sets the Federal minimum wage, overtime pay, recordkeeping and youth employment standards of most general application. Section 11(c) of the FLSA requires all employers covered by the FLSA to make, keep, and preserve records or employees and of wages, hours, and other conditions and practices of employment. A FLSA covered employer must maintain the records for such period of time and make such reports as prescribed by regulations issued by the Secretary of Labor. The Department has promulgated regulations at 29 CFR part 516 to establish the basic FLSA recordkeeping requirements. The Department has also issued specific recordkeeping requirements in 29 CFR part 552 which is the subject of this collection. The Department proposes to amend recordkeeping requirements in § 552.102 and § 552.110 regarding agreements for live-in domestic workers. The Department also notes that the proposed amendments to the definition of companion results in fewer employees being exempt from the minimum wage and overtime requirements of the FLSA.

Purpose and Use: The Wage and Hour Division (WHD) and employees use this information to determine whether covered employers have complied with various FLSA requirements. Employers use the records to document FLSA compliance, including showing qualification for various FLSA exemptions.

Technology: The recordkeeping aspect of this collection makes clear that the regulations prescribe no particular order or form of records and employers may preserve records in such forms as microfilm, or automated word or data processing memory is acceptable provided facilities are available for inspection and transcription of the records.

Duplication: This information is not available through any other source.

Minimizing Small Entity Burden: Although this information collection does involve small businesses, including small State and Local government agencies, the Department minimizes respondent burden by requiring no specific order or form of records in responding to this information collection. Moreover, employers would normally maintain the records identified in this information collection under usual or customary business practices.

Agency Need: The Department is assigned a statutory obligation to ensure employer compliance with the FLSA. The Department uses records covered by this information collection to determine compliance with the FLSA.

Special Circumstances: There are no special circumstances associated with this collection.

Public Comments: The Department seeks public comments regarding the burdens imposed by information collections contained in sections 552.102 and 552.110 of this proposed rule. In particular, the Department seeks comments that: Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility; evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used; enhance the quality, utility and clarity of the information to be collected; and minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.,* permitting electronic submissions of responses. Commenters may send their views about these information collections to the Department in the same way as all other comments (*e.g.,* through the regulations.gov Web site). All comments received will be made a matter of public record, and posted without change to *http://www.regulations.gov,* including any personal information provided.

An agency may not conduct an information collection unless it has a currently valid OMB approval, and the Department has submitted the identified information collection contained in the proposed rule to the OMB for review under the PRA under the Control Number 1235–0018. *See* 44 U.S.C. 3507(d); 5 CFR 1320.11. Interested parties may obtain a copy of the full supporting statement by sending a written request to the mail address shown in the **ADDRESSES** section at the beginning of this preamble or by visiting the *http://www.reginfo.gov/public/do/PRAMain* Web site.

In addition to having an opportunity to file comments with the Department, comments about the paperwork implications of the proposed regulations may be addressed to the OMB. Comments to the OMB should be directed to: Office of Information and Regulatory Affairs, Attention OMB Desk Officer for the Wage and Hour Division, Office of Management and Budget, Room 10235, Washington, DC 20503, Telephone: (202) 395–7316/Fax: (202) 395–6974 (these are not toll-free numbers).

Confidentiality: The Department makes no assurances of confidentiality to respondents. As a practical matter, the Department would only disclose agency investigation records of materials subject to this collection in accordance with the provisions of the Freedom of Information Act, 5 U.S.C. 552, and the attendant regulations, 29 CFR part 70, and the Privacy Act, 5 U.S.C. 552a, and its attendant regulations, 29 CFR part 71.

OMB Control Number: 1235–0018.

Affected Public: Businesses or other for profit, not-for-profit institutions.

Total Respondents: 3,493,514.

Total Annual Responses: 43,478,185.

Estimated Burden Hours: 987,778.

Estimated Time per Response: 2 minutes.

Frequency: 24 times annually.

Total Burden Cost (capital/startup): 0.

Total Burden Costs (operation/maintenance): $22,580,605.

VI. Executive Orders 12866 and 13563

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. This rule has been designated a ''significant regulatory action'' because it is economically significant, under section 3(f) of Executive Order 12866, based on the Preliminary Regulatory Impact Analysis (PRIA) presented below. As a result, the OMB has reviewed this proposed rule. The Department also has concluded that this proposed rule is a major rule under the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 *et seq.*).

Preliminary Regulatory Impact Analysis of the Proposed Revisions to the Companionship

Regulations Background

Under Executive Order 12866 (58 FR 51735, October 4, 1993), the Department must determine whether a regulatory action is ''significant'' and therefore subject to OMB review and the requirements of the Executive Order. Executive Order 12866 defines ''significant regulatory action'' as one that is likely to result in a rule that may have ''an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or state, local, or tribal governments or communities; create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or raise novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.'' This proposed rule meets the criteria for a significant regulatory action because it is anticipated to have an annual effect on the economy of $100 million or more. As a result, the rule is submitted to OMB for review.

The provisions of the FLSA apply to all enterprises that have employees engaged in commerce or in the production of goods for commerce and have an annual gross volume of sales made or business done of at least $500,000 (exclusive of excise taxes at the retail level that are separately stated); or, are engaged in the operation of a hospital, an institution primarily engaged in the care of the sick, the aged, or the mentally ill who reside on the premises; a school for mentally or physically disabled or gifted children; a preschool, elementary or secondary school, or an institution of higher education (regardless whether such hospital, institution or school is public or private, or operated for profit or not);

or, are engaged in an activity of a public agency.

There are two ways an employee may be covered by the provisions of the FLSA: (1) Any employee of an enterprise covered by the FLSA is covered by the provisions of the FLSA, and (2) even if the enterprise is not covered, individual employees whose work engages the employee in interstate commerce or in the production of goods for commerce or in domestic service is covered by the provisions of the FLSA. Covered employers are required by the provisions of the FLSA to: (1) Pay employees who are not exempt from the Act's requirements not less than the Federal minimum wage for all hours worked and overtime premium pay at a rate of not less than one and one-half times the employee's regular rate of pay for all hours worked over 40 in a workweek, and (2) make, keep, and preserve records of the persons employed by the employer and of the wages, hours, and other conditions and practices of employment.

In 1974, Congress expressly extended FLSA coverage to ''domestic service'' workers performing services of a household nature in private homes not previously subject to minimum wage and overtime requirements. While domestic service workers are covered by FLSA minimum wage and overtime requirements even though they work for a private household and not a covered enterprise, Congress created exemptions from these requirements for casual babysitters and persons employed in domestic service employment to provide companionship services for individuals who (because of age or infirmity) are unable to care for themselves.[5]

Need for Regulation and Why the Department Is Considering Action

In 1974, Congress extended coverage of the FLSA to many domestic service employees performing services of a household nature in private homes not previously subject to minimum wage and overtime pay requirements. Section 13(a)(15) of the Act exempts from its minimum wage and overtime pay provisions domestic service employees employed ''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).'' Section 13(b)(21) of the FLSA exempts from the overtime pay provision any employee employed ''in domestic service in a household and who resides in such household.''

[5] 29 U.S.C. 202(a), 206(f), 207(l), and 213(a)(15).

Since the 1975 regulations were implemented, the home health care industry has evolved and expanded in response to the increasing size of the population in need of such services, the growing demand for in-home care instead of institutional care for persons of all ages, and the availability of public funding assistance for such services under Medicare and Medicaid. As the industry has expanded, so has the range of tasks performed by workers providing companionship services. The range now includes assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), and paramedical tasks (such as catheter hygiene or changing of aseptic dressings).[6] Public funding programs do not cover services such as social support, fellowship or protection.[7] According to the U.S. Department of Health and Human Services (HHS), ''[s]imple companionship or custodial observation of an individual, absent hands-on or cueing assistance that is necessary and directly related to ADLs and IADLs, is not a Medicaid personal care service.'' [8]

The Department of Labor believes that the current application of the companionship services exemption in the home health care industry is not consistent with the original Congressional intent. The Department proposes to modify the definition of companionship services to exclude personnel who perform functions that require training in the performance of medically-related duties, and to provide only a 20 percent tolerance for intimate personal care services and related household work. As a result, to qualify for the companionship services exemption, workers must spend at least 80 percent of their time in activities that provide fellowship or protection. Those workers who are providing home health care services that exceed the 20 percent tolerance for intimate personal care services and related household work must be paid in accordance with federal minimum wage and overtime requirements.

Objectives and Legal Basis for Rule

Section 13(a)(15) of the FLSA exempts from its minimum wage and overtime pay provisions domestic service employees employed ''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).'' Due to significant changes in the home health care industry over the last 36 years, workers who today provide in-home care to individuals are performing duties and working in circumstances that were not envisioned when the companionship services regulations were promulgated. Section 13(b)(21) provides an exemption from the Act's overtime pay requirements for live-in domestic workers. The current regulations allow an employer of a live-in domestic worker to maintain a copy of the agreement of hours to be worked and to indicate that the employee's work time generally coincides with that agreement, instead of requiring the employer to maintain an accurate record of hours actually worked by the live-in domestic worker. The Department is concerned that not all hours worked are actually captured by such agreement and paid, which may result in a minimum wage violation. The current regulations do not provide a sufficient basis to determine whether the employee has in fact received at least the minimum wage for all hours worked.

[6] PHI, 2010a. Background Report on the U.S. Home Care and Personal Assistance Workforce and Industry (Forthcoming). P. 22.

[7] PHI, 2010a. p. 22.

[8] ''Understanding Medicaid Home and Community Services: A Primer,'' Gary Smith, Janet O'Keefe, Letty Carpenter, Pamela Doty, Gavin Kennedy, Brian Burwell, Robert Mollica and Loretta Williams, George Washington University, Center for Health Policy Research, October 2000.

The Department has re-examined the regulations and determined that the regulations, as currently written, have expanded the scope of the companionship services exemption beyond those employees whom Congress intended to exempt when it enacted § 13(a)(15) of the Act, and do not provide a sufficient basis for determining whether live-in workers subject to § 13(b)(21) of the Act have been paid at least the minimum wage for all hours worked. Therefore, the Department proposes to amend the regulations to revise the definitions of ''domestic service employment'' and ''companionship services,'' and to require employers of live-in domestic workers to maintain an accurate record of hours worked by such employees. In addition, the proposed regulation would limit the scope of duties a companion may perform, and would prohibit employees of third-party employers from claiming the exemption.

Summary of Impacts

The Department projects that the average annualized cost of the rule will total about $4.7 million per year over 10 years. In addition to the direct cost to employers of the rule, there are also transfer effects resulting from the rule. The primary impacts of the rule are

income transfers to home health care workers in the form of: increased hourly wages to reach minimum wage (about $16.1 million in the first year, negligible thereafter); payment for time spent traveling between patients (average annualized value of $34.7 million per year); and payment of an overtime premium when hours worked exceed 40 hours per week. Because overtime payments depend on how employers adjust scheduling to eliminate or reduce overtime hours, the Department considered three adjustment scenarios resulting in payment of: 100 percent of current overtime hours worked (average annualized value of $180.7 million per year); 50 percent of current overtime hours worked (average annualized value of $90.4 million per year); or no payment of overtime. On the basis of previous evidence on the impact of overtime pay, the Department judges that overtime payments in the range of scenarios 2 and 3 are more likely than scenario 1.

Although the transfer of income to workers in the form of higher wages is not considered a cost of the rule from a societal perspective, higher wages do increase the cost of providing home health care services, resulting in the provision of fewer services. This reduction in the provision of services causes the market to function less efficiently, and this allocative inefficiency is a cost from a societal perspective. With a 3% real rate, the Department measures the range of average annualized deadweight loss attributable to this allocative inefficiency as $105,000 when no overtime pay adjustment is assumed, $36,000 when 50% of overtime pay is assumed to adjust and $3,000 when a 100% adjustment in overtime pay is assumed. The relatively small deadweight loss primarily occurs because both the demand for and supply of home health care services appear to be inelastic—that is, the equilibrium quantity of companionship services is not very responsive to changes in price, possibly due to the importance of these services and the coverage of many companionship services by Medicare and Medicaid. Table 1 summarizes the projected costs, transfer effects and impacts of the proposed revisions to the FLSA.

TABLE 1—SUMMARY OF IMPACT OF PROPOSED CHANGES TO FLSA

	Year 1 ($ mil.)	Years 2–10 ($ mil.)[a]		Average Annualized Value ($ mil.) 3% Real Rate	Average Annualized Value ($ mil.) 7% Real Rate
Costs					
Regulatory Familiarization Agencies	$3.9	$0.3	$0.3	$0.7	$0.8
Families Hiring Self-employed	6.0	3.2	4.0	3.8	3.9
Total Costs	9.9	3.5	4.4	4.6	4.7
Transfers					
Minimum Wages (MW)					
To Agency-Employed Workers	13.0	0.0[b]	0.0[b]	1.5	1.7
To Self-Employed Workers	3.1	0.0[b]	0.0[b]	0.4	0.4
Travel Wages	26.7	27.8	45.8	35.4	34.7
Overtime Scenarios					
OT 1	139.3	144.8	238.8	184.2	180.7
OT 2	69.7	72.4	119.4	92.1	90.4
OT 3	0.0	0.0	0.0	0.0	0.0
Total Costs and Transfers by Scenario					
Reg Fam + MW + Travel + OT 1	192.1	176.2	289	226	222.2
Reg Fam + MW + Travel + OT 2	122.4	103.8	169.6	133.9	131.9
Reg Fam + MW + Travel + OT 3	52.7	31.4	50.2	41.8	41.5
Deadweight Loss					
Reg Fam + MW + Travel + OT 1	0.103	0.080	0.132	0.105	0.103
Reg Fam + MW + Travel + OT 2	0.042	0.027	0.044	0.036	0.036
Reg Fam + MW + Travel + OT 3	0.008	0.002	0.004	0.003	0.003
Disemployment (number of workers)					
Reg Fam + MW + Travel + OT 1	793	739	1,169	938[c]	
Reg Fam + MW + Travel + OT 2	505	435	686	544[c]	
Reg Fam + MW + Travel + OT 3	218	132	203	172[c]	

[a] These costs are a range where the first number represents the estimate for Year 2; the second estimate for Year 10.
[b] 2010 statistics on PCA and HHA wages indicate that few workers, if any, are currently paid below minimum wage (*i.e.* in no state is the 10th percentile wage below $7.25 per hour). See the BLS Occupational Employment Statistics, 2010 state estimates, at URL: *http://stats.bls.gov/oes/.*
[c] Simple average over 10 years.
Columns may not sum to totals due to rounding.

State Law Requirements

In evaluating the economic impact of the proposed rule, it is important to consider the current wage requirements for home health care workers. There are numerous state laws pertaining to home health care workers. The State Medicaid Manual requires states to develop qualifications or requirements (such as background checks, training, age, supervision, health, literacy, or

education, or other requirements) for Medicaid-financed personal care attendants. These state programs can each have multiple delivery models, with care being agency-directed or consumer-directed with care given by agencies or independent providers. These delivery models are not necessarily mutually exclusive. In general, for the purposes of this analysis, we refer to independent providers as workers providing services through informal arrangements, and therefore they are not counted in the statistics on home health care providers used as the basis for this analysis.

A 2006 report by the HHS Office of the Inspector General (OIG) found that states have established multiple sets of worker requirements that often vary among the programs within a state and among the delivery models within programs, resulting in 301 sets of requirements nationwide.[9] Four of the consumer-directed programs in the OIG review had no attendant requirements.

Furthermore, states define these requirements differently, and specify different combinations of requirements in different programs. The most common requirements, and some characterization of how these might be defined by different programs, include:

- *Background Checks.* May include the following: criminal background checks; checks of abuse or neglect registries; and checks of Federal or State exclusion lists for previous fraudulent or abusive activities.
- *Training.* May include the following: First aid or cardiopulmonary resuscitation (CPR); basic health knowledge (*e.g.,* food and nutrition, blood-borne pathogens, hygiene, universal precautions); assistance with daily living activities (*e.g.,* patient transfer techniques, proper patient bathing and showering techniques, and grooming); program orientation (*e.g.,* beneficiary rights and responsibilities, safety, behavioral issues, patient confidentiality); training specific to an individual beneficiary's needs; or other training.
- *Supervision.* Might be performed by registered or licensed practical nurses (RN or LPN); home health or personal care service agency staff; case managers; other qualified staff or individuals; or the beneficiary.
- *Minimum Age.* Most commonly set at 18-years-old, but in some states might be 14-years-old, 19-years-old, or of ''legal working age.''
- *Health.* May include the following: Test negative for tuberculosis; be able to perform the services in the plan of care; meet an established minimum level of physical ability (*e.g.,* able to lift a certain weight or stand for a certain time); be free of communicable disease; pass a physical examination; or drug test.
- *Education/Literacy.* Minimum requirements might include: An ability to read and write adequately to follow instructions or to keep records; a General Education Diploma (GED) or high school diploma; completed a certain grade; be a Certified Nursing Assistant (CNA) or a home health aide; have a Homemaker/Personal Care Service Provider certification issued by the state; be able to communicate with the beneficiary and/or supervisory staff; pass a competency test or have previous experience; have the skills, knowledge, and abilities necessary to perform the services needed; be able to meet the needs of the beneficiary; or be mature and sympathetic.
- *Other.* Might be required to: Have a Social Security number; have an identification card; be a U.S. citizen; or meet state motor vehicle requirements if providing transportation.

The number of states that included each requirement in at least one program and the number of state program sets that include each requirement are summarized in Table 1–1.

TABLE 1–1—SIX MOST COMMON ATTENDANT REQUIREMENTS

Requirement	Number of states that utilized requirement in at least one program	Number of sets containing requirement (of 301 sets)
Background Checks	50	245
Training	46	227
Age	42	219
Supervision	43	198
Health	39	162
Education/Literacy	31	125

Source: DHSS OIG, 2006. p. 9.

States' laws also vary in whether they extend minimum wage and overtime provisions to home health care workers. In many states companions or home health care workers are not explicitly named in the regulations, but often fall under those regulations that apply to domestic service employees.

- 16 states extend both minimum wage and overtime coverage to most home health care workers who would otherwise be excluded under the current regulations: California, Colorado, Hawaii, Illinois, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Jersey, New York, Pennsylvania, Washington, and Wisconsin. However, in some states certain types of these workers remain exempt, such as those employed directly by households or by non-profit organizations. Additionally, New York's overtime law provides that workers who are exempt from the FLSA and employed by a third-party agency need only be paid time and one-half the minimum wage (as opposed to time and one-half of the worker's regular wage). Minnesota's overtime provision applies only after 48 hours of work.
- Five states (Arizona, Nebraska, North Dakota, Ohio, and South Dakota) and the District of Columbia extend minimum wage, but not overtime coverage to home care workers. There are again some exemptions for those workers employed directly by households or who live in the household.
- 29 states do not include home health care workers in their minimum wage and overtime provisions: Alabama, Alaska, Arkansas, Connecticut,

[9] U.S. Department of Health and Human Services (HHS) Office of the Inspector General (OIG). States' Requirements for Medicaid-Funded Personal Care Service Attendants, available at *http://oig.hhs.gov/oei/reports/oei-07-05-00250.pdf.* (2006).

Delaware, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Mississippi, Missouri, New Hampshire, New Mexico, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia, and Wyoming.[10]

Of the 22 jurisdictions that extend minimum wage to at least some home health care workers, 12 have a state minimum wage that is higher than the current federal minimum wage of $7.25 an hour.[11] These state laws are summarized in Table 1–2.

TABLE 1–2—STATE MINIMUM WAGE AND OVERTIME COVERAGE OF NON-PUBLICLY EMPLOYED COMPANIONS

State	State minimum wage [a]	MW	OT	Neither	Analysis and citations [b]
AL				x	
AK	$7.75			x	
AZ	7.35	x			Minimum wage but no overtime coverage for companions as defined in the FLSA. No state overtime law. See Ariz. Rev. Stat. Ann. §§ 23–362, 23–363; see also Office of the Attorney General of the State of Arizona, Opinion No. I07–002 (Feb. 7, 2007).
AR	6.25			x	
CA	8.00	x			All companions as defined in the FLSA are entitled to minimum wage. California's overtime rules create in terms of overtime four categories of workers who provide home care. (1) Those who are employed by non-profits and do no additional work beyond feeding, dressing, and supervising the person do not receive overtime. (2) Those who are employed by non-profits but do additional work beyond feeding, dressing, and supervising do receive overtime. (3) All for-profit workers receive overtime regardless of their job description. (4) County-employed home care worker, of whom there are approximately 367,000, receive up to $11.50 an hour straight time per their union contracts and may also receive overtime under those contracts. Industrial Welfare Commission Order No. 5–2001, "Judge Orders State to Halt Wage Cut for California Home Care Workers, *http://www.seiu.org/2009/06/judge-orders-state-to-halt-wage-cut-for-california-home-care-workers.php* (last visited Jun. 28, 2011); PHI, 2010a. p. 14.
CO	7.36	x	x		Minimum wage and overtime coverage for third-party-employed home care workers who do work beyond Colorado's definition of "companion." Colorado's definition of "companion" is much narrower than the FLSA definition. Companions may not help to bathe and dress the person, do any amount of housekeeping, or remind the person to take medication. People who do those tasks are more than just "companions" they are "personal care" attendants. Personal care attendants are entitled to minimum wage and overtime. However, PCAs employed directly by private households are exempt from minimum wage and overtime. Colorado Minimum Wage Order No. 26 § 5; 7 Colo. Code Regs. § 1103–1:5.
CT	8.25			x	
DE	7.25			x	
DC	8.25	x			Minimum wage for companions as defined in the FLSA. D.C. Mun. Regs. tit. 7, § 902.1, 902.3, 902.4 (West 2011).
FL	7.25			x	
GA	5.15			x	
HI	7.25	x	x		Minimum wage and overtime coverage for companions as defined in the FLSA, but exemption for those employed directly by private households. Haw. Rev. Stat. § 387–1.
ID	7.25			x	

[10] National Employment Law Project (NELP). 2011. Fair Pay for Home Care Workers, available at *http://www.nelp.org/page/-/Justice/2011/FairPayforHomeCareWorkers.pdf?nocdn=1.*

[11] U.S. Department of Labor (DOL). 2011. Minimum Wage, available at *http://www.dol.gov/dol/topic/wages/minimumwage.htm.*

TABLE 1–2—STATE MINIMUM WAGE AND OVERTIME COVERAGE OF NON-PUBLICLY EMPLOYED COMPANIONS—Continued

State	State minimum wage [a]	MW	OT	Neither	Analysis and citations [b]
IL	$8.25	x	x		Minimum wage and overtime coverage for any person whose primary duty is to be a companion for individual(s) who are aged or infirm or workers whose primary duty is to perform health care services in or about a private home. There may be an exemption for those employed solely by private households as a result of a general exemption for employers with fewer than four employees. 820 Ill.Comp. Stat. § 105/3(d); Ill. Adm. Code § 210.110.
IN	7.25			x	
IA	7.25			x	
KS	7.25			x	
KY	7.25			x	
LA				x	
ME	7.50	x	x		Minimum wage and overtime coverage for all companions as defined in the FLSA. No relevant exemptions. Me. Rev. Stat. Ann. tit. 26, §§ 663, 664.
MD	7.25	x	x		Minimum wage coverage for all companions as defined in the FLSA. Overtime coverage for most home care workers but exemption for workers employed by non-profit agencies that provide "temporary at-home care services". Md. Code Ann., Lab. & Empl. § 3–415.
MA	8.00	x	x		Minimum wage and overtime coverage for all companions as defined in the FLSA. No relevant exemptions. Mass. Gen. Laws Ch. 151, § 1.
MI	7.40	x	x		Minimum wage and overtime coverage for companions as defined in the FLSA, but exemption for live-in workers. Mich. Comp. Laws § 408.394(2)(a). Exemption for workers employed solely by private household as a result of exemption for employer with fewer than two employees. Mich. Comp. Laws § 408.382(c).
MN	6.15 or 5.25 for employers grossing under $625,000 per year.	x	x		Minimum wage and overtime coverage after 48 hours for all companions as defined in the FLSA, but nighttime hours where companion is available to provide services but does not actually do so need not be compensated. Minn. Stat. § 177.23(11).
MS				x	
MO	7.25			x	
MT	7.35	x	x		Minimum wage and overtime coverage for companions as defined in the FLSA, but exemption for those employed directly by private households. Mont. Code. Ann. § 39–3–406(p).
NE	7.25	x			Minimum wage but no overtime coverage for companions as defined in the FLSA. No state overtime law. De facto exemption for most households as a result of general exemption for employers with fewer than four employees. Neb. Rev. Stat. §§ 48–1202, 48–1203.
NV	8.25	x	x		Minimum wage and overtime coverage for companions as defined in the FLSA, but exemption for live-in workers. Also, business enterprises with less than $250,000 annually in gross sales volume need not pay overtime. Nev. Rev. Stat. § 608.250(2)(b).
NH	7.25			x	
NJ	7.25	x	x		Minimum wage and overtime coverage for all companions as defined in the FLSA. No relevant exemptions. N.J. Stat. Ann.§ 34:11–56a *et seq.*
NM	7.50			x	
NY	7.25	x	x		Minimum wage coverage for all companions as defined in the FLSA. N.Y. Labor Law § 651(5). There is overtime coverage for all companions but those employed by third party agencies receive overtime at a reduced rate of 150% of the minimum wage (rather than the usual 150% of their regular rate of pay). N.Y. Labor Law §§ 2(16), 170; N.Y. Comp. Codes R. & Regs. tit. 12, § 142–2.2. Overtime coverage for live-in workers after 44 hours/week (rather than the usual 40 hours) at the same rates detailed above. *Id.*

TABLE 1–2—STATE MINIMUM WAGE AND OVERTIME COVERAGE OF NON-PUBLICLY EMPLOYED COMPANIONS—Continued

State	State minimum wage [a]	MW	OT	Neither	Analysis and citations [b]
NC	7.25			x	
ND	7.25	x			Minimum wage but no overtime coverage for companions as defined in the FLSA. However, companions who are certain first or send-degree relatives of the person receiving care do not receive minimum wage. Additionally, nighttime hours where companion is available to provide services but does not actually do so need not be compensated. N.D. Cent. Code § 34–06–03.1.
OH	7.40			x	Minimum wage but not overtime coverage for companions as defined in the FLSA. Ohio Rev. Code Ann. § 4111.03 (A) § 4111.14 (West 2011). Additional overtime exemptions for live-in workers. *Id.* § 4111.03(D)(3)(d).
OK	7.25			x	
OR	8.50			x	
PA	7.25	x	x		Minimum wage and overtime coverage for companions as defined in the FLSA, but exemption for those employed solely by private households. Pa. Stat. Ann. tit. 43, § 333.105(a)(2). *Bayada Nurses* v. *Commonwealth of Pennsylvania,* 8 A.3d 866 (Pa. 2010).
RI	7.40			x	
SC				x	
SD	7.25	x			Minimum wage but no overtime coverage for companions as defined in the FLSA. No state overtime law. S.D. Codified Laws §§ 60–11–3, 60–11–5.
TN				x	
TX	7.25			x	
UT	7.25			x	
VT	8.15			x	
VA	7.25			x	
WA	8.67	x	x		Washington minimum wage and overtime coverage for most companions as defined in the FLSA, but exemption for live-in workers. Wash. Rev. Code § 49.46.010(5)(j).
WV	7.25			x	
WI	7.25	x	x		Minimum wage and overtime coverage for most companions as defined in the FLSA, but overtime exemption for those employed directly by private households, Wis. Admin. Code § 274.015, and those employed by non-profit organizations. Wis. Admin. Code §§ 274.015, 274.01. Companions who spend less than 15 hours a week on general household work and reside in the home of the employer are also exempt from minimum wage. Wis. Admin. Code § 272.06(2).
WY	5.15			x	

Abbreviations: MW = Minimum Wage, OT = Overtime, FLSA = Fair Labor Standards Act.
Sources: [a] DOL, 2011; [b] NELP, 2011.

