Economic and Legal Aspects of FLSA Exemptions: A Case Study of Companion Care

By Jeffrey A. Eisenach and Kevin W. Caves

I. Introduction

Section 13(a)(15) of the Fair Labor Standards Act (FLSA) exempts workers "employed in domestic service employment to provide companionship services for individuals who (because of age or infirmity) are unable to care for themselves" from the FLSA's minimum wage and overtime provisions.[1] In addition, Section 13(b)(21) of the FLSA exempts from FLSA's overtime provisions (but not minimum wage provisions) any worker employed "in domestic service in a household and who resides in such household."[2] The Department of Labor (DOL) issued implementing regulations in February 1975 (the 1975 Rules),[3] under which most providers of companion care services, regardless of whether they are employed directly by the household or through a third-party employer, and even if they occasionally provide ancillary services such as driving or limited housework, are not covered by the FLSA's minimum wage or overtime provisions. Section 13(a)(15) and its implementing regulations are commonly referred to as the "Companion Care Exemption" while Section 13(b)(21) is referred to as the "Live-in Exemption."

On December 27, 2011, the DOL published in the *Federal Register* a Notice of Proposed Rulemaking (NPRM)[4] which would narrow the Companion Care Exemption and the Live-In Exemption significantly, eliminating them entirely for workers employed by third-party employers, and restricting the types of activities companion care workers and domestic live-in providers who are employed directly can engage in while still being classified as exempt.

[†] *Jeffrey A. Eisenach is a Managing Director and Principal at Navigant Economics LLC and an Adjunct Professor at George Mason Law School. Kevin W. Caves is a Director at Navigant Economics LLC.* *We are grateful to Chris Holt for research assistance. Support was provided by the National Association for Home & Hospice Care, the National Private Duty Home Care Association, and the Private Care Association. The views expressed are our own.*

Because the proposed changes would have an annual economic impact of more than $100 million (and other significant effects), the DOL is required under Executive Order 12866 to conduct a Regulatory Impact Analysis of the effects of the proposed rule. The Department's Preliminary Regulatory Impact Analysis (PRIA) was published with the NPRM on December 27, 2011, and concludes that the proposed changes would result in annual costs (comprised of transfers and efficiency losses) averaging between $42 million and $226 million over the next 10 years, and cause annual employment losses of between 172 and 938 jobs.[5] The DOL concludes, however, that these costs are more than compensated for by unquantifiable benefits, such as an increased supply of companion care labor and improved quality of care.

The economic effects of this proposal (on workers in the industry and others) depend critically on (1) the extent to which labor costs would increase as a result of the cost of compliance; and (2) the elasticity of demand for companion care labor, which itself is derived from the demand for companion care services. In this case study, we review the available evidence and find that the economic impact of repeal is likely to substantially exceed the DOL's estimates. Due primarily to data limitations, key cost categories are underestimated or ignored altogether in the DOL's analysis, as are the disproportionate overtime and recordkeeping costs that would likely be imposed on the market for live-in care. The PRIA also assumes an extremely low value for the elasticity of demand for companion care labor that ignores entirely the "scale effect," which reflects the tendency for firms to scale back their operations (or even shut down) in response to an increase in input costs. Using data from the industry, we conduct an econometric analysis, which indicates that the demand for companion care labor (and, by implication, the demand for companion care services), is elastic, and therefore quite sensitive to increases in the cost of labor. We conclude that the compliance costs associated with the proposal would cause aggregate worker compensation in the industry to decline, reduce the availability of companionship care services to the special needs populations that typically require them, and have other adverse effects. More generally, our case study suggests that efforts to expand the FLSA's minimum wage and overtime provisions to previously exempt occupations may result in unintended harm to both workers in the industry and others.

II. Overview of Proposed Regulations, Industry, and Economic Impact

A. Industry Overview

Home health care services are a rapidly growing sector of the U.S. economy, primarily reflecting the convergence of two significant trends: the aging of the U.S. population, and a growing preference for the elderly and other special needs populations to receive care within their own homes, whenever possible, rather than being institutionalized. Employment in the primary job classifications that account for most home health care is expected to grow by roughly 50 percent between 2008 and 2018.[6]

The labor services covered by the companion care and live-in exemptions are provided both formally and informally, through direct employment and third-party agencies, and by workers with a variety of backgrounds and skill sets. They are paid for to a significant extent by third-party payers, including most significantly Medicaid, under which individual state programs pay for various forms of home care services. In general, there is little data on the number of workers or amount of services provided specifically under the companion care and live-in exemptions, as such. Rather, economic data (employment, output, etc.) on these services is tracked under broader categories. As a result, relatively little is known with precision about the size and characteristics of the workforce covered by the companion care and live-in exemptions, or about terms under which they are employed, the wage rates they currently earn, or the hours they currently work.