Data Sources

The primary data services used by the Department to estimate the number of workers, establishments, and customers likely to be impacted by the proposed rule include:

- Bureau of Labor Statistics (BLS) 2009 Occupational Employment Survey, employment and wages by state for SOC codes 39–9021 (Personal Care Aides) and 31–1011 (Home Health Aides);
- BLS Quarterly Census of Employment and Wages, 2009 for NAICS 6216 and 62412;
- BLS National Employment Matrix, 2008;
- 2007 Statistics of U.S. Businesses, for NAICS 6216 and 62412; and
- 2007 Economic Census, by state for NAICS 6216 and 62412.

The key limitation of this set of data sources is that it results in an inconsistency between the Department's best estimate of agency-employed caregivers (from the 2009 BLS Occupational Employment Survey), and its best estimate of independent providers directly employed by families (from the 2008 BLS National Employment Matrix). The Occupational Employment Survey (OES) is employer based, and does not collect data from the self-employed. The National Employment Matrix (NEM) obtains estimates on the self-employed from the Current Population Survey. However, it is not possible to match the OES estimates by subtracting the estimated number of self-employed workers from the NEM. Because these two estimates cannot be completely reconciled, the Department uses each source as the best estimate for one segment of the labor market and acknowledges there is some inconsistency between the two.

Care Recipients and Demand for Services

Demand for home health care services is anticipated to continue to grow in the

next few decades with the aging of the ''baby boomer generation.'' According to PHI:

Nearly one out of four U.S. households provides care to a relative or friend aged 50 or older and about 15 percent of adults care for a seriously ill or disabled family member. Over the next two decades the population over age 65 will grow to more than 70 million people [the U.S. population 65 years and older was estimated at 40 million in 2009 [12]]. Additionally, with significant increases in life expectancy and medical advances that allow individuals with chronic conditions to live longer, the demand for caregiving is expected to grow exponentially. The growth in the demand for in-home services is further amplified by an increasing preference for receiving supports and services in the home as opposed to institutional settings. This emphasis has been supported by the increased availability of publicly funded in-home services under Medicaid and Medicare as an alternative to traditional and increasingly costly institutional care.[13]

While many recipients of home health care services are elderly, about two-fifths of those in need of these services are under 65 and include those with varying degrees of mental or developmental disabilities. This group of home health care recipients is also anticipated to grow rapidly as more individuals opt for home-based care over institutional settings.[14] It is estimated that the demand for home health care workers will grow to approximately 5.7 to 6.6 million workers in 2050, an increase in the current demand for workers of between 3.8 and 4.6 million (200 percent and 242 percent respectively).[15] The home health care industry has grown significantly over the past decade and is projected to continue growing rapidly; for example:

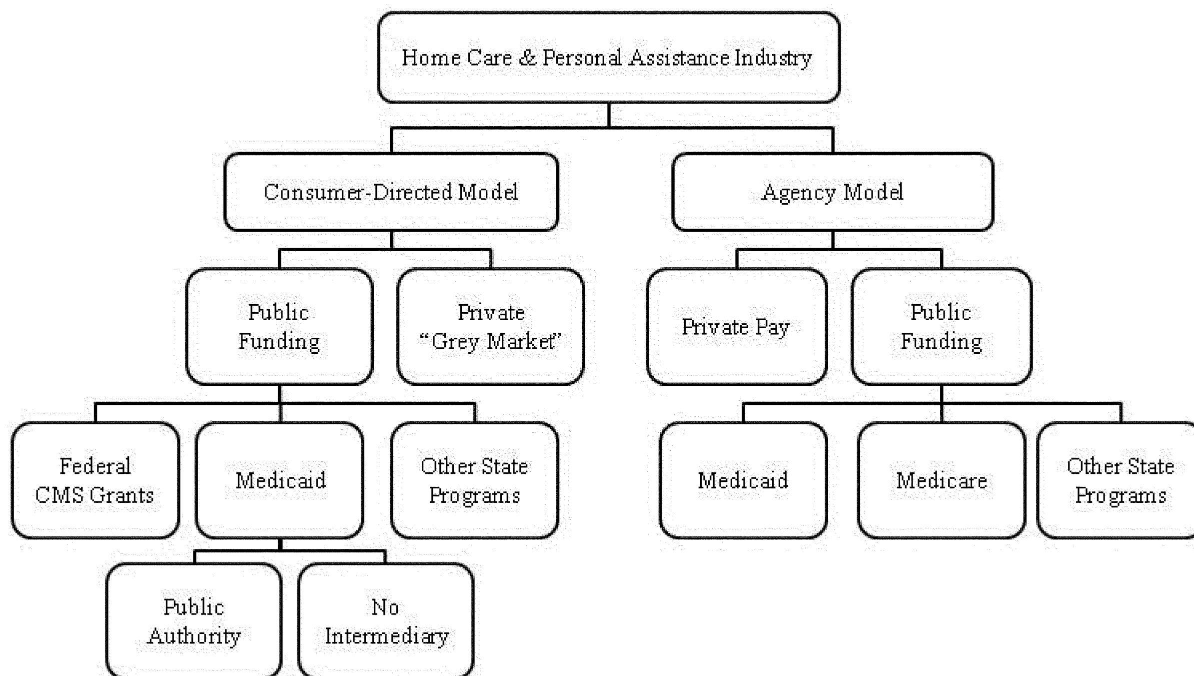
- The number of establishments in Home Health Care Services (HHCS) grew by 70 percent between 2001 and 2009; during that same period, the number of establishments in Services for the Elderly and Persons with Disabilities (SEPD) grew by 355 percent.[16]
- Between 2008 and 2018 the number of home health aides is projected to increase by 50 percent and the number of personal care aides by 46 percent.

Employers and Funding Sources

This section focuses on the employers of workers who are currently classified as companions and common sources of funding for the services they provide; the next section describes the workers and the work they do. Services in the home health care industry are provided through two general delivery models: Agencies and consumer-directed (which often use independent providers and family caregivers).

Figure 2 provides a visual overview of the home care and personal assistance industry and the two primary models for service provision, which are discussed in more detail in the sections that follow.

Figure 2. Overview of the Home Health Care Industry and Funding Sources



Agency Model

Under the agency model a third-party provider of home care and personal assistance services (usually a home health care company) employs the home care workers and is responsible for ensuring that services authorized by a public program or contracted for by a private party are in fact delivered.[17] There are currently about 73,000 establishments providing these services. The services are paid for through public programs such as Medicaid, Medicare, and other state programs, and through private sources such as private health

[12] 2011 Statistical Abstract, U.S. Census Bureau.

[13] National Alliance for Caregiving and the American Association of Retired Persons. 1997. Family caregiving in the U.S.: Findings from a national study. Available from *http://www.caregiving.org.*

[14] PHI, 2003. The Personal Assistance Services and Direct-Support Workforce: A Literature Review, available at *http://www.directcareclearinghouse.org/download/CMS_Lit_Rev_FINAL_6.12.03.pdf.*

[15] HHS, 2001. Pgs. 4, 5, and 7.

[16] U.S. Bureau of Labor Statistics (BLS). 2008. National Employment Matrix—Search by Occupation, available at *http://data.bls.gov/oep/nioem?Action=empios&Type=Occupation.*

[17] Seavey and Marquand, 2011, pg. 26. Available at: *http://www.directcareclearinghouse.org/download/caringinamerica-20111212.pdf.*

insurance or out-of-pocket payments. In 2009, public programs (Medicare, Medicaid, and other government spending) accounted for about 75 percent ($63.1 billion) of the $84.1 billion in annual revenue dispersed to these agencies.[18]

Agencies providing home care and personal assistance services are covered by two primary industries: Home Health Care Services (HHCS, NAICS 6216), and Services for Elderly and Persons with Disabilities (SEPD, NAICS 62412).[19] HHCS is dominated by for-profit agencies that are Medicare-certified and depends on public programs for three-quarters of its revenue.[20] SEPD is a rapidly growing industry that is dominated by small non-profit enterprises. Table 2–1 provides an overview of these two industries in terms of number of employees, establishments, payroll and wages, and estimated revenues.

TABLE 2–1—SUMMARY OF HHCS AND SEPD, 2009

Industry	Employees [a]	Establishments	Total wages ($ mil.)	Avg weekly wage	Est. revenue ($ mil.)
SEPD + HHCS	1,714,000	73,200	$413,181	$464	$80,307
SEPD	679,600	49,100	133,247	377	28,645
HHCS	1,034,400	24,100	279,934	520	51,662

[a] Employees include HHA, PCA, and other occupations.
Sources: BLS QCEW 2009; BLS National Employment Matrix, 2008.

These two industries primarily employ workers as home health aides (HHA) and personal care aides (PCA) in addition to other occupations. However, not all of the HHA and PCA employed by these agencies work as companions under the companionship exemption; these agencies provide a variety of health-related services that may be delivered in private homes (and potentially companionship services) or in public or private facilities (and not defined as companionship services). Simply put, only a fraction of the 1.7 million employees listed in the table above are currently working as exempt companions who may see changes in their wages and/or work schedules as a result of the proposed rule.

Within these two industries there are three broad employer types: Home health care companies, for-profit franchise chains, and private-duty home care companies. The latter two types are smaller, emerging types of employers that focus on the provision of non-medical care for clients. Home health care companies focus on providing medically-oriented home health care services and non-medical home care or personal assistance services. Many of these agencies are Medicare-certified; those that avoid obtaining certification do so because they do not provide the skilled nursing care required by Medicare. These companies also derive a significant portion of their revenue from the provision of medical devices to customers.[21]

Consumer-Directed Models

Under the consumer-directed model, the consumer or his/her representative has more control than in the agency-directed model over the services received, and when, how, and by whom the services are provided. The approaches to delivering services under this model range from the more formal state-organized systems to informal arrangements coordinated through word-of-mouth between care recipients. In the public version of this model, the care is funded either by Medicaid, directly by states, or through programs or grants administered by the HHS Centers for Medicare & Medicaid Services (CMS).

Other recipients arrange for and pay for care privately through informal negotiations with individual service providers. In this model, the customer may act as the sole or a joint employer and has varying degrees of responsibility for interviewing, hiring, training, managing, and firing the provider. Due to the sometimes informal nature of the consumer-directed employment arrangements, there are no data on the total number of customers under this model, and there is limited information on the total number of providers. BLS National Employment Matrix data show that 127,000 Personal Care Aides (about 16 percent) are employed in private households and 61,500 (about 8 percent) are self-employed, for a total of 188,500 workers (about 23 percent) that may provide services as independent contractors.[22] Fewer Home Health Aides are employed in this manner, with 1,700 (less than one percent) working for private households and 16,400 (about two percent) who are self-employed. Combining the data for Personal and Home Health Aides suggests that 206,600 of these workers (about twelve percent) may be either self-employed or employed in private households. The Department believes that these workers can reasonably be described as independent providers that directly provide caregiver services to families, perhaps through informal arrangements.

However, consumer-directed employment is sometimes referred to as a "grey market;" that contains an element of "over-the-back-fence network of women [who are] usually untrained, unscreened, and unsupervised, but more affordable without an agency's fee, less constrained by regulations and hired through personal recommendation." [23] The term "grey market" is sometimes used to suggest that at least some of these private arrangements are designed to avoid applicable labor laws; the extent to which care recipients use private arrangements for this purpose is unclear; there is very little information available about this segment of the market for home health services. It is also possible, and likely, that care providers who are employed by an agency or who provide services through a state registry also occasionally provide services through informal arrangements. The Department's best estimate of consumer-directed employment is

[18] Seavey and Marquand, 2011, pgs 22, 23. Available at: *http://www.directcareclearinghouse.org/download/caringinamerica-20111212.pdf.*

[19] These two industries are the primary employers of workers currently classified as companions; however, based on data reported by BLS in the National Employment Matrix there are approximately 25 other industries that also employ these workers. Since these other industries employ so few of the workers under consideration here they will be minimally affected by this proposed rule.

[20] Seavey and Marquand, 2011, pgs 20–22. Available at: *http://www.directcareclearinghouse.org/download/caringinamerica-20111212.pdf.*

[21] PHI, 2010a. p.2.

[22] BLS, 2008.

[23] Gross, J., *New Options (and Risks) in Home Care for Elderly.* New York Times available at *http://nytimes.com/2007/03/01/us/01aides.html.* (March 1, 2007).

summarized in the previous paragraph, and we are unable to estimate the extent to which the group of providers described above participates in the informal market. We are also unable to characterize the extent to which other providers not included in this estimate participate in the ''grey market.''

There is no consolidated source of data on state consumer-directed programs; however, PHI offers an overview of what programs are offered: Seven states have no publicly-funded consumer-directed program, 38 states offer options under one or more Medicaid Waivers, seven states offer options under Medicaid Home Health programs, and 12 states offer consumer/participant-directed options under Medicaid Personal Care Option.[24]

Of those states that do offer a consumer-directed program, some have implemented a ''public authority'' model. In this model, a public authority or some other governmental or quasi-governmental entity plays a role in setting compensation and other employment terms for the service provider, who is compensated through public funds, acts as the ''employer-of-record,'' and may provide training, and create and maintain registries of providers.[25] Service providers in this system have the option to select representatives for collective bargaining with the state. Six states (California, Massachusetts, Michigan, Oregon, Washington, and Wisconsin) have fully implemented a public authority, and Missouri is in the process of doing so. Several states have implemented a consumer-directed program without creating a public authority, they include: Illinois, Iowa, Maryland, and Ohio.

California's policies are of particular note because it has one of the largest home care caseloads. This is due to a combination of demographic factors and a robust social movement of the disabled community that created Centers for Independent Living in the 1970s.[26] California's In-Home Supportive Services (IHSS) program was created in 1973. IHSS is the largest personal care program in the nation and is funded through a combination of state, county, and federal Medicaid funds.[27] A 2000 study of independent home care workers found that IHSS employed more than 200,000 independent personal care workers through IHSS, 72,000 in Los Angeles County alone.

IHSS initially allowed counties to organize the service in different ways, and each had a different approach to employing the worker. Under the individual provider model, the consumer hired the worker and the worker was considered an independent contractor, with the state paying for the service and social workers allocating hours. Under the county model, the worker was a government employee. Under the contract model, the county contracted with an agency which became the employer.[28] Ambiguity about who was really employing IHSS workers continued in the following decades. In 1985, California's attorney general determined that IHSS attendants came under state workers' compensation and other labor laws, and were county employees for purposes of collective bargaining. However in *Service Employees International Union, Local 434* v. *County of Los Angeles,* the court found IHSS workers to be independent contractors because the counties did not control their activities directly.[29] In 1992, California began to establish county-based public authorities. Under the public authority model, workers are no longer self-employed, and the employer responsibilities are split between the public authority (which serves as the employer in collective bargaining with the union) and the consumer (who is responsible for the selecting, hiring, and supervising of workers).[30] Today there are approximately 367,000 home care workers employed by the California public authority.[31]

In an effort to connect participants in consumer-directed programs with care providers, some states and public authorities have created matching registries; these systems provide some insight into how consumers identify care providers to meet their needs. Depending on the registry, consumers can either search the worker database online, or speak to trained staff who conduct the search and report the results to the consumer. Some registries may also offer worker screening and orientation, access to consumer and worker training, and recruitment and outreach to potential workers.[32] Others stipulate that providers in the database have not been pre-screened in any way and such responsibilities lie with the consumer. The PHI Matching Services Project[33] has identified 16 state-based matching services and six states with regional matching services. Of the 16 state-based matching services, five (California, Massachusetts, Michigan, Oregon, and Washington) operate under a public authority. Wisconsin's registry, which also operates under a public authority, is currently regional but scheduled to become state-wide in 2011. These registries are listed in Table A–1 in APPENDIX A. PHI notes that these public matching registries are not to be confused with the registries that exist in all states to perform criminal background checks on potential care providers or verify nursing training.

The Department also located registries operated by not-for-profit organizations, such as the Meals on Wheels of Contra Costa County Home Care Registry,[34] where the registry recruits, screens, and checks the references of local care providers, but the care providers are self-employed and work as independent contractors. Various private sector entities that refer to themselves as registries,[35] [36] [37] [38] however, appear to be operating under an agency or quasi-agency model, with the care recipient paying the company a weekly or bi-weekly registry fee in addition to paying the caregiver, or with the company receiving some portion of the caregiver's hourly rate.

When consumers are allowed to hire any worker they choose, many choose friends or family members. For instance, the Cash and Counseling demonstration program provides a monthly allowance to Medicaid beneficiaries that beneficiaries can use to hire their choice of worker. In this program, 58 percent

[24] Seavey and Marquand, 2011, pg 28. Available at: *http://www.directcareclearinghouse.org/download/caringinamerica-20111212.pdf.*

[25] PHI, 2010a. p. 14.

[26] Boris, E. & Klein, J. 2006. Organizing home care: Low-waged workers in the welfare state, available at *http://escholarship.org/uc/item/21x6q48g;jsessionid=197876DF1E12B3D17476457ED5FE5E24#page-6.*

[27] PHI, 2010b. California's Direct-Care Workforce. Available at *http://www.directcareclearinghouse.org/download/CA%20Fact%20Sheet-%2011-04-10.pdf.*

[28] Boris & Klein, 2006.

[29] Boris & Klein, 2006.

[30] PHI, 2011b. California Direct Care Workforce Initiatives,. available at *http://www.directcareclearinghouse.org/s_state_det1.jsp?res_id=5&action=null.*

[31] PHI, 2010a.

[32] PHI, 2011a. The PHI Matching Services Project, available at *http://phinational.org/policy/the-phi-matching-services-project/.*

[33] PHI, 2011a.

[34] Meals on Wheels of Contra Costa County. 2011. Home Care Registry, available at *http://www.mowsos.org/pages/page.php?pageid=48.*

[35] Experienced Home Care Registry. 2011. About Us, available at *http://www.experiencedhomecare.com/pgs/about_us.php.*

[36] Angelic Nursing & Home Care Registry, Inc. 2011. Home Care Services for Seniors in Tolland and Hartford Counties in Connecticut, available at *http://angelicregistry.com/.*

[37] Golden Care Co. Inc. 2011. Billing Policy, available at *http://www.goldencareco.com/billing.asp.*

[38] American HealthCare Capital. 2011. $1.5 Million Oregon Private Pay Homecare Registry for Sale, available at *http://www.americanhealthcarecapital.com/Listings/Current/orpd1a.html.*

of directly hired workers in Florida, 71 percent in New Jersey, and 78 percent in Arkansas were related to the consumer, and about 80 percent of those directly hired workers had provided unpaid care to the consumer before the demonstration began.

Since the passage of the National Family Caregiver Support Program enacted under the Older Americans Act Amendments of 2000, Medicaid waivers and state-funded programs have provided the bulk of public financing to support family caregiving.[39] A survey of state consumer direction and family caregiving programs found that:

Over one-half (86 out of 150, or 57 percent) of the programs in 44 states and the District of Columbia say family members can be paid to provide care. Viewed another way, the vast majority of programs that offer some component of consumer direction, allow payment to relatives to provide care (86 out of 106 programs, or 81 percent). Only six states (Alaska, Delaware, Mississippi, Nevada, Pennsylvania, and Tennessee) did not allow payments to family members in any of their programs at the time of the study.[40]

Of the 86 programs that allow relatives to be paid providers, 73 percent allow family members to provide personal care, 70 percent allow family members to provide respite care, 20 percent allow family members to act as homemakers or do chores, and 6 percent allowed family members to provide any service needed.[41] Some programs place restrictions on what type of family members are allowed to be paid providers as well. Among these 86 programs, 61 percent do not permit spouses to be paid providers, while others do not permit parents/guardians (37 percent), primary caregivers (18 percent), legal guardians (8 percent), children 18 and under (6 percent), or other relatives (4 percent).[42] These programs and their stipulations about payment to family caregivers are summarized in Table B–1 in APPENDIX B.

Funding Sources

There are a variety of different funding sources for provision of home health services. Table 2–3 provides an overview of these funding sources, care recipient eligibility requirements, and types of home health services covered. Public funding sources such as Medicare and Medicaid provide a majority of the reimbursement for services. In 2008, Medicare and Medicaid accounted for nearly 75 percent of home health care services revenue, followed by 15 percent from private insurance coverage, five percent from patients paying out-of-pocket, and the remaining five percent contributed by a mix of other government programs.[43]

In 2009, HHS outlays for Medicare programs totaled $424 billion, and outlays in support of Medicaid totaled $251 billion.[44] Under Medicare, an estimated $18.3 billion went to home health programs.[45] In 2006, Medicaid programs accounted for approximately $38.1 billion (about $40 billion inflated to 2009 dollars) through Medicaid Home Health ($4.6 billion), State-Plan Personal Care Services benefit ($8.5 billion), and Medicaid Home and Community-based Services (HCBS) benefits ($25 billion).[46] Thus, payments for home health care programs composed approximately 4 percent of Medicare spending, and about 15 percent of Medicaid spending.

Both Medicaid and Medicare pay the service provider directly. The Medicare program uses a prospective payment system (PPS) to reimburse home health agencies a pre-determined base payment for an episode of care; this base payment is adjusted for the condition and needs of the beneficiary as well as geographic variation in wages.[47] Under Medicaid, the state agency implementing the program pays the service provider directly except under certain consumer-directed programs.

The Medicare and Medicaid programs also work together to provide services for a group of care recipients referred to as ''dual eligibles,'' that is, care recipients that are eligible for both Medicare and Medicaid coverage. Studies have found that individuals covered by both Medicare and Medicaid are among the most expensive groups to cover and are more likely to use more Medicare-covered home health services than Medicare home health care patients not also covered by Medicaid. Also, states with low Medicaid spending appear to shift costs to the Medicare home health program spending.[48] Most of the public matching registries listed in Appendix A are funded by the state, with a few receiving federal dollars through reimbursement for Medicaid administrative costs or receiving initial funding through federal Medicaid Systems Transformation grants.[49]

[39] Feinberg, L. & Newman, S. 2005. Consumer Direction and Family Caregiving: Results from a National Survey, State Policy in Practice, available at *http://www.hcbs.org/files/79/3926/ConsumerDirection&FamilyCaregivingNWEB.pdf* Feinberg, L. *et al.* 2004. The State of the States in Family Caregiver Support: A 50–State Study. San Francisco, CA: Family Caregiver Alliance; available at *http://www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=1276.*

[40] Feinberg & Newman, 2005. p. 8.

[41] Feinberg & Newman, 2005. p. 8.

[42] Feinberg & Newman, 2005. p. 9.

[43] PHI, 2010a, p.6.

[44] U.S. Department of Health & Human Services (HHS). 2011. FY 2011 Budget, available at *http://dhhs.gov/asfr/ob/docbudget/2011budgetinbrief.pdf.* p. 13.

[45] Medpac. 2010. A Data Book: Healthcare Spending and the Medicare Program, p. 139, available at *http://www.medpac.gov/documents/jun10databookentirereport.pdf.*

[46] PHI, 2010a, p. 18. Note, not all of the HCBS goes to personal care services; a more detailed breakdown of this spending is not available. For additional data, see Kaiser Family Foundation, State Health Facts: *http://statehealthfacts.org/comparetable.jsp?ind=242&cat=4.*

[47] For additional detail see Center for Medicare & Medicaid Services (CMS). 2011a. Home Health PPS, available at *http://www.cms.gov/HomeHealthPPS/.*

[48] Center for Medicare & Medicaid Services (CMS). 2011b. Home Health Study Report: Literature Review, available at *http://www.cms.gov/HomeHealthPPS/Downloads/HHPPS_LiteratureReview.pdf. p.16.*

[49] Seavey & Marquard, 2011.

TABLE 2–2—SUMMARY OF HOME HEALTH CARE SERVICE PAYERS AND SERVICE COVERAGE

Payer	Description	Eligibility	Home health service coverage
Public			
Medicare	Federal government program to provide health insurance coverage, including home health care, to eligible individuals who are disabled or over age 65. The program pays a certified home health agency for a 60 day episode of care during which the agency provides services to the beneficiary based on the physician approved plan of care.	Individual is under the care of a doctor and receiving services under plan of care; has a certified need for intermittent skilled nursing care, physical therapy, speech-language pathology services, continued occupational therapy; and must be homebound. HHA providing services is Medicare-certified; services needed are part-time or intermittent, and are required <7 days per week or <8 hours per day over 21 day period.	Intermittent skilled nursing care, physical therapy, speech-language pathology services, continued occupational therapy. Does not cover 24hr/day care at home; meals delivered to home; homemaker services when it is only service needed or when not related to plan of care; personal care given by home health aides when it is only care needed.
Medicaid	A joint federal-state medical assistance program administered by each state to provide coverage for low income individuals. The program pays home health agencies and certified independent providers.	Eligibility and benefits vary by state. In general, states must cover individuals who receive federally assisted income maintenance payments such as Social Security, individuals who are eligible for Temporary Assistance for Needy Families and to other individuals defined as "categorically needy."	Coverage of home health services must include part-time nursing, home care aide services, medical supplies and equipment. Optional state coverage may include audiology; physical, occupational, and speech therapies; and medical social services. Coverage is provided under: Medicaid Home Health, State Plan Personal Care Services benefit, and Home and Community-Based state plan services and waivers.
Older Americans Act	Provides federal funding for state and local social service programs that provide services so that frail, disabled, older individuals may remain independent in their communities.	Must be 60 yrs of age or older	Home care aides, personal care, chore, escort, meal delivery, and shopping services.
Veterans Administration	Home health care services provided through the VA's network of hospital-based home care units.	Veterans who are at least 50% disabled due to service-related conditions.	Home health care. Does not include nonmedical services provided by HCAs.
Social Services Block Grant	Federal block grants to states for state-identified service needs.	Varies by state	Often includes program providing home care aide, homemaker, or chore worker services.
Community organizations	Some community organizations provide funds for home health and supportive care.	Varies by program	Covers all or a portion of needed services. Vary by program.
Private			
Commercial Health Insurance Companies.	Many policies cover home care services for acute, and less often, long-term needs.	Varies by policy	Varies by insurance policy
Medigap Insurance	Covers some personal care services when a Medicare beneficiary is receiving covered home health services.	Varies by policy	Focused on short-term personal care services in support of Medicare covered home health care skilled nursing services.
Self-Pay	The individual receiving the services pays "out of pocket."	Individuals who are not eligible for covered services under third-party public or private payers.	Services that do not meet the eligibility criteria of other payers.

Sources: National Association for Home Care. 1996. Who Pays for Home Care Services? Available at URL: *www.nahc.org/consumer/wpfhcs.html;* Centers for Medicare and Medicaid Services (CMS). Medicare and Home Health Care. Available at URL: *http://www.medicare.gov/publications/pubs/pdf/10969.pdf.*

Home Health Care Workers

This section provides an estimate of the total number of home health care workers who may be impacted by the proposed rule as well as the characteristics of these workers, the services they provide, and the wages they receive for their work.

Number of Affected Workers

The workers who will be directly affected by the change to the companionship exemption are concentrated in two occupations: Home Health Aides (SOC 31–1011) and Personal Care Aides (39–9021). These workers are concentrated in two industries: Home Health Care Services (NAICS 6216) and Services for the Elderly and Disabled Persons (NAICS 62412).

These workers are predominantly women in their mid-forties, minorities, with a high school diploma or less education but this varies highly by

region. A similar percentage of PCAs are Black and Hispanic (20% and 19%, respectively), but a much higher percentage of HHAs are Black (35%) than Hispanic (8%). One in four (25%) PCAs are foreign-born, with higher percentages (over 50%) in certain regions of the country, *e.g.,* California and New York. California also has a high percentage of caregivers who are paid family members.[50]

Home health care workers are called by a variety of titles, including: home health aides, home care aides, personal care aides, personal assistants, home attendants, homemakers, companions, personal care staff, resident care aides, and direct support professionals. They are tracked by the following occupational titles.[51]

Personal Care Aide (SOC 39–9021): ''Assist the elderly, convalescents, or persons with disabilities with daily living activities at the person's home or in a care facility. Duties performed at a place of residence may include keeping house (making beds, doing laundry, washing dishes) and preparing meals. May provide assistance at non-residential care facilities. May advise families, the elderly, convalescents, and persons with disabilities regarding such things as nutrition, cleanliness, and household activities.''

Home Health Aide (SOC 31–1011): ''Provide routine individualized healthcare such as changing bandages and dressing wounds, and applying topical medications to the elderly, convalescents, or persons with disabilities at the patient's home or in a care facility. Monitor or report changes in health status. May also provide personal care such as bathing, dressing, and grooming of patient.''

Note that the companionship services of fellowship and protection are not included in either the definition of personal care aide or home health aide. Companionship services as defined in this NPRM are separate from the services provided by home health care workers as defined officially above and outlined in detail below.

The Department uses BLS' employer-based OES estimate of the number of workers in the PCA and HHA occupational categories as its best estimate of the number of caregivers employed by agencies that might be affected by the proposed rule. There were approximately 1.59 million caregivers employed by agencies in 2009, composed of

- 631,000 PCAs, and
- 955,000 HHAs.[52]

These data do not include workers providing these services as independent providers who may be affected by the proposed rule. As described above, the Department determined from the NEM that an estimated additional

- 188,500 PCAs, and
- 18,100 HHAs [53]

can be considered independent providers directly employed by families. Thus, we estimate

- 819,500 PCAs, and
- 973,100 HHAs,

for a total of 1.79 million caregivers, might be affected by the proposed rule.

However, not all 1.79 million of these PCAs and HHAs are employed as FLSA-exempt companions. Many of these workers are employed at agencies that provide a variety of health-related services that may or may not be provided in the home; HHA and PCA employed in facilities, such as nursing homes and hospitals, are not classified as providing companionship services. Furthermore, many of these workers who are classified as companions are employed in states which currently provide minimum wage and overtime coverage. Only a subset of the 1.79 million workers, those who provide services in the home and are not eligible for minimum wage or overtime pay under state law, will be directly impacted by the proposed rule. The Department will define the number of workers directly affected by both the minimum wage and overtime pay provisions of the proposed rule.

While many agency-employed caregivers might work in various facilities that make them ineligible for the FLSA companionship exemption, there is little information available concerning independent providers. The Department assumes that all PCAs and HHAs classified in the NEM as self-employed or employed by households are independent providers directly employed by the family, and are thus by assumption currently exempt from the FLSA.

Tasks, Wages, Hours

Traditionally, companionship tasks have been defined to include fellowship, care, protection, and a limited amount of assistance with general household tasks.[54]

- Fellowship: Defined in the proposed regulation as meaning ''to engage the person in social, physical, and mental activities, including conversation, reading, games, crafts, walks, errands, appointments, and social events''.[55] Fellowship services are generally not covered by public programs.
- Protection: Defined in the proposal as ''being present with the person in their home or to accompany the person when outside of the home to monitor the person's safety and well-being.'' [56] Some states reimburse specific types of participants (*i.e.,* those living with mental disabilities) for protection services.
- Social support: Services that enable the consumer to take an active part in his or her family and community, includes accompanying the consumer to regular social activities and ensuring that the consumer's cognitive state does not deteriorate due to social isolation.

The spectrum of tasks performed by modern workers classified as companions has expanded beyond traditional companionship to include: activities of daily living (ADLs), instrumental activities of daily living (IADLs), and paramedical (''medicalized'') tasks.

- ADLs: Assistance with the following activities: personal hygiene, dressing and changing clothes, transferring, toileting, eating and drinking, maintaining continence, and ambulation.
- IADLs: Includes tasks such as light housework, preparation of meals, assistance with physical taking of medications, shopping for groceries or clothes, using the telephone, escorting, assistance with the management of money, and other tasks that allow the consumer to live independently in the community.
- Paramedical tasks: May include tasks such as changing of aseptic dressings, administration of non-injectible medications (*e.g.,* blood pressure medication in tablet form); [57] and ostomy, catheter and bowel hygiene.

While PCAs and HHAs overlap to some extent in the type of services they provide—both generally provide assistance with ADLs and IADLs—it is primarily HHAs who are employed by Medicare-certified agencies who may be asked to perform paramedical tasks. Those workers are required by Medicare to be trained and certified to perform these types of tasks.

[50] PHI, 2010a. p. 9.

[51] U.S. Bureau of Labor Statistics (BLS). 2011. Standard Occupational Classification, available at *http://www.bls.gov/soc/home.htm.*

[52] 2009 BLS Occupational Employment Survey, employment and wages for SOC codes 39–9021 and 31–1011.

[53] BLS, 2008.

[54] **Federal Register**, 2001. p. 5481.

[55] Proposed § 552.6.

[56] Proposed § 552.6.

[57] Administration of an injectible medication is a medical task generally performed by workers with additional training in medical tasks, such as Certified Nurse Assistants (CNAs).

Generally speaking, a home health aide or agency is authorized to provide a specific number of hours of service to care recipients depending on their needs. Agencies work to schedule home health aides to cover the number of hours needed for the portfolio of cases they have, often taking into account continuity of service to each recipient, total number of hours each aide is scheduled per week, frequency of weekend services needed, and the distance between the aide's home residence and the care recipient's. In the home care industry, agencies typically strive to provide services seven days a week and 24 hours a day.

The greatest scheduling challenges to the agencies come from 12-hour and 24-hour (or sleep-in) cases; these cases are also of particular concern with respect to overtime. A 12-hour case is a care recipient who requires services to be provided by a home health aide for a 12-hour block of time; a 24-hour case is a care recipient who requires a home health aide to be present to provide services around the clock. The key scheduling concerns that agencies contend exist with these cases are that:

- Because workers are scheduled to work in lengthy shifts (up to 12 hours), it is difficult to redistribute overtime hours to workers with fewer hours;
- Aides are paid an hourly rate, plus an hourly overtime premium where applicable; however, agencies are often reimbursed for these cases on a flat rate that does not account for overtime premiums or other costs;
- Sleep-in cases usually include an eight-hour period to allow the worker to sleep while on site; however, the aide is not necessarily off-duty because s/he would be expected to assist the client if an urgent need arose. If the agency is required to count sleep hours toward the total number of hours worked per week then it may become costly to provide 24-hour care.

Some agencies take a proactive approach to scheduling these cases in order to manage the total number of hours on duty required from each worker. For example, an agency may split a 12-hour case between two aides by having one aide provide services Sunday through half of the Wednesday shift when the second aide would take over and work through Saturday.[58] This reduces the total number of hours each aide must work, limits the work to one weekend day, and avoids overwhelming the care recipient with too many different care providers. A similar approach may be applied to cases that require 24-hour care.[59]

The workers themselves report working an average of 31 to 35 hours per week and available data suggest that very few work overtime.[60] Based on an analysis of the 2007 National Home Health Aide Survey and the 2009 Annual Social and Economic Supplement of the Current Population Survey, PHI reports that 92 percent of HHAs and 85 percent of PCAs work less than 40 hours per week for an average of 31 hours and 35 hours per week, respectively. By extension, only eight percent of HHAs and 15 percent of PCAs reported working greater than 40 hours per week.

However, this information may not fully capture the total number of hours worked by these individuals because some aides work for multiple employers, many aides work part-time, and some employers do not compensate workers for travel time between clients (because they are not reimbursed for this time). Furthermore, there is very limited information on hours worked by independent providers or those working as live-in, on-call, or night shift aides. The Department assumes that in general independent providers directly employed by families work similar hours as caregivers employed by agencies.

The wages for these workers vary widely by occupation and geographic location. Based on detailed wage data from the BLS Occupational Employment Statistics Survey, the hourly wages of PCAs and HHAs range from about $6.79 to $20.61 (approximately 0.5% earn less than $6.79 and 0.5% earn more than $20.61) with the average wage being approximately $10.14.[61] As discussed above, wages for PCAs tend to be slightly lower on average than those for HHAs. The Department assumes that in general independent providers directly employed by families receive similar hourly wages as caregivers employed by agencies. In 70 percent of states (36 states), average hourly wages for PCAs were below 200 percent of the federal poverty level wage ($10.42) for individuals in one-person households working full-time. Current research suggests that these workers find it difficult to support their households on these wages; approximately 44 percent of PCAs have to rely on public benefits and fewer than 20 percent report having health insurance.[62]

Costs and Transfers

This section describes the costs and transfers associated with the proposed rule and the Department's approach to estimating their magnitude. The primary costs of this rule are expected to be regulatory familiarization. The Department estimates the first-year cost of the rule will total $9.9 million. In following years, regulatory familiarization costs are projected to increase from $3.5 million in year 2, to $4.4 million in year 10 as new firms enter the market and new families hire home health care workers.

Transfers result from the wage increases to comply with minimum wage and overtime pay requirements. Total estimated transfers depend in part on the response of employers to the regulatory changes; in other words, will employers respond by paying overtime to current workers, changing scheduling practices to avoid paying overtime, hiring additional workers, or some combination of these approaches. Based on the methods described below, the Department estimates that first-year transfers from the rule will range from $42.8 to $182.1 million. In years 2 through 10, the lower end of the range is projected to increase from $27.8 million to $45.8 million while the upper end of the range is projected to increase from $172.6 million to $284.6 million.

Total costs and transfers from the rule will range from $52.7 to $192.1 million in the first year. In subsequent years, the lower end of the range is projected to increase from $31.4 million to $50.2 million in total costs and transfers. The upper range of total costs and transfers is projected to increase from $176.2 million to $289.0 million.

Regulatory Familiarization

When a new rule is promulgated, all the establishments affected by the rule will need to invest time to read and understand the components of the new rule; this is commonly referred to as regulatory familiarization. Each establishment will spend resources to familiarize itself with the requirements of the rule and ensure it is in compliance.

Each home health care establishment will require about two hours of an HR staff person's time to read and review the new regulation, update employee

[58] Elsas, M. & Powell, A. 2011. Interview of Michael Elsas, President, and Adria Powell, Executive Vice President of Cooperative Health Care Associates by Calvin Franz and Lauren Jankovic of ERG. April, 2011.

[59] Some agencies have experimented with breaking a 24 hour case into two 12 hour cases that are staffed by four home care aides; this reduces total number of hours worked and eliminates the need for the 8 hour rest period but also increases the number of aides that the client must become comfortable with.

[60] Seavey and Marquand, 2011, pgs. 61–64. Available at: *http://www.directcareclearinghouse.org/download/caringinamerica-20111212.pdf;* HHS, 2011. p. 26.

[61] BLS, 2009.

[62] PHI, 2010a., p. 30, 32.

handbooks and make any needed changes to the payroll systems. Based on our analysis of the industry and occupational data, the Department judges that each employer in HHCS and SEPD likely employs workers who could be classified as companions and therefore will need to review the proposed rule. There are about 73,000 establishments in SEPD and HHCS; assuming a mid-level HR wage of $26.79 per hour over two hours equals about $4 million for regulatory familiarization in the first year following promulgation of the rule.[63]

For independent providers, the employer is considered to be the family that hires them. Therefore, families that directly employ these caregivers will also have to review the regulatory revisions. Because the employer-employee relationship is less complex than for an agency that employs multiple workers caring for multiple clients, the Department expects the burden of regulatory familiarization will be smaller. The Department therefore assumes that each family that directly hires a caregiver will spend one hour on regulatory familiarization. The Department uses the national average hourly wage of $29.07 (loaded) to represent the opportunity cost of reviewing the regulatory revisions.[64]

The Department has found no data to support an estimate of the number of families that directly hire independent providers. The Department assumes each independent provider is hired by a single family, and therefore, because it estimates there are 206,600 independent providers, 206,600 families will incur the cost of one hour to review the revised regulations. These families incur one hour of time at an opportunity cost of $29.07 per hour for a total of about $6 million for regulatory familiarization in the first year following promulgation of the rule. The Department acknowledges this estimate is based on an assumed value and requests from commenters information or data that would allow it to better estimate the number of families that directly hire independent providers.

Wages and Overtime[65]

Many home care workers are already covered by minimum wage and overtime provisions at the state level and will not drive additional costs related to the proposed rule. Sixteen states require minimum wage for all hours worked for most home health care workers and guarantee some type of overtime pay for home health care workers who would otherwise be excluded under the FLSA.[66] Five states and the District of Columbia require minimum wage for all hours worked but do not guarantee overtime.[67] Twenty-nine states do not require minimum wage or overtime. Table 3–1 summarizes the wages for PCA and HHA occupations based on state level minimum wage and overtime coverage.

TABLE 3–1—SUMMARY OF WAGES BY STATE MINIMUM WAGE AND OVERTIME COVERAGE FOR HHAS AND PCAS

Area name	Employment	Hourly wages		
		Minimum 10th percentile wage	Weighted average median wage	Maximum 90th percentile wage
All States	1,585,990	$6.79	$9.71	$20.61
States with MW and OT:				
Total	780,480	7.32	10.39	20.61
PCA	320,010		10.38	
HHA	460,470		10.41	
States with MW but no OT:				
Total	120,610	7.20	9.85	16.40
PCA	30,700		9.95	
HHA	89,910		9.75	
States without MW or OT:				
Total	684,900	6.79	8.90	18.76
PCA	280,060		8.49	
HHA	404,840		9.30	

Source: BLS OES, 2009; Note: based on the hourly wage percentiles, the minimum wage paid to workers is below the Federal minimum wage in some states with minimum wage laws.

In order to define the subset of workers from the table that will be directly affected by the minimum wage and overtime components of the proposed rule, the Department made three primary calculations: (1) Removed from the data set those workers not currently employed as exempt companions (those providing services in facilities rather than homes); (2) added employees of tax exempt organizations in states with overtime coverage to the set of workers without state-level overtime coverage (as they are sometimes exempt from the state overtime laws); and (3) identified the number of workers currently receiving less than the federal minimum wage ($7.25 per hour).

The data presented in Table 3–1 do not differentiate the workers who provide services in the homes of clients (eligible for companionship services exemption) and those that provide services primarily in facility settings (not eligible for companionship services exemption). To identify agency-employed HHAs and PCAs likely to be providing services in facilities and exclude them from the estimation of costs, the Department examined the BLS National Employment Matrix of industries for each occupation. Based on the description of the industry employing the HHA or PCA, the Department made a judgment of

[63] Mid-level HR loaded hourly rate from BLS.

[64] BLS National Compensation Survey, July 2009, Hourly mean wage for full-time Civilian Worker is $22.36; the Department estimates the fully loaded wage at the hourly wage × 1.3. URL: *http://www.bls.gov/eci/*.

[65] These costs to employers are also transfer payments that will benefit employees. See Benefits, below.

[66] California, Colorado, Hawaii, Illinois, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Jersey, New York, Pennsylvania, Washington, and Wisconsin. NELP, 2011 and SOL internal analysis.

[67] Arizona, Nebraska, North Dakota, Ohio and South Dakota. NELP, 2011.

whether the actual services were being provided in a facility or in a private home; then, the number of workers likely to be providing services in the home were summed and compared to the total number of workers in the occupation to estimate the percent of that occupation providing services in the home. Table 3–2 summarizes the data as well as the determination of whether the industry would be home or facility-based. This percentage, approximately 80 percent of PCAs and 45 percent of HHAs, is used to adjust the number of workers below minimum wage and the number of workers without overtime pay used in the more detailed calculations described below. By definition, the Department assumes that 100 percent of PCAs and HHAs working as independent providers work in the home setting.

TABLE 3–2—SUMMARY OF INDUSTRIES EMPLOYING HHAS AND PCAS IN 2008 AND LIKELIHOOD OF THE AIDE WORKING IN A HOME OR FACILITY

Industry	HHA		PCA	
	Employment (1000)	Facility or home	Employment (1000)	Facility or home
Total, All workers [a]	1	100%	1	100%
Home	0.449172577	45%	0.801039861	80%
Facility	0.550827423	55%	0.198960139	20%
Total, All workers	100	Home	100	Home.
Accounting, tax preparation, bookkeeping, and payroll.	0.06	Facility	0.15	Facility.
Activities related to real estate	NA	NA	0.06	Facility.
Child day care services	0.07	Facility	0.41	Facility.
Civic and social organizations	NA	NA	0.11	Facility.
Community care facilities for the elderly	15.34	Facility	NA	NA.
Community food and housing, and emergency and other relief services.	0.1	Facility	0.28	Facility.
Educational services, public and private	0.25	Facility	0.18	Facility.
Employment services	2.16	Facility	1.84	Facility.
Fitness and recreational sports centers	NA	NA	0.01	Facility.
Grant making and giving services	NA	NA	0.28	Facility.
HHCS	30.94	Home	27.9	Home.
Hospitals, public and private	2	Facility	0.61	Facility.
Hotels, motels and other traveler accommodations.	NA	NA	0.03	Facility.
Lessors of real estate	0.04	Facility	0.2	Facility.
Local government, excluding education and hospitals.	1.33	Facility	NA	NA.
Management of companies and enterprises.	0.14	Facility	0.54	Facility.
Management, scientific, and technical consulting.	NA	NA	0.04	Facility.
Nursing care facilities	5.73	Facility	0.39	Facility.
Offices of all other health practitioners	0.06	Facility	0.06	Facility.
Offices of mental health practitioners (except physicians).	0.04	Facility	0.01	Facility.
Offices of physical, occupational, and speech therapists, and audiologists.	0.11	Facility	0.05	Facility.
Offices of physicians	0.24	Facility	0.07	Facility.
Other ambulatory health care services	0.05	Home	NA	NA.
Other financial investment activities	NA	NA	0.03	Facility.
Other investment pools and funds	NA	NA	0.02	Facility.
Other personal services	NA	NA	0.41	Home.
Other residential care facilities	2.18	Facility	0.4	Facility.
Outpatient mental health and substance abuse centers.	0.27	Facility	0.22	Facility.
Personal care services	NA	NA	0.07	Home.
Residential mental health and substance abuse facilities.	2.16	Facility	0.24	Facility.
Residential mental retardation facilities	16.9	Facility	3.04	Facility.
SEPD	12.3	Home	28.12	Home.
Social advocacy organizations	0.05	Facility	0.97	Facility.
State government, excluding education and hospitals.	1.91	Facility	NA	NA.
Unpaid family workers	NA	NA	0.05	Home.
Vocational Rehabilitation	1.92	Facility	3.78	Facility.

Source: BLS 2008 National Employment Matrix; note that employment does not sum to the total provided by BLS, the percent of the occupation employed in the home versus a facility is calculated based on the actual sum of the number appearing in the table.

[a] Note: this excludes self-employed workers and those employed in private households because they will be added to the population of affected workers separately.

It is important to note that the determination of whether the industry is home- or facility-based is an estimate; some industries that appear to provide services primarily in a nursing facility, for example, may employ a few aides who provide services in the homes of clients to assist with transitioning of the client from the facility back to their home. Also, some industries that appear to provide services primarily in the home, HHCS for example, may also employ aides that work primarily in facilities.

Next, the workers in the states with minimum wage and overtime pay are, in general, already receiving at least the minimum wage and some form of overtime premium for hours worked beyond 40 hours and do not need to be included when calculating the costs associated with additional wages resulting from the application of the federal minimum wage or payment of an overtime premium. The exception is for workers employed by public agencies, non-profit organizations, and other tax exempt entities who are exempt from many of the applicable state laws. To account for these workers, the Department used the 2007 Economic Census to estimate the proportion of workers in those states who are employed in establishments exempt from Federal income tax; this proportion was multiplied by the number of workers in each state to estimate the number of workers likely to be employed by an employer not covered by the state level laws related to minimum wage and overtime.[68] These workers were added to the total number of workers without overtime coverage in order to estimate the costs of providing overtime pay to workers under the proposed rule. States vary widely in terms of exemptions from minimum wage and overtime rules and not all states have these types of exemptions; as a result, this approach results in an overestimate of the number of workers who will receive additional overtime wages as a result of the proposed rule. The Department judges that this is the best available method to estimate these additional workers given available data.

The Department then analyzed the 2009 BLS OES data on PCA and HHA wages by percentile to identify those workers receiving less than the federal minimum wage (usually those in the 10th and 25th percentiles in states without minimum wage coverage).

Finally, due to lack of data, the Department selected the assumptions it would use to analyze independent providers directly employed by families. The Department assumes that independent providers: (1) Generally will not be eligible for overtime wage premiums, and (2) earn less than the current federal minimum wage in the same proportion as agency-employed caregivers.

To be eligible for the overtime wage premium, an independent provider would have to work more than 40 hours per week for the same employer (*i.e.,* family); an agency-employed caregiver is eligible if he or she works more than 40 hours for the agency regardless of the number of families visited. Thus, the Department believes that independent providers are much less likely to be eligible for the overtime premium than agency-employed workers; those independent providers who work more than 40 hours per week are likely to be employed by more than one family.

By assuming that the proportion of independent providers earning less than the federal minimum wage is identical to that for agency-employed caregivers, the Department implicitly assumes independent providers work in similar patterns as agency-employed caregivers. That is, independent providers are distributed across states in the same proportion as agency-employed caregivers, and are as likely to earn less than minimum wage as those employed by agencies.

Table 3–3 summarizes the number of workers estimated to be directly impacted by the minimum wage and overtime provisions of the proposed rule. These numbers reflect the adjustments discussed above that account for employees of tax-exempt organizations not covered by their state's overtime requirements and for the percent of workers likely to be employed in a home versus a facility. These estimates are described in more detail in the following sections.

From the initial total of 1.59 million agency-employed workers, the Department estimates 934,000 are employed in homes as exempt companions. Of all agency-employed PCAs and HHAs, the Department estimates that 738,000, almost 47 percent are unlikely to be covered by current overtime provisions[69] and 31,000 (1.9%) are paid less than the federal minimum wage.

Since 3.9 percent of agency-employed PCAs earn less than minimum wage, the Department assumes 3.9 percent of the 188,500 PCA independent providers also earn less than minimum wage, about 7,350 caregivers. Similarly, because 0.7 percent of agency-employed HHAs earn less than minimum wage, 0.7 percent of the 18,100 HHA independent providers, about 120 workers, also earn less than minimum wage.

TABLE 3–3—SUMMARY OF WORKERS THAT ARE DIRECTLY IMPACTED BY PROPOSED RULE

Affected workers	Number of workers	Source
Agency-employed PCA and HHA	1,585,990	BLS 2009 OES; State-level occupational employment and wages for SOC 39–9021 and 31–1011.
PCA	630,770	
HHA	955,220	
Percent PCA and HHA working in homes:		
PCA	80.1%	BLS 2008 National Employment Matrix for SOC 39–9021 and 31–1011.
HHA	44.9%	
Number of PCA and HHA working in homes:		
PCA	505,272	Total Workers multiplied by percent working in homes; BLS 2009 OES and 2008 National Employment Matrix.
HHA	429,059	

[68] The Department used a proportion of 100 percent for workers in New York to account for the fact that New York law establishes an overtime premium for these workers of one and one-half times the minimum wage (rather than the workers' regular rate). This produces an overestimate of the number of workers who will receive additional overtime pay as a result of the proposed rule.

[69] The total number of workers without overtime coverage does not include the 367,000 providers in California because they are currently covered by an overtime provision under a collective bargaining agreement. If the terms of that agreement change, then costs will be impacted.

TABLE 3–3—SUMMARY OF WORKERS THAT ARE DIRECTLY IMPACTED BY PROPOSED RULE—Continued

Affected workers	Number of workers	Source
Total	934,331	
Workers without OT Coverage:		
Number of PCA and HHA in States without OT Coverage	290,089	Sum of employees working in homes in selected states; BLS 2009 OES.
Number of PCA and HHA in NY	227,100	Employees working in homes in NY; BLS 2009 OES.
Number of PCA and HHA in public agencies and nonprofits in states with OT.	220,589	Total workers in states with OT laws multiplied by proportion of workers in state employed by tax-exempt organizations; BLS 2009 OES and 2007 Economic Census.
Total workers without OT coverage	737,779	
Workers below Minimum Wage	....	Number of workers with wage below $7.25; BLS 2009 OES. 3.9% of PCA, 0.7% HHA.
Number of PCA and HHA worker below minimum wage	30,955	
Independent Providers employed by families	206,600	BLS 2008 National Employment Matrix for SOC 39–9021 and 31–1011.
PCA	188,500	
HHA	18,100	
Independent Providers below MW	....	Total number of workers multiplied by percent of agency-employed PCA and HHA that are paid below minimum wage.
PCA	7,345	
HHA	121	

Minimum Wage

Based on BLS data describing the wages of PCAs and HHAs by percentile, there are 14,200 HHAs and 30,700 PCAs in 13 states where the minimum wage is below the federal minimum wage of $7.25. Approximately 32,600 of those workers are providing services in homes rather than facilities (85 percent multiplied by 30,700, plus, 46 percent multiplied by 14,200), and therefore are receiving only their states' minimum wage. The average wage of these workers is $7.02 per hour. As a result of the proposed changes to the companionship exemption, these workers will receive an additional $0.23 per hour. Based on available data on the number of hours worked by PCAs and HHAs, drawn from several nationally representative surveys, the Department judges that 35 hours per week is a reasonable upper-bound assumption of the average number of hours worked per week. Assuming that each of these workers is employed for 52 weeks per year, and works an average of 35 hours per week [70] then the additional cost of wages paid to these workers will be approximately $13.0 million in the first year. Review of BLS data suggests that the number of workers earning less than minimum wage should be negligible in subsequent years.[71]

Since the Department assumes all independent providers are employed by families, then all of the estimated 7,350 PCAs and 120 HHAs earning less than the minimum wage provide service in homes, and no further adjustment to these numbers is necessary. If these 7,470 caregivers also receive an additional $0.23 per hour to raise their wage to the federal minimum, and work an average of 35 hours per week, then the additional cost of wages paid to these workers will be approximately $3.1 million in the first year. With no evidence to the contrary, we maintain our working assumption that wages for self-employed caregivers track those of agency-employed caregivers.

Overtime

Limited data exist on the amount of overtime worked by this population. A PHI analysis of the U.S. Census Bureau's Current Population Survey, Annual Social and Economic Supplement (ASEC) on home health care workers found 8 to 15 percent of PCAs and HHAs may work overtime. Among home health aides, 8 percent worked more than 40 hours per week, and 2 percent worked more than 50 hours per week; 15 percent of personal care attendants appeared to work more than 40 hours per week, although PHI believes this may be an overestimate based on the 2010 ASEC supplement that suggests that approximately 42 percent of aides in HHCS report working full-time year round. [72]

A significant overtime pay issue in this industry is associated with overtime pay for the care of patients requiring 24-hour services. Attending staff may be eligible for pay up to 16 of every 24 hours or even more (if the staff is not provided a bona fide sleep period). The City of New York and New York State Association of Counties filed an amicus brief with the U.S. Supreme Court in *Long Island Care at Home, Inc.* v. *Coke.*[73] The brief asserted that changing the FLSA companionship services exemption would significantly increase the cost to the City and State for providing home healthcare services. The brief included an estimate of the increased costs. The additional costs for home health care workers in New York City attending patients requiring 24-hour attendance is by far the largest component of these costs, exceeding the Department's estimate of nationwide overtime for all workers in all states not currently covered by overtime.

Unfortunately the brief does not adequately describe how the cost estimates were arrived at, nor does it provide estimates of the number of patients requiring 24-hour care or the workers caring for them. The numbers presented in the brief suggest over 33.6 million hours of annual overtime are worked just to care for patients requiring 24-hour care plus an additional 14.6 million hours of overtime hours are worked to care for other patients.[74] This exceeds by 37

[70] Seavey and Marquand, 2011, pgs. 61–64. Available at: *http://www.directcareclearinghouse.org/download/caringinamerica-20111212.pdf.*

[71] BLS, Occupational Employment Statistics Survey, by state, 2000–2010. Available at URL: *http://stats.bls.gov/oes/.*

[72] Seavey and Marquand, 2011, pgs. 61–64. Available at: *http://www.directcareclearinghouse.org/download/caringinamerica-20111212.pdf.*

[73] 551 U.S. 158 (2007). Brief of Amici Curiae City of New York and New York State Association of Counties in Support of Petitioners.

[74] The incremental cost of requiring overtime pay under this regulation is the difference between the current hourly rate paid for home health care workers, and the rate that would be paid if this

Continued

percent the total amount of overtime the Department estimated for the 34 states and Washington, DC that do not currently require overtime pay, based on estimates of hours worked derived from a nationwide, statistically representative sample.[75] Furthermore, this sample, from the Current Population Survey Annual Social and Economic Supplement, should reflect all hours worked, including that of home health care workers caring for patients requiring 24-hour care. In addition, the need to provide a patient with 24-hour care does not necessarily result in 72 hours of overtime per week. Maintaining continuity of care does not require a single care giver in attendance for the entire week; service can be provided with adequate continuity of care by two or four workers.[76] Therefore, because the brief does not explain the basis for the numbers, the Department has not relied upon those estimates, but rather has generally relied upon nation-wide data from BLS in developing this economic impact analysis.

BLS data show there are about 492,000 total home health care workers in facilities and private homes in states without state-mandated overtime coverage, plus 143,000 workers employed in New York, and an additional 136,000 workers employed by tax-exempt organizations in states with overtime coverage who are not eligible for coverage. In total, the Department estimates that there are 770,445 workers without overtime coverage that will be eligible for it as a result of the proposed rule.

Based on the PHI analysis of ASEC data on overtime worked in this industry, the Department calculates that if 10 percent of these 770,445 home health care workers are employed 45 hours per week (5 hours of overtime), and an additional 2 percent are employed 52.5 hours per week (12.5 hours of overtime), then about 30 million hours of overtime are worked per year. Using the weighted median wage of $9.51 per hour, these workers would earn an overtime premium of $4.75 per hour. Under these assumptions the additional cost of overtime pay would be approximately $143 million per year absent changes to employment practices that could reduce or even eliminate overtime for these employees.[77]

As described above, the Department does not expect independent providers to be affected by overtime provisions. It expects few, if any, of these caregivers work more than 40 hours per week for the same family.

Market Response to Overtime Requirement

It is highly unlikely that agencies will simply accept overtime costs without changing operating and staffing policies. Currently, agencies have little incentive to manage overtime because hours worked in excess of 40 per week are paid at the same rate as hours less than 40 per week. Because overtime hours will now cost agencies more, they will have an incentive to manage those hours better to reduce costs.

At least three possible agency responses to overtime pay requirements can be identified. First, the agency might manage existing staff to reduce overtime hours while maintaining the same caseload and staffing levels. However, there is little evidence on which to predict how agencies might reorganize staff time to support the same caseload. It seems doubtful that many agencies can support their caseload without at least some overtime payments, but it is unclear how much overtime might be reduced. In addition, the time spent reorganizing staffing plans is not costless. In this scenario agencies will incur opportunity costs for managerial time in addition to overtime pay, even if management pay is unchanged.

Second, as suggested in the City of New York's amicus brief, agencies might choose not to allow staff to exceed 40 work hours per week.[78] After the Court of Appeals for the Second Circuit concluded in *Coke* that home health care workers were entitled to overtime pay, the experience of New York City indicates this might be a common response in some regions. Such an approach will require increased staffing to cover the existing caseload. The New York City experience suggests it became common for staff that worked more than 40 hours per week at a single agency to continue to work more than 40 hours per week, but for multiple agencies.[79] For example, a home health care worker might work perhaps 25 hours per week at two different agencies, thus not becoming eligible for overtime pay despite working 50 hours per week. Once again, agencies will incur additional managerial costs as they hire and manage additional staff. Employees that begin to work for more than one agency will also incur opportunity costs as they coordinate their schedules with multiple agencies. Finally, agencies might increase staffing by hiring new workers; depending on the tightness of the labor market, this might necessitate increasing hourly wages to attract new workers.

The third scenario comprises a mix of the first and second approach. Neither of those approaches is costless to agencies, therefore, agencies will weigh the cost of hiring additional workers with the cost of paying overtime to existing workers to determine the optimal mix of overtime and new hires appropriate to their circumstances. Agency caseload, current staffing patterns, the cost of hiring new workers, and managerial preferences for staffing mix will affect the final decision.

One factor that may help determine how many employees currently exceeding 40 hours of work per week would receive overtime pay compared to having their hours reduced below 40 per week is the potential for existing workers to absorb additional hours without exceeding 40 hours per week. Available data suggest many employees are working significantly less than 40 hours per week and at least some of those workers are interested in working additional hours. As has been mentioned, studies show that HHAs and PCAs work, on average, 35 hours per week at most, and approximately 45 percent of workers in HHCS work part-time.[80] In addition, the 2010 CPS ASEC asked part-time workers why they did not work full-time; 22 percent of aides indicated they could only find part-time work and 18 percent stated they worked part-time due to business conditions. Thus potentially 40 percent of part-time aides might be interested in increasing their hours worked if more hours were available.

This suggests that of 1.59 million PCAs and HHAs, approximately 720,000 are part-time, and 288,000 might be interested in increasing their hours worked. Employees in this industry currently average at most 35 hours worked per week; if each of the 288,000 part-timers that might like to work

regulation is promulgated (*i.e.,* the overtime differential) applied to hours worked in excess of 40 hours per week. If straight time pay is currently about $10 per hour, the incremental cost will be $5 per hour. New York City projects the rule will cost $168 million per year for care of patients requiring 24 hour care; $168 million divided by $5 suggests that roughly 33.6 million overtime hours per year are worked in New York City alone to care for these patients.

[75] The PHI analysis is based on the U.S. Census Bureau, Current Population Survey, 2009 Annual Social and Economic (ASEC) Supplement.

[76] Elsas & Powell, 2011.

[77] If the 367,000 providers in CA that currently receive overtime coverage under the terms of a collective bargaining agreement lose that coverage due to a change in the terms, the additional costs of overtime would be approximately $75 million under the same assumptions.

[78] Brief of Amici Curiae City of New York, 2007.

[79] Elsas & Powell, 2011.

[80] PHI, 2010a. p. 35. HHS, 2011. P. 26.

additional hours increased their average hours worked by 1.8 per week, they could absorb the estimated 26.8 million hours of overtime currently worked without exceeding 40 hours per week themselves. Not all employers will be able to redistribute hours to interested part-time workers in this way, and it may be difficult for agencies to adjust worker schedules to come close to, but not exceed, 40 hours due to the nature of the work; the types of services they provide do not necessarily fit into one-hour increments. However, those employers who can adjust schedules and redistribute hours can be expected to decrease overtime costs significantly.

Travel Time

The FLSA requires that employees who, in the normal course of work, travel to more than one worksite during the workday be paid for travel time between each worksite. (If the home health care worker travels to the first client directly from home, and returns directly home from the final client, travel time for the first trip and last trip generally are not eligible for pay.) It is clear that at least some home health care workers travel between clients and are thus eligible to be paid for that time. However, the Department has been unable to find evidence concerning how many workers routinely travel as part of the job, the number of hours spent on travel, or what percentage of that travel time currently is compensated.

New York City's amicus brief does suggest, however, that projected travel costs would be about 19.2 percent of the size of overtime costs.[81] With no other data available, this ratio seems reasonable to estimate potential travel costs. A number of qualifications apply to the use of this ratio. First, there is anecdotal evidence that agencies that operate in the city make little effort to minimize travel on the part of their workers; since travel is ''free'' to the agency, there is little incentive to manage travel time. Second, because there is no explanation of how either overtime or travel time estimates were generated, a closer examination of the data might change either or both estimates.[82] Third, it is unclear how work and travel patterns in New York City apply to the rest of the country. For example, anecdotal evidence suggests that home health care workers in rural areas might have to travel further between clients, but their typical caseload patterns and total travel time are unknown. A survey of 131 home health care workers in Maine found companions traveled between 0 to 438 miles per week for an average unreimbursed mileage of 45 miles per week. One survey participant's comment was compelling: ''I had to give up my other clients because the price of gas and low wages I wasn't making ends meet.[83]

The Department expects no independent providers will be affected by the travel time provision. Although the FLSA requires that employees who travel to more than one worksite during the workday be paid for travel time between each worksite, in the case of independent providers, any travel between work sites most likely represents travel from one employer to another, not travel between sites for the same employer. Therefore the Department anticipates independent providers will not be eligible for travel costs.

Subject to the qualifications described above, using New York City's 19.2 percent of overtime figure, the Department estimates that the requirement to pay travel time under the FLSA might add approximately $26.7 million per year to home health care agency costs.[84] Because the Department has assumed that travel costs will maintain a constant proportion to overtime pay (as calculated under Scenario 1), we project that travel pay will increase from $27.8 million to $45.8 million from year 2 through year 10.

Market Response to Travel Time Requirement

As a result of this provision, agencies should have significant incentive to reduce travel between clients for their employees, and therefore costs. It is difficult, however, to predict the potential magnitude of the cost reduction. It might be difficult to reduce travel due to client preferences for specific caregivers, or the geographical dispersion of clients (especially in rural areas).

Agencies might also find alternative methods to reduce the travel costs it pays to employees without reducing actual travel time. For example, an agency might be able to reduce its employees' hourly wage, but increase hours paid by including travel time in such a way that employees' take-home pay is left unchanged. There are, however, some constraints that might limit agencies' ability to utilize such a strategy. First, employees must earn at least the federal minimum wage for all hours worked, including travel time, after this policy is implemented. Second, agencies will expend managerial resources implementing such a policy, which may at least partially offset the savings from reduced wages. Third, management frequently has multiple goals, some of which might conflict with such a policy. If, for example, newer employees are paid a wage closer to the federal minimum, then their hourly wages might be reduced a lesser amount than more senior staff. This might conflict with the agencies' desired pay scale, as well as other goals such as employee retention.

Therefore, although the Department anticipates travel will be reduced as a result of the proposed rule, it cannot predict the magnitude of this reduction. First, there may be some minimum level of necessary travel that is irreducible. Second, although agencies have incentive to more carefully manage costs associated with employee travel, they might be able to do so in such a way that agencies avoid increased costs, but results in little reduction in travel by their employees.

Live-in Domestic Staff

The proposed rule would limit the application of the overtime exemption contained in § 13(b)(21) of the Act to the individual, family or household employing the live-in domestic worker. Third-party employers would no longer be entitled to claim the exemption. In addition, the proposed rule would require employers of live-in domestic workers to maintain an accurate record of hours worked, rather than simply keeping a copy of the agreement made by the employer and employee covering hours of work. The cost to employers of the proposed recordkeeping requirement, discussed more fully in the Paperwork Reduction Act section of this preamble, is estimated to be $22,580,605 (which reflects the amount for the entire information collection-approximately $3,059,650 of which stems from this NPRM). The Department has been unable to identify current data to

[81] Brief of Amici Curiae City of New York, 2007.

[82] Thus, it is plausible that a modification in the assumptions used to generate one estimate might also affect the second estimate. The ratio of travel time to overtime might remain relatively stable even if the absolute values of the estimates change.

[83] Ashley, A., Butler, S., Fishwick, N. Home care aide's voices from the field: Job experiences of personal support specialists. The Maine home care worker retention study. *Home Healthcare Nurse,* July/August 2010, 28(7), 399–405.

[84] It is unknown whether travel hours will be paid at straight time or overtime rates; this will vary according to the circumstances of the individual worker. If we assume all travel hours are overtime hours, and are paid at approximately $15 per hour, then the $31 million in incremental travel costs suggests about 2.1 million hours per year are spent in travel. If we assume all travel hours are straight time hours, and are paid at approximately $10 per hour, then the $31 million in incremental travel costs suggests about 3.1 million hours per year are spent in travel.

estimate the number of live-in domestic workers employed by third-party agencies, but based on historical data, we do not expect the impact of the proposed change concerning third-party employment to be substantial. Although the Department has estimated the number of live-in domestics for purposes of the Paperwork Reduction Act (PRA), we have not included such data in the economic analysis as the Department relied upon aged data for the PRA section. The Department utilized a 1979 study of Domestic Service Employees which incorporated 1974 data and assumed for purposes of the PRA that a similar percentage of the current domestic worker population is employed in live-in domestic work today. The Department specifically invites comments and data on the number of live-in domestic workers and their employers who may be subject to this rule.

Total Transfers

Due to the continuum of different responses to the proposed regulation, the Department analyzed three possible scenarios with respect to overtime. One approach assumes the agency pays employees the overtime premium for all overtime hours worked. Conversely, the employer might change scheduling practices to avoid overtime costs and hire additional workers as necessary to work the extra hours. The final approach is modeled as a combination of the first two, half of employers pay overtime as in the first scenario and half of employers hire more workers, as in the second scenario. As described above, additional managerial costs to agencies might occur as a result of changes in staffing; the Department has no basis for estimating these costs, but believes they are relatively small. Therefore, they are not included in the three scenarios.

The three scenarios in rank order from highest to lowest amount are:

- *OT Scenario 1:* The Department assumes agencies make no adjustments to staffing and pay employees the overtime premium for all hours worked in excess of 40 per week.
- *OT Scenario 2:* The Department assumes agencies make a partial adjustment to staffing; overtime pay is reduced, but not eliminated, by hiring some additional staff or increasing hours to part-time workers. For the purposes of this estimate, the Department assumes agencies evenly split the current overtime hours between current workers (who will thus work 50 percent of the overtime hours they currently work), and new workers (who will not work any overtime hours).
- *OT Scenario 3:* The Department assumes agencies ban overtime and increase staffing to ensure no employee works more than 40 hours per week. In addition, it is assumed that additional staff can be hired at the current going wage rate.

Table 3–4 presents an overview of the total estimated transfers of this rule where the scenarios represent a range of potential outcomes and actual transfers will depend on the response of employers to the proposed rule.

TABLE 3–4—SUMMARY OF TRANSFERS

Transfer components	Total transfers ($ mil.)	Comments
Minimum Wages to Agency-employed Workers	$13.0	
Minimum Wages to Independent Providers	3.1	
Travel Wages	26.7	
Overtime Scenarios:		
OT1	139.3	
OT2	69.7	
OT3	0.0	
Total Transfers by Scenario		
Minimum Wage + Travel + Overtime Scenario 1	182	Employers in states with no coverage begin paying minimum wage and overtime.
Minimum Wage + Travel + Overtime Scenario 2	112	Employers in states with no coverage begin paying minimum wage and adopt a 50:50 mix of OT pay and new hires in response to overtime requirements.
Minimum Wage + Travel + Overtime Scenario 3	43	Employers in states with no coverage begin paying minimum wage and hire new workers to cover overtime.

The Department examined three scenarios representing varying agencies' potential responses to the overtime pay requirement. There is little hard evidence concerning the likelihood that each scenario might occur. However, the Department expects: Scenario 1 is the least likely; there is no reason to believe agencies will simply continue current staffing patterns and pay workers overtime for any hours exceeding 40 per week. Scenario 1 represents an upper bound estimate that projected transfer effects should not exceed.

Scenarios 2 and 3 are more likely to occur.[85] Agencies have alternatives to paying the overtime premium: Spreading existing overtime hours to other workers, either new employees or current employees who want more hours. Thus, the Department believes the true transfer effects resulting from the overtime requirement:

- Will exceed the estimate presented as Scenario 3; agencies are unlikely to be able to perfectly spread all overtime hours. This may result from specific rigidities associated with individual agencies: An inability to divide certain cases among workers so that none exceed 40 hours; insufficient part-time staff willing to take on additional hours, or a local labor pool with workers unwilling to work at the current wage level. Scenario 3 thus represents a lower

[85] National level quantitative analyses have produced results consistent with the Department's qualitative analysis for this labor market:

Barkume, Anthony. 2010. ''The Structure of Labor Costs with Overtime Work in U.S. Jobs,'' Industrial and Labor Relations Review, 64(1): 128–142.

Trejo, Stephen. 1991. ''The Effects of Overtime Pay Regulation on Worker Compensation,'' American Economic Review, 81(4): 719–40.

Trejo, Stephen. 1993. ''Does the Statutory Overtime Premium Discourage Long Workweeks?'' Industrial and Labor Relations Review, 56(3): 530–551.

bound estimate below which projected transfers are unlikely to fall.

The degree to which actual transfer effects will be greater than or less than Scenario 2 is uncertain. However, the Department expects the lower scenario is more likely; there are multiple channels through which hours can be spread to additional workers without significantly increasing non-overtime wages. The extent to which current employees work more than 40 hours per week provides little evidence of a potential labor shortage in this industry; because most agencies are not covered by overtime requirements, they have had no incentive to manage workers in a way to avoid overtime.

Projected Future Costs and Transfer Effects Due to Industry Growth

As documented above in this analysis, the demand for home health care workers has grown significantly over the past decade and is projected to continue growing rapidly. One researcher has projected at least a 200 percent increase in demand for home health care workers over the next 40 years.[86] Therefore, the Department examined how the provisions in the proposed rule might impact a rapidly growing industry.

To estimate projected regulatory familiarization costs, the Department first estimated both the number of agencies and the number of independent providers likely to enter the market. The Department used U.S. Census' Business Dynamics Statistics to estimate an average annual firm ''birth'' rate of 8.6 percent of existing firms.[87] With 73,175 affected agencies in the baseline, this projects to 6,314 new agencies per year that will incur incremental regulatory familiarization costs.

The projected number of families expected to hire independent providers was calculated using U.S. Census population projections by age. Census projected that the number of individuals age 65 and older will increase from 40.2 million in 2010 to 50.8 million in 2020 (36 percent), while those age 85 and older will increase from 5.8 million to 6.6 million (15 percent) over the same time period.[88] The Department selected the midpoint of these two age groups to estimate the growth rate of the population most likely requiring assistance; including all those in their mid 60s and early 70s was judged to be too inclusive and would overestimate the growth of the relevant population, while many requiring assistance might have died before the age of 85, and thus that age group would underestimate growth. This growth rate over 10 years (34 percent) was applied to the number of independent home care providers in the baseline year (206,600) to estimate that 285,900 independent providers would be supplying services by 2020, an average of 7,208 new workers per year from 2010 to 2020.

However, this estimate does not account for turnover among families hiring independent home care providers; the Department accounted for this by assuming that 50 percent of the previous year's independent home health care providers would gain a new client, and that client's family would require regulatory familiarization. Thus, on average, regulatory familiarization costs among families hiring independent providers each year was calculated at 50 percent of the previous year's providers plus 7,208.

Consistent with the baseline estimate, new agencies projected to incur regulatory familiarization costs are assumed to require two incremental hours at a rate $26.79 per hour. Families hiring independent providers are assumed to require one hour of regulatory familiarization at a rate of $29.07. Table 3–5 summarizes the estimation of projected regulatory familiarization costs.

TABLE 3–5—PROJECTED REGULATORY FAMILIARIZATION COSTS

Year	Agencies requiring regulatory familiarization		Families requiring regulatory familiarization				Costs ($ mil.)
	Number	Costs ($ mil.)	Total IPs	New IPs	Turnover	Costs ($ mil.)	
2009	73,175	$3.92	206,600	....	....	$6.01	$9.93
2010	6,314	0.34	213,529	6,929	103,300	3.20	3.54
2011	6,314	0.34	214,529	1,000	106,765	3.13	3.47
2012	6,314	0.34	222,457	7,929	107,264	3.35	3.69
2013	6,314	0.34	230,386	7,929	111,229	3.46	3.80
2014	6,314	0.34	238,314	7,929	115,193	3.58	3.92
2015	6,314	0.34	246,243	7,929	119,157	3.69	4.03
2016	6,314	0.34	254,172	7,929	123,122	3.81	4.15
2017	6,314	0.34	262,100	7,929	127,086	3.92	4.26
2018	6,314	0.34	270,029	7,929	131,050	4.04	4.38
2019	6,314	0.34	277,957	7,929	135,014	4.16	4.50
2020	6,314	0.34	285,886	7,929	138,979	4.27	4.61

To estimate the number of incremental home healthcare providers that might earn an overtime wage premium or travel pay under the proposed revisions, the Department utilized BLS Occupational Outlook employment projections for 2018.[89] The Department interpolated employment data for 2011 through 2017, and extrapolated the time series through 2020 using a constant rate of growth assumption. Wage data were directly extrapolated using the time trend from 2000 through 2010. Based on these time series:

• Home Health Aide employment will increase by an average of 4.08 percent per year.[90] Median nominal wage will increase by an average of 1.66 percent per year while median real wage

[86] PHI, 2010a. p. 8. HHS, 2001. Pgs. 4, 5, and 7.

[87] U.S. Census Bureau, Center for Economic Studies. Business Dynamics Statistics: Firm Age by Firm Size. Available at: *http://www.ces.census.gov/index.php/bds/bds_database_list.* Accessed June 17, 2010.

[88] U.S. Census Bureau. 2008 National Population Projections. Table 2: Projections of the Population by Selected Age Groups and Sex for the United States: 2010 to 2050. Available at: *http://www.census.gov/population/www/projections/summarytables.html.* Accessed November 3, 2011.

[89] Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Outlook Handbook, 2010–11 Edition,* Home Health Aides and Personal and Home Care Aides, on the Internet at *http://www.bls.gov/oco/ocos326.htm* (visited September 20, 2011).

[90] Total hours worked and overtime hours worked will increase at the same rate in this model.

will increase by an average of 0.11 percent per year.[91]

- Personal Care Aide employment will increase by an average of 6.95 percent per year. Median nominal wage will increase by an average of 1.88 percent per year, and the median real wage will increase by an average of 0.33 percent per year.

Table 3–6 summarizes the projections of HHA and PCA employment and wages developed for this analysis.

TABLE 3–6—PROJECTED EMPLOYMENT AND HOURLY WAGE, HHAS AND PCAS, 2009–2020 [a]

Year	Home health aides			Personal care aides		
	Total employment (millions)	Median wage		Total employment (millions)	Median wage	
		Nominal	Inflation adjusted [b]		Nominal	Inflation adjusted [b]
2009	0.96	$9.85	$9.85	0.63	$9.46	$9.46
2010	0.98	9.89	9.74	0.69	9.44	9.29
2011	1.03	10.21	9.90	0.75	9.71	9.42
2012	1.08	10.38	9.92	0.81	9.92	9.48
2013	1.13	10.56	9.93	0.88	10.13	9.53
2014	1.18	10.74	9.95	0.94	10.34	9.58
2015	1.23	10.91	9.96	1.00	10.55	9.63
2016	1.28	11.09	9.96	1.07	10.76	9.67
2017	1.33	11.27	9.97	1.13	10.97	9.71
2018	1.38	11.45	9.97	1.19	11.18	9.75
2019	1.43	11.62	9.97	1.26	11.39	9.78
2020	1.48	11.80	9.97	1.32	11.61	9.81

[a] Derived from BLS Occupational Outlook.
[b] Estimate based on 10 year average change in PPI for Home Health Services.

The Department did not project transfer effects associated with minimum wage provisions of the FLSA on these occupations. BLS Occupational Employment Statistics on PCA and HHA wages for 2010 indicate that few, if any, workers are currently paid below minimum wage. BLS found no state in which the tenth percentile wage was below $7.25 per hour.[92]

Projected Cost Impacts

This section draws on the estimates of costs to determine the anticipated impact of the proposed regulations in terms of total cost across all industries as well as estimated cost per firm and per employee. Table 4–1 summarizes the first year costs, transfer effects and impacts of the proposed rule.

TABLE 4–1—SUMMARY OF FIRST YEAR IMPACT OF PROPOSED CHANGES

Impact	Amount
Transfers	Total ($ mil.)
Minimum Wages	$13.0
Minimum Wages to Self-Employed Workers	3.1
Travel Wages	26.7
Overtime Scenarios	
OT1	139.3
OT2	69.7
OT3	0.0
Total Transfers by Scenario	
Minimum Wage + Travel + Overtime Scenario 1	182.1
Minimum Wage + Travel + Overtime Scenario 2	112.5
Minimum Wage + Travel + Overtime Scenario 3	42.8
Deadweight Loss	Total
Disemployment Effect (number of workers)	505
Amount ($)	42,000

Costs	Year 1 ($ mil.)	Years 2–10 ($ mil.)	Annualized at 7% real discount rate ($ mil.)
Regulatory Familiarization	$3.9		
Self-employed Regulatory Familiarization	$6.0		

[91] The Department adjusted nominal wages for inflation using the average increase in the PPI for Home Health Services over the last 10 years (1.55 percent).

[92] BLS Occupational Employment Statistics, 2010 state estimates, at *http://stats.bls.gov/oes/*.

Table 4–2 presents the impact of regulatory familiarization costs on existing agencies and families in the first year. First year regulatory familiarization costs total $9.9 million; when annualized at a 7 percent discount rate over 10 years, total annualized costs are $1.3 million per year. Cost per agency is $54, while families employing independent providers will incur costs of $29 per family.

TABLE 4–2—IMPACT OF REGULATORY FAMILIARIZATION COSTS

Regulatory familiarization costs to:	Total projected compliance costs ($ mil.)			Cost to employers	
	Year 1 [a]	Years 2–10 [b]	Annualized at 7%	Cost per establishment [a]	Cost as percent of revenue
Home Healthcare Agencies	$3.9	$0.30–$0.3	$0.85	$54	0.0049
Families Employing Independent Providers	6.0	3.20–4.0	03.98	29	[b,c]

[a] Regulatory familiarization applies to 73,175 establishments; self-employment regulatory familiarization will impact 77,900 entities.
[b] Average revenue not calculated because for the purpose of this analysis the ''employer'' is the family employing the self-employed worker; therefore, there is no revenue available.
[c] Average revenue not calculated because for the purpose of this analysis the ''employer'' is the family employing the self-employed worker; therefore, there is no revenue data available.

Regulatory familiarization costs are only incurred once by an affected entity; additional regulatory familiarization costs are not incurred by these agencies and therefore do not affect their ability to bear regulatory familiarization costs. The approach to estimate regulatory familiarization costs to new entrants is discussed above in Projected Future Costs.

Market Impacts

The Department anticipates that the proposed rule will have relatively little effect on the provision of companionship services. There are almost no data, such as price elasticities of supply or demand, that can directly be used to model the market for companionship services. Furthermore, because approximately 75 percent of expenditures on home health services are reimbursed by Medicare and Medicaid, the effect of the rule depends vitally on how Medicare and Medicaid respond to the increase in the cost of providing home health services. However, despite these limitations, the Department used available data combined with best professional judgment to appropriately adjust parameter values, to project deadweight loss and disemployment effects of the proposed rule.

In this section, the Department first presents estimated costs and transfer effects for each provision of the proposed rule, along with qualitative discussion of potential market adjustments and impacts of that provision. The Department then presents the projected deadweight loss and disemployment effects of the proposed rule using a market model framework.

The Department estimates:

- Regulatory familiarization and adjustments to managing travel and overtime are projected to cost less than $4 million in the first year, or about $54 per establishment, which is perhaps 0.005 percent of average annual establishment revenue. As noted previously in this analysis, between 8 and 15 percent of PCAs and HHAs may work overtime, and employers currently manage these issues for other occupational categories. Furthermore, while employers of PCAs and HHAs who work overtime may require more time spent in managing travel and overtime, the Department believes, on average, there should be little impact on employment attributable to regulatory familiarization costs.
- Minimum wage provisions total $13.0 million (Table 3–4), a 3.3 percent increase in wage for 31,000 affected workers employed by agencies. In addition, the Department estimates that 7,500 independent providers directly employed by families might also receive a 3.3 percent wage increase attributable to the minimum wage provisions. If the price elasticity of demand for these workers is similar to the national average price elasticity of demand for all workers (−0.3),[93] about 310 agency-employed and 74 independent providers might lose their positions because of this provision. However, because many of these services are paid by Medicare and Medicaid, demand for them might be less elastic than the overall national average; this would reduce the disemployment effect; this will be discussed in greater detail below. Furthermore, it is likely these workers will be able to find new positions due to the overtime pay provisions and because the demand for these workers is projected to grow by 200 percent by 2050.[94]
- Projected travel costs represent a transfer of $27 million per year from agencies to employees (Table 3–4, although this might decline as agencies will now have incentive to more closely manage travel time). If these payments are spread equally over all agencies in this industry, they represent about a 0.06 percent increase in wages to employees. It is more likely that these payments will be distributed less uniformly; employees of some agencies might receive significant travel transfer effects, while others receive less.
- Transfer effects associated with overtime are most difficult to project. If Scenario 2 represents the best point estimate of overtime payments, then the $69.7 million in additional wages compose about 0.17 percent of annual wages if overtime is spread over all workers, or about 0.09 percent of average industry annual revenues if spread over all establishments. Again, it is likely that overtime payments will be distributed less uniformly in a way that is difficult to predict.

However, changes in wages are not the only determinant of how the market might tend to respond to the proposed rule; the demand for home health services, and therefore the demand for workers in this industry, also affects the market response. Conceptually, the demand for companionship services probably has two distinct components: Patients covered by Medicare and Medicaid, and out-of-pocket payers. According to the Medicare Payment Advisory Commission (MEDPAC), Medicare and Medicaid accounted for 35 and 41 percent, respectively, of total spending on home health in 2008.[95] Of the remaining 24 percent, out-of-pocket payers (including private insurance) are 20 percent (the remaining 4 percent is a mix of other governmental sources).[96]

[93] Hamermesh, D.S., Labor Demand. Princeton, N.J.: Princeton University Press. 1993.

[94] HHS 2003, p. v.

[95] Home Health Care Services Payment System. The Medicare Payment Advisory Commission (MedPAC). October 2010, available at: *http://www.medpac.gov/documents/MedPAC_Payment_Basics_08_HHA.pdf.*

[96] U.S. Census Bureau: Health Care and Social Assistance, Estimated Year-to-Year Change in

Continued

Currently, Medicare will cover, without a copayment requirement, all—or almost all—of allowed payment rate for home health care services for patients eligible for Medicare payments. Thus, the demand for services by these patients is likely to be highly inelastic, and the purchase of these services is dependent primarily on need and eligibility rather than price.[97] In addition, Medicare has historically determined the payment rate to providers of these services based in part on regional market prices of inputs, which in home health care services labor constitutes 77 percent of the cost of services.[98] Because minimum wage and travel are unavoidable costs of providing these services, it seems reasonable to assume that these costs will eventually be reflected in payment rates. The impact of overtime pay on reimbursement rates is more uncertain.

Patients that pay all, or a significant share, of costs out-of-pocket might have a significantly different price elasticity of demand for home health care services. Little information is known about this market segment, including the percent of home health care patients paying out-of-pocket, or the extent to which some have private insurance to cover costs. Because Medicare and Medicaid account for about 75 percent of total payments for home health care services, it is likely that the self-pay market segment is significantly smaller. To the extent that these patients are not covered by private insurance and pay out-of-pocket, they are likely to have a more elastic demand for services; if the prices for home health services increases, these patients are more likely to search for lower cost alternatives, including relying on family members to provide care, institutionalizing the patient (but see discussion of Medicare and Medicaid, infra, indicating that this may not occur), or accessing the grey market. However, the size of such an effect is difficult to predict on the basis of extant information.

Because incremental transfers are projected to be small relative to industry wages and revenues, and because the market for these services is dominated by government payers, the Department expects the impact of the proposed rule on the market for home health care services to be relatively small. However, to the extent that some transfers are not reimbursed by government payers, and that agencies might therefore increase price to patients, they might result in some patients seeking alternatives to the organized market for home health care services.

Deadweight Loss

Deadweight loss from a regulation results from a wedge driven between the price consumers pay for a product or service, and the price received by the suppliers of those services. In this case, the transfer of income from agency owners to agency employees through minimum wage and overtime provisions reduces agencies' willingness to provide companionship services at the current market price. Because patients and their families must now pay more to receive the same hours of service, they reduce the number of hours of services they purchase; it is this reduction in services that causes the allocative inefficiency (deadweight loss) of the rule.

To estimate deadweight loss, the Department must estimate the reduction in services agencies are willing to provide at the current market price, the resulting increase in market price paid by patients and families, and their reduced purchases of companion services. To do this, the Department will use: (1) The current market wage and hours purchased of companion services; (2) the estimated regulatory costs and income transfers resulting from the rule; and (3) the price elasticity of demand for and supply of companion services.

As described above, the Department has estimated approximately 353,000 HHAs and 423,000 PCAs work in states without current overtime and/or minimum wage provisions or are directly employed by the home; of these, 339,000 HHAs and 399,000 PCAs are employed in agencies and are potentially affected by the overtime provisions of the proposed rule. These caregivers each provide about 35 hours per week of companion services in the home. The average hourly wage in these states is $9.85 for HHAs and $9.45 for PCAs. The Department used the number of employees affected by overtime provisions in its calculation of deadweight loss because: (1) The populations of affected workers in states without minimum wage and overtime provisions are largely overlapping and thus create potential double-counting; (2) under Scenario 2, overtime premiums are four times larger than projected minimum wage payments, and (3) spreading costs and transfers over a smaller worker population results in a more conservative estimate of deadweight loss (that is, the Department is more likely to overestimate, than underestimate deadweight loss).

The Department estimated a range of regulatory costs and income transfers depending on the assumptions made concerning business response to the regulation. As discussed above, the most probable of the three scenarios considered (Scenario 2) assumes an equal split of overtime costs between agencies, who pay at least some limited amount of overtime, and caregivers, who reduce hours worked at that agency (although they might seek additional hours to work at other agencies). Combining projected costs under Scenario 2, with the amounts due based upon the minimum wage and travel pay provisions, the Department estimated the deadweight loss of the rule based on first year compliance costs of $122.4 million. Thus, the rule might cost $166 per potentially affected worker, or approximately $0.0912 per hour assuming workers average 35 hours per week, about 0.93 percent of current hourly wage for HHAs and 0.96 percent for PCAs.

There are no econometric estimates of the price elasticity of demand or supply for companionship services. The price elasticity of demand for labor services has been estimated as -0.3 (a 1 percent increase in wages will cause a 0.3 percent reduction in hours purchased). However, it is reasonable to expect that the demand for companionship services is less elastic than the demand for general labor services because much of the cost is paid by Medicare and Medicaid. As a result, patients and family members are largely cushioned from the direct effects of changes in price for these services and are thus less likely to change their demand for them. Therefore, the Department assumes the demand for home companionship services is one-half the price elasticity of demand for general labor services, or -0.15.

The price elasticity of supply for hourly labor has been estimated at 0.1 (a 1 percent increase in wages will cause

Revenue for Employer Firms by Source, Table 8.9. Available at: *http://www.census.gov/services/sas_data.html*.

[97] Home Health Care Services Payment System. The Medicare Payment Advisory Commission (MedPAC). October 2010, available at: *http://www.medpac.gov/documents/MedPAC_Payment_Basics_08_HHA.pdf*. Medicare, for example, does not require copayment for eligible patients.

[98] Section 1895 of the Social Security Act required that that the home health prospective payment system (HH PPS) make payment for all costs of home health services. As such, under the HH PPS, Medicare covers and pays for all home health services, including medical supplies, that are reasonable and necessary, for beneficiaries that are eligible for the Medicare home health benefit. The law requires that the HH PPS rates be updated, on an annual basis, by the home health market basket update (plus or minus any percentage legislated by Congress). CMS uses the home health market basket index, which measures (and tracks) inflation in the prices of an appropriate mix of goods and services that HHAs purchase in furnishing home health care. Medicare cost report data are used to construct the cost weights for the blended wage and benefit index. See also Home Health Care Services Payment System. MedPAC. 2010.

a 0.1 percent increase in hours supplied). However, among married women, that price elasticity of supply is estimated to be about 0.14; because hours worked in this labor market are primarily supplied by married women, the Department selected a value of 0.14 to use as the price elasticity of supply of home healthcare services in this analysis.

Based on these price elasticities of supply and demand, the estimated cost per caregiver hour, and baseline employment and wages, the Department projects that for:

- HHAs, hourly wage will increase by $0.044 to $9.89, and employment will decrease by about 227, or about 413,000 hours of companionship services annually; deadweight loss will be $18,800 annually.
- PCAs, hourly wage will increase by $0.044 to $9.50, and employment will decrease by 278, or about 507,000 hours of companionship services annually; deadweight loss will be $23,100 annually.

In addition, transfers to home caregivers will be borne by the patients and their families in the form of higher prices, and by agencies and their owners in the form of reduced income. The determination of who pays these transfers is a function of the relative price elasticities of supply and demand; with inelastic demand and labor supply, these transfers are approximately equally shared between purchasers (about 48.3 percent borne by patients, their families, and Medicare and Medicaid) and agencies (about 51.7 percent). For:

- HHAs, about $27.1 million is estimated to be paid by patients, their families, and Medicare and Medicaid; while $29.1 million is estimated to be paid by agencies and their owners in the form of reduced income.
- PCAs, patients, their families, and Medicare and Medicaid are estimated to pay about $31.9 million, and $34.2 million is estimated to be paid by agencies and their owners in the form of reduced income.

Table 4–3 summarizes both the values of the parameters used in the deadweight loss analysis and the results of the analysis.

TABLE 4–3—SUMMARY OF DEADWEIGHT LOSS ESTIMATION

	HHA	PCA	Total
Values Used in Deadweight Loss Analysis			
Price Elasticity of Demand	−0.15	−0.15	
Price Elasticity of Supply	.14	.14	
Baseline Hourly Wage	$9.85	$9.46	
Baseline Employment[a]	338,801	398,960	737,761
Compliance Costs ($ mil.)[b]			$122.4
Compliance Costs per Hour[c]			$0.0912
Results of Deadweight Loss Analysis			
Post-Rule Hourly Wage	$9.89	$9.50	
Post-Rule Hourly Employment	338,574	398,682	737,255
Change in Hourly Wage	$0.044	$0.044	
Change in Employment	−227	−278	−505
Deadweight Loss	$18,837	$23,096	$41,933
Percent of Costs and Transfers Paid by Purchasers[d]	48.3%	48.3%	48.3%
Costs and Transfers Paid by Purchasers ($ mil.)	$27.1	$31.9	$51.9
Percent of Costs and Transfers Paid by Employers[e]	51.7%	51.7%	51.7%
Costs and Transfers Paid by Employers ($ mil.)	$29.1	$34.2	$63.3

[a] Agency employment in states without minimum wage and/or overtime laws plus independent providers in states without minimum wage laws.
[b] Estimated sum of transfers and costs from overtime scenario 2, travel, minimum wage, and regulatory familiarization costs.
[c] Assumes each caregiver works 35 hours per week 52 weeks per year.
[d] Costs and transfers paid by purchasers in the form of higher prices; includes direct purchase of home health care services and services purchased through Medicare/Medicaid.
[e] Costs and transfers paid by employers in the form of lower profits.
Individual components may not sum to totals due to rounding.

Impact to Medicare and Medicaid Budgets.

In 2009, HHS outlays for Medicare programs totaled $424 billion, and outlays in support of Medicaid totaled $251 billion.[99] Under Medicare, an estimated $18.3 billion went to home health programs, while Medicaid programs accounted for approximately another $38.1 billion (approximately $40 billion inflated to 2009 dollars) through various programs.[100] In 2008, Medicare and Medicaid accounted for nearly 75 percent of home health care services revenue; thus, the impact of the proposed rule on home health care will depend vitally on how Medicare and Medicaid respond to increased labor costs.

Although increased payments to workers associated with minimum wage, travel, and overtime provisions of the proposed rule are considered transfer effects from a societal perspective, the Department expects agencies will try to pass these transfers through to Medicare and Medicaid. Under the three overtime scenarios examined, average annualized payments range from $41.5 to $226.0 million depending on how home health care agencies respond to overtime requirements. If Medicare and Medicaid continue to pay 75 percent of home health care costs, roughly $31.1 million to $169.5 million in costs might be incurred by these government programs. These costs compose 0.06 to 0.29 percent of total HHS and state outlays for home health care programs ($58.1 billion).

We invite comment on the impact of the rule of on Medicaid, Medicare, and the private market, including the impact on the affordability of home health and home and community-based services.

[99] U.S. Department of Health and Human Services (HHS). 2011. FY 2011 Budget, available at *http://dhhs.gov/asfr/ob/docbudget/2011budgetinbrief.pdf.* p. 13.

[100] *Id.*

Projected Future Transfer Effects Due to Industry Growth

This section projects costs, and impacts over 10 years. The Department used several key assumptions to develop these projections. First, the Department assumed that the number of home healthcare workers directly employed in the homes or employed in states without current overtime premium requirements will remain a constant percentage of total employment in those occupations between 2010 and 2020 (about 35.5 percent of HHAs and 63.3 percent of HHAs).

Second, we also maintained the assumptions that 12 percent of workers exceed 40 hours worked per week and that 10 percent of these caregivers work 45 hours per week while 2 percent work 12.5 hours of overtime per week. These overtime assumptions are identical to those used to estimate costs and transfers for 2009, while the percentages used to estimate the number of workers potentially affected in each year were calculated from the 2009 analysis.

Third, consistent with the 2009 analysis, we project two three overtime scenarios: And one for travel costs:

- *Scenario 1:* Employers make no adjustment to hours worked and pay all workers the overtime premium for all hours worked in excess of 40 per week.
- *Scenario 2:* Employers adjust schedules and/or hire additional workers to reduce overtime payment; we assume 50 percent of overtime payments can be avoided through these market adjustments.
- *Scenario 3:* Employers adjust schedules and/or hire additional workers to eliminate overtime payments.

Finally, we continue to estimate travel costs 19.2 percent of Overtime Scenario 1 costs.

The Department excluded potential transfer effects associated with the minimum wage provision from the projections because the current number of workers earning less than the minimum wage is relatively small and will decline steadily as nominal wages increase. Although the Department expects that the parameters used in this analysis will not remain constant, it has no information on which to base estimates of how these key variables might change over time. Therefore, maintaining the assumptions used in the analysis for 2009 provide the best basis for projecting future costs and transfer effects.

Based on the data and assumptions described in this section, and the employment and wage projections in Table 3–6, Table 4–4 presents the Department's projections through 2020 of overtime and travel payments attributable to the revisions to the companionship regulations FLSA proposed in this notice.

TABLE 4–4—PROJECTED HHA AND PCA OVERTIME HOURS, OVERTIME PAY AND TRAVEL PAY ATTRIBUTABLE TO PROPOSED REVISIONS, 2010–2020[a]

Year	Overtime hours worked (millions)[b]		Overtime and travel payments (millions)[c]		
	Scenario 1	Scenario 2	Scenario 1	Scenario 2	Travel/ Scenario 3
			Nominal dollars		
2010	30.5	15.3	$147.1	$73.6	$28.2
2011	32.8	16.4	162.7	81.3	31.2
2012	35.0	17.5	177.2	88.6	34.0
2013	37.3	18.6	192.2	96.1	36.9
2014	39.5	19.8	207.7	103.9	39.9
2015	41.8	20.9	223.6	111.8	42.9
2016	44.0	22.0	240.0	120.0	46.1
2017	46.3	23.2	256.8	128.4	49.3
2018	48.6	24.3	274.0	137.0	52.6
2019	50.8	25.4	291.8	145.9	56.0
2020	53.1	26.5	309.9	155.0	59.5
			Inflation adjusted dollars		
2010	30.5	15.3	144.8	72.4	27.8
2011	32.8	16.4	157.8	78.9	30.3
2012	35.0	17.5	169.3	84.6	32.5
2013	37.3	18.6	180.8	90.4	34.7
2014	39.5	19.8	192.4	96.2	36.9
2015	41.8	20.9	204.0	102.0	39.2
2016	44.0	22.0	215.6	107.8	41.4
2017	46.3	23.2	227.2	113.6	43.6
2018	48.6	24.3	238.8	119.4	45.8
2019	50.8	25.4	250.3	125.2	48.1
2020	53.1	26.5	261.9	130.9	50.3

[a] Calculations based on employment and wage data in Table 3–6 and specified assumptions.
[b] Under Scenario 3, no overtime payments are incurred.
[c] Because overtime payments under Scenario 3 are zero, total payments under Scenario 3 are identical to travel payments. Total payments under Scenarios 1 and 2 are equal to overtime payments under that scenario plus travel payments.

The Department projects that paid overtime hours will increase from 30.5 million to 53.1 million between 2010 and 2020 with a consequent increase in overtime pay from $147.1 million to $309.9 million assuming employers make no adjustment to overtime work patterns (Scenario 1). In inflation-adjusted dollars, overtime pay is projected to increase from $144.8 million to $261.9 million. Assuming employers are able to cover 50 percent of overtime hours through scheduling changes and/or hiring additional workers (Scenario 2), the projected

increase is half that of Scenario 1. Travel pay is projected to increase from $28.2 million to $59.5 million in nominal dollars ($27.8 million to $50.3 million in inflation-adjusted dollars) over that same period.

To place these projected future transfer effects resulting from the proposed rule in context, the Department compared nominal transfer effects to projected Medicare spending over the same period. The Centers for Medicare & Medicaid Services report that in 2010 Medicare expenditures totaled $522.8 billion, $19.1 billion of which was spent on the provision of home health care services, and that annual Medicare expenditures are projected to increase to $932.1 billion by 2020.[101] Assuming that expenditures of home health services as a percent of total Medicare expenditures remains constant, annual home health care expenditures might increase to $34.1 billion by 2020.[102]

However, the total overtime and travel payments projected to result from the proposed rule will not paid by Medicare. On average, about 51.7 percent of projected costs and transfer effects are expected to be paid by providers in the form of lower profits (see discussion of deadweight loss for details). Further, only about 75 percent of payments for home health care services are attributable to Medicare and Medicaid; patients and their families and their private insurance account for 20 percent of payments. About 5 percent is accounted for by a mix of other governmental programs.

After adjusting projected overtime and travel transfer effects, the Department expects incremental Medicare payments attributable to the rule will increase from about $59.8 million in 2010 to $133.8 million in 2020 under Scenario 1, and from $34.7 million to $77.6 million under the more probable Scenario 2, and from $9.6 million to $21.5 million under Scenario 3 (as discussed above, the Department expects the market response to the rule will most likely lie somewhere between Scenario 2 and Scenario 3). These incremental payments compose no more than 0.4 percent of projected Medicare Home Health Care expenditures under Scenario 1, and 0.23 percent of those expenditures under Scenario 2, and 0.06 percent under Scenario 3. Table 4–5 summarizes projected Medicare budgets, incremental payments attributable to the proposed rule, and those payments as a percent of Medicare Home Health Care expenditures from 2010 through 2020.

TABLE 4–5—PROJECTED OVERTIME AND TRAVEL PAY AS PERCENT OF MEDICARE HOME HEALTH CARE EXPENDITURES

Year	Medicare expenditures (billions)[a]		Adjusted overtime & travel payments in nominal dollars (millions)[b]			OT & Travel as % Medicare home health care		
	Total	Home health care	OT 1 + Travel	OT 2 + Travel	OT 3 + Travel	OT 1 + Travel	OT 2 + Travel	OT 3 + Travel
2010	$522.8	$19.1	$59.8	$34.7	$9.6	0.31	0.18	0.05
2011	522.8	19.1	63.5	36.9	10.2	0.33	0.19	0.05
2012	557.4	20.4	70.2	40.8	11.3	0.34	0.20	0.06
2013	572.2	20.9	76.5	44.4	12.3	0.37	0.21	0.06
2014	606.6	22.2	83.0	48.2	13.4	0.37	0.22	0.06
2015	643.4	23.5	89.6	52.0	14.4	0.38	0.22	0.06
2016	675.8	24.7	96.5	56.0	15.5	0.39	0.23	0.06
2017	716.1	26.2	103.6	60.1	16.7	0.40	0.23	0.06
2018	760.3	27.8	110.8	64.3	17.9	0.40	0.23	0.06
2019	809.6	29.6	118.3	68.7	19.1	0.40	0.23	0.06
2020	864.5	31.6	125.9	73.1	20.3	0.40	0.23	0.06

[a] Total Medicare expenditures projected by CMS; Home Healthcare Expenditures extrapolated based on the percent of total Medicare expenditures in 2010.

[b] Projected payments reduced by 9.1 percent to adjust for average percent of costs paid by agencies in the form of lower profits, then reduced by 25 percent to adjust for percent of home health care purchases paid by patients and their families.

The Department also projected deadweight loss and employment impacts over 10 years. These projections are calculated maintaining the assumptions concerning the price elasticities of supply and demand discussed in the first year deadweight loss analysis, projected regulatory familiarization costs summarized in Table 3–5, and projected overtime and travel payments presented in Table 4–4. The Department's calculated deadweight loss and employment impacts over 10 years are summarized in Table 4–6.

TABLE 4–6—PROJECTED DEADWEIGHT LOSS AND EMPLOYMENT IMPACTS

	Year 1 ($ mil.)	Years 2–10 ($ mil.) [a]	Years 2–10 ($ mil.) [a]	Average annualized value ($ mil.)	
				3% Real rate	7% Real rate
Regulatory Familiarization Costs					
Agencies	$3.9	$0.3	$0.3	$0.7	$0.8
Families Hiring Self-employed	6.0	3.2	4.0	3.8	3.9

[101] The Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Washington, DC, May 13, 2011. 2011 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. Accessed at: *https://www.cms.gov/reportstrustfunds/downloads/tr2011.pdf,* October 7, 2011.

[102] The report indicates that expenditures of home health services as a percent of total Medicare expenditures are expected to increase by a small amount over that period.

TABLE 4–6—PROJECTED DEADWEIGHT LOSS AND EMPLOYMENT IMPACTS—Continued

	Year 1 ($ mil.)	Years 2–10 ($ mil.) [a]		Average annualized value ($ mil.)	
				3% Real rate	7% Real rate
Transfers					
Minimum Wages (MW)					
to Agency-Employed Workers	13.0	0.0	0.0	1.5	1.7
to Self-Employed Workers	3.1	0.0	0.0	0.4	0.4
Travel Wages	26.7	27.8	45.8	35.4	34.7
Overtime Scenarios					
OT 1	139.3	144.8	238.8	184.2	180.7
OT 2	69.7	72.4	119.4	92.1	90.4
OT 3	0.0	0.0	0.0	0.0	0.0
Total Costs and Transfers by Scenario					
Reg Fam + MW + Travel + OT 1	192.1	176.2	289.0	226.0	222.2
Reg Fam + MW + Travel + OT 2	122.4	103.8	169.6	133.9	131.9
Reg Fam + MW + Travel + OT 3	52.7	31.4	50.2	41.8	41.5
Deadweight Loss					
Reg Fam + MW + Travel + OT 1	0.103	0.080	0.132	0.105	0.103
Reg Fam + MW + Travel + OT 2	0.042	0.027	0.044	0.036	0.036
Reg Fam + MW + Travel + OT 3	0.008	0.002	0.004	0.003	0.003
Disemployment (number of workers)					
Reg Fam + MW + Travel + OT 1	793	739	1,169	938 [b]	
Reg Fam + MW + Travel + OT 2	505	435	686	555 [b]	
Reg Fam + MW + Travel + OT 3	218	132	203	172 [b]	

[a] These costs are a range where the first number represents the estimate for Year 2; the second estimate for Year 10.
[b] Simple average over 10 years.

Total average annualized regulatory familiarization costs, and minimum wage, overtime premium, and travel payments range from $41.5 million to $226.0 million per year based on how employers adjust to the requirement to pay overtime wage premiums. These costs and transfers are projected to cause average annualized deadweight loss ranging from $3,000 to $105,000 per year. These costs and transfers are also projected to cause disemployment impacts ranging from 172 to 938 workers per year.

Non-monetized Projected Impact

Two additional aspects of home health care services might be affected by the proposed rule. First, the proposed rule might result in increased purchases of home health care services through the informal, or ''grey,'' market. Second, although the hours of care received by patients might be unaffected by the increased costs of care, the quality of that care might suffer (however, the quality of care also may increase due to increased professionalism and decreased turnover). These are discussed in turn below.

The Grey Market

An unknown number of patients receive home care services through more informal arrangements with care providers, sometimes called the ''grey'' market. Here, informal agreements are reached between the patient (or patient's family) and the caregiver regarding hours of care and hourly pay rates. Because income and payroll taxes can be avoided, services can be provided at lower cost than when provided through agencies.

The proposed rule will increase costs to home health care agencies that offer services in states where they are not required to pay the minimum wage and/or overtime pay and an unknown percentage of those costs might be reimbursed by Medicare and Medicaid. If the costs are not fully reimbursed, home health care agencies might increase the rates they charge patients, have their profit margin squeezed, or both. If costs are passed through to patients and their families, they will have incentive to look for lower cost alternatives such as the grey market. In addition, workers who desire to work more than 40 hours per week might have opportunities to provide services through the grey market rather than work for multiple agencies. Although the proposed rule might increase incentives on both sides to use the grey market, there is no information available to project potential changes to that market.

Continuity of Care

Continuity of care ''is commonly framed as being composed of provider continuity (a relationship between a patient and provider over time), information continuity (availability and use of data from prior events during current client encounters) and management continuity (coherent delivery of care from different doctors).'' [103] In the home care scenario, concerns have been raised that continuity of care, specifically provider continuity, may suffer if employers opt not to pay overtime for aides who, for example, work more than 40 hours per week for a single client and instead employ other aides to also provide companionship to that client in the same workweek. Some are concerned that a break in the continuity of care

[103] Walraven, C., Oake, N., Jennings, A., *et al.* The association between continuity of care and outcomes: a systematic and critical review. *Journal of Evaluation in Clinical Practice,* April 2009, 947–956.

may result in a reduction in the quality of care.

The Department understands that home health care involves more than the provision of impersonal services; when a caregiver spends significant time with a client in the client's home, the personal relationship between caregiver and patient can be very important. Certain clients may prefer to have the same caregiver(s), rather than a sequence of different caregivers. The extent to which home health care agencies choose to spread employment (hire more companions) rather than pay overtime may cause an increase in the number of caregivers for a client; the client may be less satisfied with that care, and communication between caregivers might suffer, affecting the quality of care for the client.[104]

Although matching client and caregiver in a long-term personal relationship is the ideal for many clients, it may not be the norm. For instance, the turnover rate (those leaving and entering home care work) for workers in the home health care industry has been estimated to range from 44 to 65 percent per year.[105] Other studies have found turnover rates to be much higher, up to 95 percent [106] and, in some cases, 100 percent annually.[107] Thus, many clients already experience a sequence of different caregivers, and it is not apparent that the proposed rule will necessarily worsen the turnover rate. In fact, coverage under the FLSA may reduce turnover rates. Frequent turnover is costly for employers in terms of recruitment costs and training of new aides and also in terms of the likelihood of a reduction of quality care or not being able to provide care at all. The employee turnover rate in this industry is high because of low wages, poor or nonexistent benefits, and erratic and unpredictable hours. Job satisfaction, and the desire to remain in a given position, is highly correlated with wages, workload, and working conditions. Increased pay for the same amount of work and overtime compensation likely would aid in employee retention and attracting new hires. Those employers who choose not to pay overtime essentially would need to spread the hours among their employees, resulting in more consistent work hours for many aides. Moreover, any extra wages earned may be used to pay for other benefits, such as health insurance coverage. As one study found, for this low-income workforce, ''compensation accounts for more actual job turnover. [Therefore, h]igher wages, more hours, and travel cost reimbursement are found to be significantly associated with reduced turnover.'' [108] Another report determined that ''increases in the federal or state minimum wage can make home care employment more desirable.'' [109]

For the estimated 8 to 15 percent of aides who work more than 40 hours per week, only a portion of that percentage likely provides services for the same client. Many who work overtime accrue long hours in the service of at least a few clients, traveling between client homes during the workweek. It is also conceivable that in a minority of cases, the aide provides companionship services around the clock for a stretch of a few or several days. Most, however, have been estimated to work 45 hours per week on average, not including travel time between client homes.

Provider continuity that results in overtime work, however, has drawbacks. From the aide's perspective, the long work hours can be a burden. For instance, ''it cannot be denied shifts beyond the traditional 8 hours have been associated with increased risk of errors, incidents, and accidents.'' [110] Many studies have shown that extended work hours result in increased fatigue, decreased alertness and decreased productivity, negatively affecting employee health and well-being. Long work hours in the healthcare field ''have adverse effects on patient outcomes and increase health care errors and patient injuries.'' [111] For example, nurses working more than 8 hours report more medication errors, falling asleep at work, a decrease in productivity, and impaired critical thinking abilities. The error rates double when nurses work 12.5 or more consecutive hours. A 2004 National Institute for Occupational Safety and Health report found that ''12-hour shifts combined with more than 40 hours of work per week reported increases in health complaints, deterioration in performance, or slower pace of work.'' [112] One study that analyzed 13 years worth of data and nearly 100,000 job records notes that ''long working hours indirectly precipitate workplace accidents through a causal process, for instance, by inducing fatigue or stress in affected workers.'' [113] It is therefore telling that ''[d]irect care workers have the highest injury rate in the United States, primarily due to work-related musculoskeletal disorders.'' [114] One of the purposes of the FLSA's overtime pay requirement is to induce employers to hire more people to work fewer hours each. Doing so in those circumstances where excessive overtime hours are worked may therefore result in better care provided.

Many regard having the same home care aide for long hours as a cornerstone of ''continuity of care'' and having more aides to cover the same number of companion hours for a client as negatively impacting quality of care. As discussed above, however, the opposite may be true. Working extended hours may affect the quality of care that the aide is able to provide and even the aide's own health and well-being. Coverage for companions under wage and hour laws may also result in improved retention and hiring, which saves the employer costs related to turnover rates; job satisfaction; and increase in pay. Attendant benefits of spreading work hours more evenly may include job stability for companions, decreased risk of fatigue, errors and work-related injuries, and better overall job performance, resulting in improved client care and outcomes.

Furthermore, it has been shown that paying employees below minimum wages, not paying for all hours worked or overtime, and providing no training or benefits is not the only path to success that an employer has in the home care industry. Another business model, in which employees receive training, an overtime wage differential, and health care benefits, has been

[104] Brief of Amici Curiae City of New York. 2007.

[105] PHI, 2010a.

[106] Zontek, T., Isernhagen, J., Ogle, B. Psychosocial factors contributing to occupational injuries among direct care workers. *American Association of Occupational Health Nurses Journal,* August 2009, 338–347.

[107] Ashley, A., Butler, S., Fishwick, N. Home care aide's voices from the field: Job experiences of personal support specialists. The Maine home care worker retention study. *Home Healthcare Nurse,* July/August 2010, 28(7), 399–405.

[108] Morris, L. Quits and job changes among home care workers in Maine: The role of wages, hours and benefits. *The Gerontologist,* 2009, 49(5), 635–650.

[109] Burbridge, L. The labor market for home care workers: Demand, supply, and institutional barriers. *The Gerontologist,* 1993, 33(1), 41–46.

[110] Keller, S. Effects of extended work shifts and shift work on patient safety, productivity, and employee health. *American Association of Occupational Health Nurses Journal,* December 2009, 57(12), 497–502.

[111] Keller, S. 2009.

[112] Caruso, C., Hitchcock, E., Dick, R., *et al.* Overtime and extended work shifts: Recent findings on illnesses, injuries, and health behaviors. *National Institute for Occupational Safety and Health, U.S. Department of Health and Human Services.* April 2004.

[113] Dembe, A., Erickson J., Delbos, R., *et al.* The impact of overtime and long work hours on occupational injuries and illnesses: new evidence from the United States. *Occupational and Environmental Medicine,* 2005, 62, 588–597.

[114] Zontek *et al,* 2009. Psychosocial Factors Contributing to Occupational Injuries Among Direct Care Workers. AAOHN Journal, 2009, Vol. 57, No. 8, 338–347. In this study, direct care workers includes nursing aides, orderlies, and attendants in any setting (institutional or residential).

successful. Cooperative Home Care Associates (CHCA), based in New York, for example, has always paid workers overtime. Although overtime at CHCA is carefully managed, it can still be substantial (*e.g.,* 30 percent or more of employees exceed 40 work hours per week); allowing, even expecting overtime, permits CHCA, however, to use a staffing plan that maintains continuity of care. These policies have driven CHCA's turnover rate far below the industry average, a major factor in its financial success.[115] In terms of employee coverage, CHCA cases requiring weekday and weekend coverage are assigned permanent aides who work on alternate weekends. Also, cases requiring 24-hour coverage, seven days per week, are shared among four aides, requiring only some overtime hours.[116] Other agencies such as Community Care Systems, Inc., in Springfield, Illinois, have reduced overtime costs by distributing extra hours more evenly among workers through better tracking of work hours. Close monitoring of employee workloads and spreading of work hours also curbed overtime use for Illinois-based Addus HealthCare, one of the nation's largest home care employers. These employers pay overtime even in those states that do not require it, demonstrating that ''wage and hour protections are economically realistic for the industry, and can be achieved without excessive use of costly overtime hours.'' [117] These examples suggest that requiring overtime pay in this industry does not inevitably cause disruption of employer-employee relationships and caregiver-patient relationships leading to higher turnover, discontinuity of patient care, and increased use of the grey market.

Benefits

This section describes the expected benefits of the proposed change to the companionship exemption. Potential benefits of this revision to the ''companionship services exemption'' flow from the transfer of regular and overtime wages to workers from their employers, and include: Reduced worker turnover, reduced worker injury rates, and decreased worker reliance on public assistance programs.

Transfer Effects

Perhaps the most significant effect of the proposed rule is the transfer of income from businesses and their owners to workers, and potentially, from one group of workers to another group of workers. In economics, a transfer payment is broadly defined as a redistribution of income in the market system that does not affect output.

Transfer Effects Associated With Minimum Wage and Travel Provisions

The proposed rule leads to an unambiguous transfer from employers to employees in those states that currently do not require agencies to pay minimum wage to employees who provide this type of home health care services. Similarly, payment for travel time is also an unambiguous transfer of income from businesses and their owners to workers. These are estimated to be approximately $39.7 million. In addition, the $3.1 million in minimum wage payments to independent providers directly employed by families represent an unambiguous transfer from families to caregivers.

Two factors could change the dynamics of this transfer scenario. First, increased wages and travel cost might be passed through to patients in the form of higher prices for home health care services. If those higher prices result in patients finding alternatives to home health care services (*e.g.,* accessing the grey market for services or institutionalizing the patient), then the income transfer through travel and overtime pay is partially offset because the provision of home health services is reduced, resulting in reduced revenues to agencies, and the deadweight loss to the economy. This reduction in demand by households will be less pronounced if the demand for home health care services is inelastic (*i.e.,* the hours of home health care services purchased does not change when price increases), as assumed in this analysis. The Department believes the market response to the proposed rule will be relatively small, but did not estimate the response due to lack of information.

Second, the Department expects that over time some of these costs may be reimbursed to agencies through increased Medicare and Medicaid payments. To the extent that Medicare and Medicaid increase reimbursement rates to cover these costs, the transfer is from the federal and state agencies to workers.

Transfer Effects Associated With Overtime Provisions

The transfer of income associated with the payment of the overtime differential is more ambiguous. Employers are likely to respond to overtime pay requirements along a spectrum ranging from (1) banning all overtime and spreading hours to other workers or hiring new workers to fill the available hours, to (2) maintaining current staffing patterns and paying overtime for all work hours exceeding 40 per week. To the extent that employers choose to pay overtime, the income transfer is from businesses and their owners to workers. However, to the extent that employers eliminate overtime and spread the now available hours to other employees or new hires, the transfer is from worker to worker. Employees who used to exceed 40 hours of work per week will work fewer hours, transferring income to fellow workers who will absorb the extra hours. It is also possible that those employees working greater than forty hours may distribute those hours among multiple employers.

Potential Macroeconomic Impacts of Transfer Effects

In the first year, the proposed rule is expected to transfer $42.8 million in income from businesses and families to home health care workers due to minimum wage and travel time pay requirements. Up to $139.3 million more might be transferred in the first year to workers due to the overtime provisions, although the total amount transferred, and the percent transferred from owners versus other workers depends on how owners modify staffing plans in response to the rule.

Because employees in this industry earn on average hourly wages of approximately $10.14, it is reasonable to assume that a high percentage of the extra income would be spent by the employees and their families. The percent spent of each additional dollar earned is the marginal propensity to consume (MPC) out of income. It is also reasonable to assume that the MPC for these employees is higher than the MPC of their employers; for example, employees might spend $0.90 of each additional dollar earned, while their employers, with significantly higher incomes, might spend only $0.50 of each additional dollar earned. Thus, the transfer of income from employers to employees is likely to result in increased aggregate consumption because of employees' higher MPC.

The additional consumption might stimulate the economy an amount that exceeds the initial expenditure through the multiplier effect (*e.g.,* the increased purchases by home health care workers generate additional income for those businesses, whose owners then increase their own spending). Moody's Economy.com model suggests the multiplier effect for low-income consumers ranges from 1.64 for income associated with food stamps to 1.73 for

[115] Elsas & Powell, 2011.

[116] NELP report, page 26.

[117] NELP report, page 25–26.

income from unemployment benefits.[118] Thus, $1 of food stamps given to low income consumers increases GDP by $1.64 dollars.

The key unknowns in estimating any multiplier effect associated with the proposed rule include:

- Estimating income transfers strictly from employers to employees, excluding transfers from one group of employees to another group of similar employees.
- The difference between the MPC of employers and employees; the Department was unable to find estimates of MPC by annual income.
- The size of the multiplier.

The Department did not estimate the multiplier effect due to the uncertainty associated with key variables and parameters for the calculation.

Reduction in Employee Turnover Rates

Researchers have found that lower wages are associated with higher turnover and lower quality of care, and that increases in wages for home health care workers result in decreased turnover rates. Excessive employee turnover is costly to businesses, and as mentioned earlier, studies have found turnover rates in the home health care industry range from 44 to 95 percent per year, and even approach 100 percent per year.[119]

Frequent turnover is costly for employers in terms of recruitment costs and training of new aides and also in terms of the likelihood of a reduction in the quality of care or not being able to provide care at all. The employee turnover rate in this industry is high because of low wages, poor or nonexistent benefits, and erratic and unpredictable hours. Job satisfaction, and the desire to remain in a given position, is highly correlated with wages, workload, and working conditions. Increased pay for the same amount of work and overtime compensation likely would aid in employee retention and attracting new hires. Those employers who choose not to pay overtime essentially would need to spread the hours among their employees, resulting in more consistent work hours for many aides.

Decreasing the rate of employee turnover may result in significant cost savings to employers. For example, an agency employing 50 workers with a turnover rate of 35 percent replaces about 18 workers per year. The new workers hired to replace the workers who left must be recruited, interviewed and trained to perform the job tasks, requiring a significant investment of time and resources by the employer. If the turnover rate decreases by 10 percent to 25 percent per year, then only about 13 workers would be replaced annually.

Reduction in Worker Injuries and Illnesses

Many studies have shown that extended work hours result in increased fatigue, decreased alertness, and decreased productivity, negatively affecting employee health and well-being. A 2004 National Institute for Occupational Safety and Health report found that ''12-hour shifts combined with more than 40 hours of work per week reported increases in health complaints, deterioration in performance, or slower pace of work.'' [120] One study that analyzed 13 years worth of data and nearly 100,000 job records notes that ''long working hours indirectly precipitate workplace accidents through a causal process, for instance, by inducing fatigue or stress in affected workers.'' [121] It is therefore telling that ''[d]irect care workers have the highest injury rate in the United States, primarily due to work-related musculoskeletal disorders.'' [122] The rate of days away from work (work days missed due to on-the-job injuries) for nursing aides, orderlies, and attendants was almost four times greater than the all-worker rate—449 per 10,000 compared to 113 per 10,000 for all workers.[123] One of the results of the FLSA's overtime pay requirement is to induce employers to hire more people to work fewer hours each. Doing so in those circumstances where excessive overtime hours are worked may therefore result in fewer injuries and illnesses incurred.

Reduced Reliance on Public Assistance

An increase in wages might reduce home care worker reliance on public assistance programs to meet the needs of their own households. Recent research finds that approximately 40 percent of home health care workers receive public assistance.[124] Almost 90 percent of these workers are women.[125]

Assuming these workers are in a family consisting of themselves and two children, the average amount of public assistance for such families is about $10,300.[126] In addition, many minimum wage workers also receive food stamps. The federally-assisted Supplemental Nutrition Assistance Program (SNAP, previously referred to as the Food Stamp Program) provided aid to 33.5 million participants in 2009 with total expenditures of $50.4 billion, an average of $1,500 in food stamps expenditures per participant.[127] This would entail $4,500 per family for an assumed family of three. In total, the average home health services worker might receive $14,800 in public assistance and food stamps to provide for her/his family.

Increased wages should reduce demand for public assistance services resulting in a savings to these programs; however, the Department is unable to quantify the savings due to lack of data on how the benefits of these programs vary with income. The savings associated with the minimum wage provisions under the proposed rule might be small; the Department estimated that the average below-minimum wage worker would receive a raise of $0.23 per hour to reach minimum wage. If such employees work the average 35 hours per week for 52 weeks per year, their additional income will be about $400 per year. To the extent that the employees' work requires significant travel time and overtime, or added hours of work due to employer schedule adjustments, they will also receive additional income. The Department did not estimate this portion of the potential economic impact due to uncertainty about the number of workers who would receive payment for travel time or additional hours of work.

Improved Quality of Care

As has been stated previously, one of the main benefits of this proposed rule is that the professionals who are entrusted to care for the elderly, disabled, and sick in their homes will have the same protections in the labor market as almost all other employees. Guaranteed minimum wage and overtime pay for home care jobs, comparable to similar occupations, will also more likely attract more qualified workers to the home care industry, which will improve the quality of care overall. The increased availability of home care workers will allow employers

[118] Nallari, R. Re-thinking Fiscal Mulitpliers. World Bank. Growth and Crisis Blog. April 20, 2010. Accessed at: *http://blogs.worldbank.org/growth/re-thinking-fiscal-multipliers.*

[119] PHI 2010a; Zontek, T., Isernhagen, J., Ogle, B., 2009; Ashley, A., Butler, S., Fishwick, N., 2010.

[120] Caruso, C., Hitchcock, E., Dick, R., *et al.* Overtime and extended work shifts: Recent findings on illnesses, injuries, and health behaviors. *National Institute for Occupational Safety and Health, U.S. Department of Health and Human Services.* April 2004.

[121] Dembe, A., Erickson J., Delbos, R., *et al.* 2005.

[122] Zontek and Isernhagen, 2009.

[123] NELP report (p. 27, FN45).

[124] PHI 2010a, p. 36

[125] PHI 2010a, p. 26

[126] TANF Eight Annual Report to Congress.

[127] Characteristics of Supplemental Nutrition Assistance Program Households: Fiscal Year 2009. U.S. Department of Agriculture, Food and Nutrition Service. October 2010.

to not only meet significant demand for home care services, but also spread employment, so that (1) workers are working fewer overtime hours which will result in less fatigue and more energy devoted to their clients; and (2) more workers will be serving fewer clients, which is a desire of many customers seeking home care. In addition, with the standard of pay raised, more highly trained and certified workers will seek out and remain in the HHA and PHA occupations, and a higher quality service will be provided to the client. While a monetary value cannot be placed on increased professionalism and improved care, those expected benefits are noteworthy.

Initial Regulatory Flexibility Analysis

The Regulatory Flexibility Act of 1980 (RFA) as amended by the Small Business Regulatory Enforcement Fairness Act of 1996 (SBREFA), hereafter jointly referred to as the RFA, requires agencies to prepare regulatory flexibility analyses and make them available for public comment, when proposing regulations that will have a significant economic impact on a substantial number of small entities. *See* 5 U.S.C. 603. If the rule is not expected to have a significant economic impact on a substantial number of small entities, the RFA allows an agency to certify such, in lieu of preparing an analysis. *See* 5 U.S.C. 605.

For the reasons explained in this section, the Department believes this NPRM is not likely to have a significant economic impact on a substantial number of small entities, and therefore an initial regulatory flexibility analysis is not required by the RFA. However, in the interest of transparency and to provide an opportunity for the public to comment, the Department has prepared the following initial regulatory flexibility analysis to assess the impact of this regulation on small entities. The Department specifically invites comment on the impacts of the proposed rule on small businesses, including whether alternatives exist that will reduce burden on small entities while still meeting the objectives of the FLSA. The Chief Counsel for Advocacy of the Small Business Administration (SBA) was notified of a draft of this rule upon submission of the rule to the Office of Management and Budget under E.O. 12866, as amended, ''Regulatory Planning and Review'' 58 FR 51735, 67 FR 9385, 72 FR 2763.

1. Reasons Why Action by the Agency Is Being Considered

The home care industry has undergone a dramatic transformation since the Department published the implementing regulations in 1975. There has been a growing demand for long-term in-home care for persons of all ages, in part because of the rising cost of traditional institutional care, and because of the availability of funding assistance for in-home care under Medicare and Medicaid. The growing demand for long-term in-home care for persons is also partly due to the significant increase in our aging population.[128]

In response to the growing demand for long-term in-home care, the home health care services industry has grown. According to the National Association of Home Care (NAHC) publication, *Basic Statistics About Home Care* (March 2000), data from the Department of Health and Human Services' Health Care Financing Administration (HCFA) showed that the number of Medicare-certified home care agencies increased from 2,242 in 1975 to 7,747 in 1999. In the NAHC 2008 update, this number increased to 9,284 by the end of 2007. The number of for-profit agencies not associated with a hospital, rehabilitation facility, or skilled nursing facility, *i.e.,* freestanding agencies, increased more than any other category of agency from 47 in 1975 to 4,919 in 2006. These for-profit agencies grew from 2 percent of total Medicare-certified agencies in 1975 to 68 percent by 2006, and now represent the greatest percentage of certified agencies. Public health agencies, which constituted over one-half of the certified agencies in 1975, now represent only 15 percent.

Public funds pay the overwhelming majority of the cost for providing home care services. Medicaid payments represent nearly 40 percent of the industry's total revenues; other payment sources include Medicare, insurance plans, and direct pay. Based on data from the Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, National Health Care Expenditures Historical and Projections: 1965–2016, Medicare and Medicaid together paid over one-half of the funds to freestanding agencies (37 and 19 percent, respectively). State and local governments account for 20 percent, while private health insurance accounts for 12 percent. Out-of-pocket funds account for 10 percent of agency revenues.

There has been a similar increase in the employment of home health aides and personal care aides in the private homes of individuals in need of assistance with basic daily living or health maintenance activities. Bureau of Labor Statistics' (BLS) national occupational employment and wage estimates from the Occupational Employment Statistics (OES) survey show that the number of workers in these jobs tripled during the decade between 1988 and 1998, and by 1998 there were 430,440 workers employed as home health aides and 255,960 workers employed as personal care aides. The combined occupations of personal care and home health aides constitute a rapidly growing occupational group. BLS statistics demonstrate that between 1998 and 2008, this occupational group has more than doubled with home health aides increasing to 955,220 and personal care aides increasing to 630,740. (*http://www.bls.gov/oes/current/oes399021.htm*).

The growth in demand for in-home care and in the home health care services industry has not resulted in growth in earnings for workers providing in-home care. The earnings of employees in the home health aide and personal care aide categories remain among the lowest in the service industry. Studies have shown that the low income of direct care workers including home care workers continues to impede efforts to improve both jobs and care.[129] Protecting domestic service workers under the Act is an important step in ensuring that the home health care industry attracts and retains qualified workers that the sector will need in the future. Moreover, the workers that are employed by home care staffing agencies are not the workers that Congress envisioned when it enacted the companionship exemption *i.e.,* neighbors performing elder sitting, but are instead professional caregivers entitled to FLSA protection. In view of the dramatic changes in the home health care sector in the 36 years since these regulations were first promulgated and the growing concern about the proper application of the FLSA minimum wage and overtime protections to domestic service employees, the Department believes it is appropriate to reconsider whether the scope of the regulations are now too broad and not in harmony with Congressional intent.

2. Statement of Objectives and Legal Basis for the Proposed Rule

Section 13(a)(15) of the FLSA exempts from its minimum wage and overtime

[128] *See* Shrestha, Laura, *The Changing Demographic Profile of the United States,* Congressional Research Service p. 13–14 (2006).

[129] *See* Brannon, Diane, *et al.,* ''Job Perceptions and Intent to Leave Among Direct Care Workers: Evidence From the Better Jobs Better Care Demonstrations'' *The Gerontologist,* Vol. 47, No. 6, p. 820–829 (2007).

pay provisions domestic service employees employed ''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).'' Due to significant changes in the home health care industry over the last 36 years, workers who today provide in-home care to individuals are performing duties and working in circumstances that were not envisioned when the companionship services regulations were promulgated. Section 13(b)(21) provides an exemption from the Act's overtime pay requirements for live-in domestic workers. The current regulations allow an employer of a live-in domestic worker to maintain a copy of the agreement of hours to be worked and to indicate that the employee's work time generally coincides with that agreement, instead of requiring the employer to maintain an accurate record of hours actually worked by the live-in domestic worker. The Department is concerned that not all hours worked are actually captured by such agreement and paid, which may result in a minimum wage violation. The current regulations do not provide a sufficient basis to determine whether the employee has in fact received at least the minimum wage for all hours worked.

The Department has re-examined the regulations and determined that the regulations, as currently written, have expanded the scope of the companionship services exemption beyond those employees whom Congress intended to exempt when it enacted § 13(a)(15) of the Act, and do not provide a sufficient basis for determining whether live-in workers subject to § 13(b)(21) of the Act have been paid at least the minimum wage for all hours worked. Therefore, the Department proposes to amend the regulations to revise the definitions of ''domestic service employment'' and ''companionship services,'' and to require employers of live-in domestic workers to maintain an accurate record of hours worked by such employees. In addition, the proposed regulation would limit the scope of duties a companion may perform, and would prohibit employees of third-party employers from claiming the exemption.

3. Description of and, Where Feasible, an Estimate of the Number of Small Entities To Which the Proposed Rule Will Apply

Definition of Small Entity

The RFA defines a ''small entity'' as a (1) small not-for-profit organization, (2) small governmental jurisdiction, or (3) small business. The Department used standards defined by SBA to classify entities as small for the purpose of this analysis. For the two industries that are the focus of this analysis, the SBA defines a small business as one that has average annual receipts of less than $13.5 million for HHCS and $7 million for SEPD.

Data Sources and Methods

The Department combined Quarterly Census of Employment and Wages data for the HHCS and SEPD industries, then used the Statistics of US Business (SUSB), 2002, data set to distribute establishments and employees to the following size categories: 0, 1–4, 5–9, 10–19, 20–99, 100–499, and 500+ employees. Therefore, the Department analyzed small business impacts using establishment size as a proxy for firm size.

Although basing this analysis on establishment size will bias results, the bias will tend to overestimate the number of small business affected by the rule and the impacts to those small businesses. First, the analysis overestimates the number of small entities; a firm composed of multiple establishments might earn aggregate revenues that exceed the threshold the SBA used to define ''small'' in these industries. Second, costs are in part a function of the number of firms in the industry due to the need for each firm to become familiar with the proposed rule. Our cost model thus assigns those familiarization costs to each establishment. Again, to the extent firms own multiple establishments, compliance costs associated with regulatory familiarization will be smaller than estimated here. Third, compliance costs are also a function of the number of establishment employees. Because there are no data linking the failure to pay minimum and overtime wages to establishment size, the Department assumed compliance costs associated with meeting those requirements would be proportionate to the number of establishment employees. Therefore, these costs increase in proportion to establishment size (as measured by the number of employees), and smaller establishments are not unduly impacted relative to larger establishments.

Number of Small Entities Impacted by Proposed Rule

Based on the estimated average annual revenues per establishment in each employment size category derived from SUSB data and attributed to the establishments in the HHCS and SEPD industries, it appears that no employers exceed the SBA size standards of $13.5 million in annual revenues for HHCS and $7 million in annual revenues for SEPD. Thus, for the purposes of this analysis, the entire HHCS and SEPD industries are composed of small businesses. Although in reality it is highly likely that there are some firms in the 100–499 and 500+ employee categories that earn revenues in excess of the SBA standard for their industry, we have not underestimated the number of small firms affected by the rule. We also believe we have not mischaracterized this sector in any meaningful way; we believe these industries are primarily, if not completely, composed of small businesses by SBA standards.

Table 6–1 presents the estimated number of establishments, employees, and revenue by establishment size, although the Department is analyzing and presenting the impacts to small businesses without identifying any of the employers as large (in the 100–499 and the 500+ employee categories). Table 6–1 shows that the 500+ employee category employs 42 percent of workers, and accounts for 19 percent of establishments and 42 percent of revenue for the combined industries. Conversely, establishments with fewer than 20 employees account for only six percent of employment but nearly 44 percent of establishments.

TABLE 6–1—AFFECTED ESTABLISHMENTS, WORKERS, AND REVENUE BY EMPLOYMENT SIZE CATEGORIES.

Number of employees	Total employees (1000)	Percent of total employment	Workers without MW	Workers without OT	Total estab.	Percent of estab.	Revenue ($ mil)	Percent industry revenue	Average revenue per estab. ($1000)
0	0	0.0	0	0	5,604	7.7	$645	0.8	$115
1–4	20	1.2	388	9,157	14,061	19.2	1,404	1.7	100
5–9	29	1.7	544	12,843	6,219	8.5	1,758	2.2	283

TABLE 6–1—AFFECTED ESTABLISHMENTS, WORKERS, AND REVENUE BY EMPLOYMENT SIZE CATEGORIES.—Continued

Number of employees	Total employees (1000)	Percent of total employment	Workers without MW	Workers without OT	Total estab.	Percent of estab.	Revenue ($ mil)	Percent industry revenue	Average revenue per estab. ($1000)
10–19	57	3.3	1,089	25,730	6,088	8.3	3,082	3.8	506
20–99	351	20.5	6,681	157,824	14,856	20.3	16,140	20.1	1,086
100–499	539	31.4	10,250	242,147	12,777	17.5	23,894	29.7	1,870
> 500	718	41.9	13,662	322,745	13,570	18.5	33,559	41.7	2,473
Total	1,714	100.0	32,614	770,446	73,175	100.0	80,482	100.0	1,100

4. Projected Reporting, Recordkeeping and Other Compliance Requirements of the Proposed Rule

The FLSA sets minimum wage, overtime pay, and recordkeeping requirements for employment subject to its provisions. Unless exempt, covered employees must be paid at least the minimum wage and not less than one and one-half times their regular rates of pay for overtime hours worked. Workers performing domestic service but not meeting the proposed definition of companionship services and companions and live-in domestic service workers employed by third parties will need to be paid in accordance with the FLSA's minimum wage and overtime pay provisions.

Every covered employer must keep certain records for each non-exempt worker. The regulations at 29 CFR part 516 requires employers to maintain records for employees subject to the minimum wage and overtime pay provisions of the FLSA. As indicated in this analysis, the NPRM would expand minimum wage and overtime pay coverage to approximately 776,000 workers. The recordkeeping requirements under 29 CFR part 516 are not new requirements, however, some employees would be included in the universe of covered employees if the NPRM were to be made final without change. This would result in an increase in employer burden and is estimated in the Paperwork Reduction Act (PRA) section of this NPRM. Note that the burdens reported for the PRA section of this NPRM include the entire information collection and not merely the additional burden estimated as a result of this NPRM.

Cost to Small Entities

Tables 6–2 through 6–4 present the results of the first year, recurring year, and annualized cost and impact analyses as distributed by establishment size. The figures in these tables include the costs of regulatory familiarization, complying with minimum wage requirements, travel pay, and overtime pay assuming employers respond to work in excess of 40 hours per week by paying the overtime premium (Scenario 1). This scenario is the most costly of the three examined, and thus the results presented here show the upper bound limit anticipated.

TABLE 6–2—FIRST YEAR COMPLIANCE COSTS BY ESTABLISHMENT SIZE

Size category	Cost ($1000)	Percent of total cost	Cost per establishment	Cost per establishment as a percent of average revenue (percent)
0	300	0.2	54	0.05
1–4	2,881	1.6	205	0.21
5–9	3,317	1.8	533	0.19
10–19	6,305	3.4	1,036	0.20
20–99	37,467	20.5	2,522	0.23
100–499	56,949	31.1	4,457	0.24
>500	75,719	41.4	5,580	0.23
Total	182,938	100.0	2,500	0.23

TABLE 6–3—RECURRING COMPLIANCE COSTS BY ESTABLISHMENT SIZE

Size category	Cost ($1000)	Percent of total cost	Cost per establishment	Cost per establishment as a percent of average revenue (percent)
0	0	0.0	0	0.00
1–4	2,128	1.2	151	0.15
5–9	2,984	1.7	480	0.17
10–19	5,978	3.3	982	0.19
20–99	36,671	20.5	2,468	0.23
100–499	56,264	31.4	4,403	0.24
>500	74,992	41.9	5,526	0.22

TABLE 6–3—RECURRING COMPLIANCE COSTS BY ESTABLISHMENT SIZE—Continued

Size category	Cost ($1000)	Percent of total cost	Cost per establishment	Cost per establishment as a percent of average revenue (percent)
Total	179,018	100.0	2,446	0.22

TABLE 6–4—ANNUALIZED COMPLIANCE COSTS BY ESTABLISHMENT SIZE

Size category	Cost ($1000)	Percent of total cost	Cost per establishment	Cost per establishment as a percent of average revenue (percent)
0	40	0.0	7	0.01
1–4	2,228	1.2	158	0.16
5–9	3,029	1.7	487	0.17
10–19	6,022	3.4	989	0.20
20–99	36,777	20.5	2,476	0.23
100–499	56,355	31.4	4,411	0.24
>500	75,088	41.8	5,533	0.22
Total	179,539	100.0	2,454	0.22

First year costs range from $54 for entities where the owner has no employees in addition to him- or herself (a 0 employee establishment), to $5,600 per establishment for entities with more than 500 employees (Table 6–2). Annual recurring costs are somewhat smaller, ranging from $151 per year per establishment in the 1 to 4 employee class, to $5,500 in the 500 employee or more size class (Table 6–3). Over ten years, the rule is projected to cost establishments an annual average ranging from $7 for 0 employee establishments to $5,500 for 500+ employee establishments per year when costs are annualized using a 7 percent real interest rate (Table 6–4).

Total costs and cost per establishment are consistently proportionate to establishment size as measured by either revenues or employment regardless of cost type (first year, recurring, or annualized). For example, employers with more than 500 employees are projected to incur 41 percent of total first year costs, which is proportionate to their share of the industry employment and revenues (see Table 6–2). In addition, the ratio of compliance costs to average establishment revenue is relatively similar regardless of establishment size. For example, Table 6–4 shows that average annualized compliance costs vary between 0.16 and 0.24 percent of average annual revenues for all establishments ranging from the 1 to 4 employee class to the 500+ employee class.

In summary, first-year compliance costs do not exceed $2,600 for establishments with fewer than 100 employees, and do not exceed $5,600 for those with more than 100 employees; first-year compliance costs do not exceed 0.24 percent of establishment revenue for all establishment size classes; average annualized compliance costs do not exceed $2,600 for establishments with fewer than 100 employees, and do not exceed $5,600 for those with more than 100 employees; and average annualized compliance costs do not exceed 0.24 percent of establishment revenue regardless of establishment size.

Impacts to small businesses are unlikely to vary significantly over time. Existing firms incur regulatory familiarization costs once, and these costs do not impose a significant economic burden. Recurring costs such as overtime and travel pay (transfer payments in the E.O. 12866 analysis) are proportionate to firm size. These costs will increase if the firm grows, but in proportion to the firm's ability to bear them. As new firms enter the market, they will bear the same costs: one-time regulatory familiarization costs, and recurring payments for overtime and travel. Again, recurring costs will be proportionate to firm size. Therefore, if the proposed revisions to the companionship regulations are affordable for existing firms, they will be affordable to new market entrants as well.

There are limitations to this analysis. It is assumed that the distribution of employees by establishment size has not changed significantly since 2002 (although the number of employees has increased significantly). We also assume that the occupations of HHA and PCA are distributed by establishment size similarly to other occupations in the HHCS and SEPD industries. With the exponential growth in these industries, it is possible that the distribution of workers by employment size class has shifted. In addition, the cost analysis conducted in this report is unable to capture the difference in costs for urban versus rural home health care agencies.

Differing Compliance and Reporting Requirements for Small Entities

This NPRM provides no differing compliance requirements and reporting requirements for small entities. The Department has strived to minimize respondent recordkeeping burden by requiring no order or specific form of records that are required under the FLSA and its corresponding regulations. Moreover, employers would normally maintain the records under usual or customary business practices.

Least Burdensome Option or Explanation Required

The Department believes it has chosen the most effective option that updates and clarifies the rule and which results in the least burden. Among the options considered by the Department, the least restrictive option was taking no

regulatory action and the most restrictive was defining companionship services as fellowship and protection of the aged or infirm individual accompanied by a five percent allowance for assistance with ADLs only. Taking no regulatory action does not address the Department's concerns discussed above under Need for Regulation. The Department found the most restrictive option to be overly burdensome on business in general and specifically small business.

Pursuant to section 603(c) of the RFA, the following alternatives are to be addressed:

i. Differing compliance or reporting requirements that take into account the resources available to small entities. The FLSA creates a level playing field for businesses by setting a floor below which employers may not pay their employees. As discussed elsewhere in this IRFA, the annualized cost of the proposed rule is estimated to be $158 for an employer with 1–4 employees and $5533 for an employer with more than 500 employees. See Table 6–4. To establish differing compliance or reporting requirements for small businesses would undermine this important purpose of the FLSA and appears to not be necessary given the small annualized cost of the rule. The Department makes available a variety of resources to employers for understanding their obligations and achieving compliance. Therefore the Department declines to establish differing compliance or reporting requirements for small businesses.

ii. The clarification, consolidation, or simplification of compliance and reporting requirements for small entities. This proposed rule simplifies and clarifies compliance requirements for employers of workers performing companionship services. The proposed rule imposes no reporting requirements. The recordkeeping requirements imposed by this proposed rule are necessary for the Department and domestic service employees to determine the employer's compliance with the law. The recordkeeping provisions apply generally to all businesses—large and small—covered by the FLSA, no rational basis exists for creating an exemption from compliance and recordkeeping requirements for small businesses in the HHCS and SEPD industries. The Department makes available a variety of resources to employers for understanding their obligations and achieving compliance.

iii. The use of performance rather than design standards. Under the proposed rule, the employer may achieve compliance through a variety of means. The employer may elect to provide companionship services as defined in the proposed rule and maintain the exemption; or hire additional workers and/or spread employment over the employer's existing workforce to ensure employees do not work more than 40 hours in a workweek, and/or pay employees time and one-half for time worked over 40 hours in a workweek. In addition, the FLSA recordkeeping provisions require no particular order or form of records to be maintained so employers may create and maintain records in the manner best fitting their situation. The Department makes available a variety of resources to employers for understanding their obligations and achieving compliance.

iv. An exemption from coverage of the rule, or any part thereof, for such small entities. Creating an exemption from coverage of this rule for businesses with as many as 500 employees, those defined as small businesses under SBA's size standards, is inconsistent with Congressional intent in expanding FLSA coverage to domestic service workers and its creation of the companionship services exemption.

5. Identification, to the Extent Practicable, of all Relevant Federal Rules That May Duplicate, Overlap, or Conflict With the Proposed rule

The Department is not aware of any federal rules that duplicate, overlap, or conflict with this NPRM.

Unfunded Mandates

Title II of the Unfunded Mandates Reform Act of 1995 (Pub. L.104–4; UMRA) establishes requirements for Federal agencies to assess the effects of their regulatory actions on State, local, and tribal governments as well as on the private sector. Under Section 202(a)(1) of UMRA, the Department must generally prepare a written statement, including a cost-benefit analysis, for proposed and final regulations that ''includes any Federal mandate that may result in the expenditure by State, local, and tribal governments, in the aggregate or by the private sector'' in excess of $100 million per year.

State, local and tribal government entities are within the scope of the regulated community for this proposed regulation to the extent government agencies employ HHAs and PCAs to provide home health care services, and claim these employees are exempt from minimum wage and overtime requirements because of the companionship services exemption under the FLSA. State governments might also be affected by the rule because Medicaid payments for such services might increase as a result of these proposed revisions to the exemption.

The Department has determined that this rule contains a Federal mandate that is likely to result in expenditures of $100 million or more for State, local, and tribal governments, in the aggregate, or the private sector in any one year. Total costs are projected to exceed $100 million in the first year of the rule and in average annualized costs (see Tables 4–1 and 4–2) under two of the three scenarios examined.

The Department has determined that the rule does not significantly affect a substantial number of small business entities that provide home health care services. Although it has not estimated the number of government agencies that provide similar services, there is insufficient basis for expecting that costs and impacts to government agencies that provide these services will differ significantly from private business. Identified compliance costs consist of a one-time cost for regulatory familiarization, and potential additional costs per employee should the agency choose to pay overtime rather than increase employment to cover hours worked in excess of 40 hours per week by its employees. The data show that a relatively small percent of employees in these professions work more than 40 hours per week for the same employer. The Department expects that compliance costs for government agencies will be a similar magnitude as for private businesses.

Finally, on average, about 75 percent of home health care costs are paid by Medicare and Medicaid, and the government agencies spent about $58.1 billion on home health care programs in 2009. The Department projects the average first year cost of the rule ranges from $43 to $182 million depending on how home health care agencies respond to overtime requirements. If Medicare and Medicaid continue to pay 75 percent of home health care costs, roughly $32 million to $137 million in costs might be incurred by these government agencies. These costs compose 0.06 to 0.24 percent of total HHS and state outlays for home health care programs.

VIII. Executive Order 13132 (Federalism)

The proposed rule does not have federalism implications as outlined in Executive Order 13132 regarding federalism. The proposed rule does not have substantial direct effects on the states, on the relationship between the national government and the states, or on the distribution of power and

responsibilities among the various levels of government.

IX. Executive Order 13175, Indian Tribal Governments

This proposed rule was reviewed under the terms of Executive Order 13175 and determined not to have ''tribal implications.'' The proposed rule does not have ''substantial direct effects on one or more Indian tribes, on the relationship between the Federal government and Indian tribes, or on the distribution of power and responsibilities between the Federal government and Indian tribes.'' As a result, no tribal summary impact statement has been prepared.

X. Effects on Families

The undersigned hereby certifies that this proposed rule will not adversely affect the well-being of families, as discussed under section 654 of the Treasury and General Government Appropriations Act, 1999.

XI. Executive Order 13045, Protection of Children

Executive Order 13045, dated April 23, 1997 (62 FR 19885), applies to any rule that (1) is determined to be ''economically significant'' as defined in Executive Order 12866, and (2) concerns an environmental health or safety risk that the promulgating agency has reason to believe may have a disproportionate effect on children. This proposal is not subject to Executive Order 13045 because it has no environmental health or safety risks that may disproportionately affect children.

XII. Environmental Impact Assessment

A review of this proposal in accordance with the requirements of the National Environmental Policy Act of 1969 (NEPA), 42 U.S.C. 4321 *et seq.;* the regulations of the Council on Environmental Quality, 40 CFR part 1500 *et seq.;* and the Departmental NEPA procedures, 29 CFR part 11, indicates that the proposed rule will not have a significant impact on the quality of the human environment. As a result, there is no corresponding environmental assessment or an environmental impact statement.

XIII. Executive Order 13211, Energy Supply

This proposed rule is not subject to Executive Order 13211. It will not have a significant adverse effect on the supply, distribution, or use of energy.

XIV. Executive Order 12630, Constitutionally Protected Property Rights

This proposal is not subject to Executive Order 12630, because it does not involve implementation of a policy ''that has takings implications'' or that could impose limitations on private property use.

XV. Executive Order 12988, Civil Justice Reform Analysis

This proposed rule was drafted and reviewed in accordance with Executive Order 12988 and will not unduly burden the Federal court system. The proposed rule was: (1) Reviewed to eliminate drafting errors and ambiguities; (2) written to minimize litigation; and (3) written to provide a clear legal standard for affected conduct and to promote burden reduction.

TABLE A–1—PUBLIC MATCHING REGISTRIES BY STATE

State	Matching Service	Name	Maintained by	Eligibility	Consumer/ provider count
AR	State-wide	Arkansas Direct Service Worker Registry.	Arkansas Department of Human Services, Division of Aging and Adult Services.	All consumers	(−/669)
CA	State-wide	In-Home Supportive Services, Regional Registries.	In-Home Supportive Services Public Authority.	Free for IHSS participants, small fee for private pay consumers.	(−/−)
CT	State-wide	Rewarding Work Resources	Connecticut Department of Disability Services and Rewarding Work Resources, Inc.	Free for individuals receiving services from CT Dept of Developmental Services (DDS), small fee for private pay consumers.	(720/2,347)
FL	State-wide	Florida Developmental Disabilities Resources-Provider Search.	Delmarva Foundation, the State of Florida Agency for Health Care Administration, and the Agency for Persons with Disabilities.	Free for all consumers	(−/−)
ID	Regional	Idaho Disability Action Center (registry Web site).	CIL–Disability Action Center	Free for all consumers	(−/−)
IL	Regional	Advocates for Access Center for Independent Living (registry Web site).	CIL–Advocates for Access	Free for all consumers	(−/−)
		Lake County Center for Independent Living (registry Web site).	CIL-Lake County	Free for all consumers	(−/−)
		LIFE Center for Independent Living (registry Web site).	CIL-LIFE	Free for all consumers	(−/−)
		Southern Illinois Center for Independent Living (registry Web site).	CIL-Southern Illinois	Free for all consumers	(−/−)
KS	Regional	Kansas Independent Living Resource Center-Registry of PAS.	CIL-Kansas Independent Living Resource Center.	Free for all consumers	(−/−)
ME	State-wide	Alpha One Center for Independent Living-PCA Registry.	CIL-Alpha One	Free for all consumers	(−/−)

TABLE A–1—PUBLIC MATCHING REGISTRIES BY STATE—Continued

State	Matching Service	Name	Maintained by	Eligibility	Consumer/ provider count
MA	State-wide	Massachusetts PCA Directory	PCA Workforce Council and Rewarding Work Resources, Inc.	Free for MassHealth PCA consumers, small fee for private pay consumers.	(2,133/8,800)
MI	State-wide	Michigan Quality Community Care Council (registry Web site).	CREATED BY: Michigan Department of Community Health and Tri-Area Aging Consortium.	Free for Medicaid Home Help consumers.	(−/−)
NH	State-wide	Granite State Independent Living-Personal Care Attendant Registry.	CIL-Granite State Independent Living.	Free for all consumers	(−/−)
NJ	State-wide	Rewarding Work Resources	New Jersey Division of Disability Services and Rewarding Work Resources, Inc.	Small fee for all consumers	(450/2,486)
NY	Regional	AIM Independent Living Center-Personal Assistants Finder's Help Page.	CIL-AIM Independent Living Center.	Free for all consumers	(−/−)
ND	State-wide	North Dakota Personal Assistance Registry.	Minot State University	Free for all consumers	(−/−)
OH	Regional	Ohio Home Care Program Provider Directory.	Ohio Department of Job and Family Services.	Free for all consumers	(−/−)
OR	State-wide	Oregon Home Care Commission Online Registry and Referral System.	Oregon Home Care Commission.	Free for all consumers	(−/−)
PA	Regional	Tri-County Patriots for Independent Living-Direct Care Workers' Registry.	CIL-Tri-County Patriots	Free for all consumers	(−/−)
RI	State-wide	Rewarding Work Resources	Rhode Island Department of Human Services and Rewarding Work Resources, Inc.	Free for consumers in the following programs: Personal Choice, Respite, or PASS, small fee for private pay consumers.	(535/1,422)
SC	State-wide	South Carolina Personal Care Worker Listing.	South Carolina Department of Health and Human services, and the Lieutenant Governor's Office on Aging.	Free for all consumers	(−/−)
VT	State-wide	Rewarding Work Resources	Vermont Department of Disabilities, Aging and Independent Living, and Rewarding Work Resources, Inc.	Free for all consumers	(990/1,333)
WA	State-wide	Washington Home Care Referral Registry.	Washington Home Care Quality Authority.	Free for publicly-funded in-home service consumers.	(−/−)
WI	Regional	Wisconsin Quality Home Care Commission-Care Registry.	Wisconsin Quality Home Care Commission.	Free for all consumers	(−/−)
Total					(4,828/17,057)

Source: PHI, 2011a.

Appendix B: Payment of Family Members To Provide Care

TABLE B–1—PAYMENT OF FAMILY MEMBERS TO PROVIDE CARE

Program		Services family members can be paid to provide						Types of family members who cannot be paid to provide care			
Type [a]	Name [b]	Respite care	Personal care	Home-maker/chore	Any service needed	Other	None	Spouses	Parents/ guardians of minors	Primary caregivers	Other
Alabama											
FC	Alabama CARES						x				
MC	Elderly & Disabled Waiver		x	x				x	x		
Alaska											
FC	NFCSP						x				
SC	Innovative Respite						x				
Arizona											
FC	NFCSP	x									
MC	AZ Long-Term Care System (ALTCS).	x	x					x	x		
SC	Non-Medical HCBS						x				
Arkansas											
FC	Caring for the Caregiver Arkansas Caregivers.		x					x	x		
MC	ElderChoices Medicaid Waiver	x		x				x	x		
California											
FC	NFCSP	x	x		x						
MC	Multipurpose Senior Services Program (MSSP).						x				
SC	Adult Day Health Care Program						x				
SC	Alzheimer's Day Care Resource Center (ADCRC).						x				
SC	Caregiver Resource Centers (CRCs).	x									
SC	In-Home Supportive Services (IHSS).	x	x					x			x
Colorado											
FC	NFCSP HCBS for the						x				
MC	Elderly, Blind and Disabled		x					x			
Connecticut											
FC	NFCSP						x				
MC	Home Care Program for Elders		x					x	x		
SC	Statewide Respite Care Program.						x				
SC	Personal Care Assistance State-Funded Pilot Program.		x	x				x			x
Delaware											
FC	CARE Delaware						x				
MC	Elderly & Disabled Waiver						x				
District of Columbia											
FC	NFCSP	x	x							x	
MC	Elderly & Physical Disabilities Waiver.	x	x					x	x		x
Florida											
FC	NFCSP	x		x							
MC	Aged & Disabled Adult Medicaid HCBS Waiver Respite for Elders.	x	x						x		
SC	Living in Everyday Families (RELIEF).						x				
SC	Home Care for the Elderly	x	x		x						
SC	Community Care for the Elderly						x				
SC	Alzheimer's Disease Initiative						x				
Georgia											
FC	NFCSP	x	x								x
MC	Community Care Services Program (CCSP).						x				

TABLE B–1—PAYMENT OF FAMILY MEMBERS TO PROVIDE CARE—Continued

Program		Services family members can be paid to provide						Types of family members who cannot be paid to provide care			
Type [a]	Name [b]	Respite care	Personal care	Homemaker/chore	Any service needed	Other	None	Spouses	Parents/guardians of minors	Primary caregivers	Other
Hawaii											
FC	NFCSP						x				
MC	Nursing Home Without Walls		x			x		x	x		
SC	Kupuna Care						x				
Idaho											
FC	NFCSP						x				
MC	HCBS Aged & Disabled Waiver		x					x	x		
SC	Senior Services Act, Respite Program.						x				
Illinois											
FC	NFCSP	x	x							x	
MC	Community Care Program (CCP).			x				x		x	x
MC	Home Services Program		x					x	x		
Indiana											
FC	Caring and Compassion	x									
MC	Aged & Disabled Medicaid Waiver.		x					x	x		
SC	CHOICE						x				
Iowa											
FC	Iowa Family Caregiver	x	x								
MC	Elderly Waiver		x					x	x		
Kansas											
FC	NFCSP						x				
MC	Home & Community-Based Frail Elder Waiver.	x	x			x		x			
SC	Senior Care Act Program		x	x				x			
Kentucky											
FC	NFCSP	x				x		x			
SC	Adult Day/Alzheimer's Respite	x	x								
Louisiana											
FC	NFCSP						x				
MC	Medicaid Home and Community-Based Waiver.		x					x	x		x
Maine											
FC	Family Caregiver Program	x						x			
MC	MaineCare	x	x					x			
SC	Home-Based Care	x	x								x
SC	Partners in Caring	x	x								
Maryland											
FC	NFCSP	x									
MC	Medicaid Waiver for Older Adults.	x	x					x			
SC	Respite for Caregivers of Adults with Functional Disabilities.						x				
Massachusetts											
FC	NFCSP		x	x				x			
MC	Home and Community-Based Waiver.						x				
SC	Home Care Program		x	x				x	x		
Michigan											
FC	NFCSP						x				
MC	MI Choice		x	x				x			
SC	State/Escheat Respite						x				
SC	Caregiver Respite Program						x				
Minnesota											
FC	NFCSP	x	x							x	

MC	Elderly Waiver						x				
SC	Alternative Care Program	x	x					x	x		
Mississippi											
FC	NFCSP						x				
MC	Elderly & Disabled Waiver						x				
Missouri											
FC	NFCSP	x								x	
MC	Aged & Disabled Waiver						x				
Montana											
FC	Family Caregiving Support						x				
MC	HCBS Program for Elderly & Physically Disabled.		x		x			x	x		
Nebraska											
FC	NFCSP	x						x	x		
MC	Aged & Disabled Waiver	x		x		x		x	x	x	x
SC	Respite Subsidy Program Across the Lifespan.	x						x	x	x	
Nevada											
FC	NFCSP						x				
MC	Community Home-Based Initiatives Program.						x				
SC	Independent Living Grant						x				
SC	Community-Based Care Caregiving Training						x				
New Hampshire											
FC	NFCSP	x	x	x						x	
MC	Elderly and Chronically Ill Waiver.	x	x					x	x		
New Jersey											
FC	NFCSP						x				
MC	Community Care Program for the Elderly & Disabled.						x				
MC	Enhanced Community Options (ECO).		x	x		x		x	x		x
SC	New Jersey Statewide Respite Care Program (SRCP).				x						
SC	Adult Day Services Program for Persons with Alzheimer's Disease or Related Dementias.						x				
SC	Jersey Assistance for Community Caregiving.		x	x				x	x		x
New Mexico											
FC	NFCSP	x	x					x			
MC	Disabled & Elderly HCBS Waiver.		x					x	x		
New York											
FC	Eldercare Family Support Program (EFSP).						x				
SC	Respite Program	x									
North Carolina											
FC	NFCSP	x	x								
MC	Community Alternatives Program for Disabled Adults (CAP/DA).	x	x	x				x			
SC	Respite Care Program	x	x	x							x
North Dakota											
FC	NFCSP	x									
MC	Aged & Disabled Waiver	x	x	x				x	x		
SC	Family Home Care	x	x						x		
Ohio											
FC	NFCSP	x	x								
MC	PASSPORT HCBS Waiver Program.						x				
SC	Alzheimer's Respite Program	x									
Oklahoma											
FC	NFCSP	x								x	x

TABLE B–1—PAYMENT OF FAMILY MEMBERS TO PROVIDE CARE—Continued

Program		Services family members can be paid to provide						Types of family members who cannot be paid to provide care			
Type [a]	Name [b]	Respite care	Personal care	Homemaker/chore	Any service needed	Other	None	Spouses	Parents/ guardians of minors	Primary caregivers	Other
MC	Advantage Program		x					x	x		
SC	Respite Resource Network	x								x	
Oregon											
FC	NFCSP						x				
MC	Medicaid Waiver/In-Home Care	x	x			x					
SC	Lifespan Respite Care Networks						x				
Pennsylvania											
FC	NFCSP						x				
MC	PA Department of Aging 60+ Medicaid Waiver.						x				
SC	PA FCSP						x				
SC	OPTIONS						x				
SC	BRIDGE						x				
Rhode Island											
FC	Partners in CaRIng	x						x		x	
MC	Home & Community-Based Waiver.						x				
South Carolina											
FC	NFCSP	x	x					x	x	x	
MC	Elderly/Disabled Home and Community-Based Waiver.		x					x	x	x	
South Dakota											
FC	Caregiver Program	x						x	x		x
MC	Home & Community-Based Elderly Waiver.						x				
Tennessee											
FC	NFCSP						x				
SC	Home & Community-Based Long-Term Care for Non-Medicaid Elderly & Adults with Disabilities.						x				
Texas											
FC	NFCSP	x						x		x	
MC	Community-Based Alternatives	x	x					x			
SC	Respite Care Program						x				
SC	In-Home & Family Support Program.						x				
Utah											
FC	Caregiver Support Program	x						x			
MC	Medicaid Aging Waiver	x	x					x			
SC	Home & Community-Based Alternatives.	x	x		x			x			
Vermont											
FC	NFCSP	x									
MC	Home-Based Medicaid Waiver	x	x					x			
Virginia											
FC	NFCSP						x				
MC	Elderly & Disabled Waiver	x	x					x	x		
SC	Caregiver Grant Program	x	x		x						
SC	Respite Care Initiative Grant						x				
SC	Respite Care Grant Program 2003.						x				
Washington											
FC	NFCSP						x				
MC	Community Options Program Entry System (COPES).		x					x	x		
SC	WA FCSP						x				

SC	Respite Care Services						x				
West Virginia											
FC	Family Caregiver Support						x				
MC	Medicaid Aged & Disabled Waiver.		x					x			
Wisconsin											
FC	NFCSP Community Options	x	x								
MC	Program Waiver (COP–W)	x	x	x		x		x	x		
SC	Alzheimer's Family & Caregiver Support Program.	x	x								
Wyoming											
FC	NFCSP	x									
MC	HCBS Waiver for Elderly & Physically Disabled.		x	x				x	x		
SC	Community Based In-Home Services Program (CBIHS).						x				

[a] Program Type: FC = National Family Caregiver Support Program; MC = Aged/Disabled Medicaid HCBS Waiver; SC = State-Funded Program
[b] Program Name: NFCSP= National Family Caregiver Support Program; HCBS = Home and Community-Based Services Sources: Feinberg *et al.,* 2004; Feinberg & Newman, 2005.

List of Subjects in 29 CFR Part 552

Domestic service workers, Companionship, Employment, Labor, Minimum wages, Overtime pay, Reporting and recordkeeping requirements, Wages.

Signed at Washington, DC on this 16th day of December.

Nancy J. Leppink,

Deputy Administrator, Wage and Hour Division.

For the reasons discussed in the preamble, the Wage and Hour Division proposes to amend 29 CFR part 552 as follows:

PART 552—APPLICATION OF THE FAIR LABOR STANDARDS ACT TO DOMESTIC SERVICE

1. The authority citation for part 552 continues to read as follows:

Authority: 29 U.S.C. 213(a)(15), (b)(21), 88 stat. 62; Sec. 29(b) of the Fair Labor Standards Act Amendments of 1974 (Pub. L. 93–259, 88 Stat. 76).

2. Revise § 552.3 to read as follows:

§ 552.3 Domestic Service Employment.

The term ''domestic service employment'' means services of a household nature performed by an employee in or about a private home (permanent or temporary). The term includes services performed by employees such as companions, babysitters, cooks, waiters, butlers, valets, maids, housekeepers, nannies, nurses, janitors, laundresses, caretakers, handymen, gardeners, home health aides, personal care aides, and chauffeurs of automobiles for family use. This listing is illustrative and not exhaustive.

3. Revise § 552.6 to read as follows:

§ 552.6 Companionship services for the aged or infirm.

(a) As used in section 13(a)(15) of the Act, the term ''companionship services'' means the provision of fellowship and protection for a person who, because of advanced age or physical or mental infirmity, is unable to care for themselves. The provision of *fellowship* means to engage the person in social, physical, and mental activities, including conversation, reading, games, crafts, walks, errands, appointments, and social events. The provision of *protection* means to be present with the person in their home or to accompany the person when outside of the home to monitor the person's safety and well-being.

(b) The term ''companionship services'' may include intimate personal care services that are incidental to the provision of fellowship and protection for the aged or infirm person. Intimate personal care services that are incidental to the provision of fellowship and protection for the aged or infirm person must be performed attendant to and in conjunction with the provision of fellowship or protection. The performance of incidental intimate personal care services must not exceed 20 percent of the total hours worked in the workweek. These incidental intimate personal care services include tasks assisting the person being cared for, such as:

(1) occasional dressing, such as assistance with putting on and taking off outerwear and footwear;

(2) occasional grooming, including combing and brushing hair, assisting with brushing teeth, application of deodorant, or cleansing the hands and face of the person, such as before or after meals;

(3) occasional toileting, including assisting with transfers, mobility, positioning, use of toileting equipment and supplies (such as toilet paper, wipes, and elevated toilet seats or safety frames), changing diapers, and related personal cleansing;

(4) occasional driving to appointments, errands, and social events;

(5) occasional feeding, including preparing food eaten by the person while the companion is present and assisting with clean-up associated with such food preparation and feeding;

(6) occasional placing clothing that has been worn by the person in the laundry, including depositing the person's clothing in a washing machine or dryer, and assisting with hanging, folding, and putting away the person's clothing; and

(7) occasional bathing when exigent circumstances arise.

(c) Incidental intimate personal care services does not include household work benefiting other members of the household, such as general housekeeping, making meals for other members of the household or laundering clothing worn or linens used by other members of the household. Similarly, household services performed by, or ordinarily performed by, employees such as cooks, waiters, butlers, valets, maids, housekeepers, nannies, nurses, janitors, laundresses, caretakers, handymen, gardeners, home health aides, personal care aides, and chauffeurs of automobiles for family use, are not ''companionship services'' unless they are performed only incidental to the provision of fellowship and protection as described in paragraph (b) of this section.

(d) The term ''companionship services'' does not include medical care (that is typically provided by personnel with specialized training) for the person, including, but not limited to, catheter and ostomy care, wound care, injections, blood and blood pressure testing, turning and repositioning, determining the need for medication, tube feeding, and physical therapy. Performing such medical care in or about a private household is included in the category of domestic service employment. The term ''companionship services'' however, includes reminding the aged or infirm person of a medical appointment or a predetermined medicinal schedule. Such a reminder is part of the intimate personal care services that are incidental to the provision of fellowship and protection for the aged or infirm person.

§ 552.102 [Amended]

4. Revise § 552.102 (b) to read as follows:

* * * * *

(b) If it is found by the parties that there is a significant deviation from the initial agreement, the parties should reach a new agreement that reflects the actual facts.

5. Amend § 552.109 to revise paragraphs (a) and (c) to read as follows:

§ 552.109 Third Party Employment.

(a) Third party employers of employees engaged in companionship services within the meaning of § 552.6 may not avail themselves of the minimum wage and overtime exemption provided by section 13(a)(15) of the Act, even if the employee is jointly employed by the individual or member of the family or household using the services. However, the individual or member of the family or household, even if considered a joint employer, is still entitled to assert the exemption, if the employee meets all of the requirements of § 552.6.

(b) * * *

(c) Third party employers of household workers engaged in live-in domestic services within the meaning of § 552.102 may not avail themselves of the overtime exemption provided by section 13(b)(21) of the Act, even if the employee is jointly employed by the individual or member of the family or household using the services. However, the individual or member of the family or household, even if considered a joint employer, is still entitled to assert the exemption.

§ 552.110 [Amended]

6. In § 552.110 revise paragraphs (b), (c), and (d) and add new paragraph (e) to read as follows:

* * * * *

(b) The employer shall keep a copy of the agreement specified by § 552.102 of this part and make, keep, and preserve a record showing the exact number of hours worked by the live-in domestic employee. The provisions of § 516.2(c) of this title shall not apply to live-in domestic employees.

(c) With the exception of live-in domestic employees, where a domestic service employee works on a fixed schedule, the employer may use a schedule of daily and weekly hours that the employee normally works and either the employer or the employee may: (1) Indicate by check marks, statement or other method that such hours were actually worked, and (2) when more or less than the scheduled hours are worked, show the exact number of hours worked.

(d) With the exception of live-in domestic employees, the employer may require the domestic service employee to record the hours worked and submit such record to the employer.

(e) No records are required for casual babysitters as defined in § 552.5 of this chapter.

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