Companion care services fall under the broader employment categories of "home health aides" (HHAs) and "personal and home care aides" (PCAs),[7] and under the industry categories of "Home Health Care Services" (NAICS 6216,

HHCS) and "Services for Elderly and Persons with Disabilities" (NAICS 62412, SEPD). As shown in Table 1, the DOL estimates that in 2009 there were approximately 1.7 million people employed by these two industry sectors, in over 73,000 separate businesses (implying average firm size of approximately 23 employees), with total wages of $413 billion.

As DOL acknowledges, however, not all employees in the HHCS and SEPD sectors are providing exempt companion care or live-in services, or even fall within the home health care or personal care services employment categories. In this sense, the figures in Table 1 represent an overestimate of the number of employees affected by the proposed rules.

On the other hand, the data in Table 1 relates only to employees who are employed by third party agencies, and does not include directly employed companion care providers or live-in aids, who work in what are commonly referred to as "consumer-directed" models, under which "the consumer or his/her representative has more control than in the agency-directed model over the services received, and how, and by whom the services are provided."[9] Based on BLS data, DOL estimates that an additional 188,500 personal care aides and 18,100 home health aides work as independent contractors or are directly employed by households.[10] In addition, however, the NPRM acknowledges that there is an informal or "grey market" component of the market, about where "very little is known."[11] In many cases, the informal component of the market consists of family members. As DOL explains:

> 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 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.[12]

Thus, the available data suggests that a large proportion of directly employed companion care providers are family members. Moreover, as DOL notes, most Medicaid-funded home health care programs allow family members to be employed as paid caregivers.[13]

Thus, a large number of companion care providers and live-in workers are likely not included in the official employment estimates, DOL concedes that it "found no data to support an estimate of the number of families that directly hire independent providers."[14] In the end, based on BLS data on the number of HHAs and PCAs working for agencies and independently, the DOL concludes that 1.59 million agency-employed workers and about 200,000 independently employed caregivers "might be affected" by the proposed rule but that "not all 1.79 million of these PCAs and HHAs are employed as FLSA-exempt companions."[15] As discussed further below, it then applies a series of assumptions to estimate the proportion of these workers most likely to be affected by the proposed regulations, i.e., those who earn less than the minimum wage and/or work more than 40 hours per week today.

By the same token, relatively little is known about the sources of funding used to pay for companion care services. It seems clear, as the NPRM states, that "public funds pay the overwhelming majority of the cost for providing home care services,"[16] with Medicaid and Medicare serving as the primary payers. What

Table 1 — HHCS and SEPD Economic Indicators, 2009[8]

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

is far less clear, however, is what proportion of *companion care services* are covered by public insurance. As the *New York Times* reported in a 2008 series of articles on home health care:

> Remaining at home often means hiring, paying for and supervising aides to help with shopping, cooking, bathing, dressing, eating, toileting and medication management. This can cost upwards of $150,000 a year for someone who needs 24/7 assistance that is custodial, rather than medical, and thus not covered by Medicare, the universal health care system. Medicare pays for doctors, hospitalizations, surgery, diagnostic tests and medication for those 65-and-over – but not for what is commonly known as long-term care.[17]

Moreover, while state Medicaid programs paid over $45 billion for home health care services in 2008 (See Figure 2 below), it is not clear how much of this funding supports the sorts of activities currently covered under the companion care exemption, or the narrower set of activities that would (for direct employers) continue to be covered under the proposed rules. Indeed, the NPRM reports:

> Public funding programs do not cover services such as social support, fellowship or protection. 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 [activities of daily living] and [instrumental activities of daily living], is not a Medicaid personal care service."[18]

Given the lack of complete data on other fronts, it is unsurprising that the precise wage and hour profile of currently exempt workers is also not well understood. The PRIA relies upon data from BLS on the hourly earnings of HHAs and PCAs, and estimates that only a small proportion of currently exempt workers earn less than the minimum wage or work more than 40 hours per week.[19] As discussed in detail below, however, it reaches these conclusions largely on the basis of assumptions for which it offers little or no empirical support. For example, the PRIA simply assumes that independent providers working directly for families work the same number of hours as those who are employed by agencies.

B. The Proposed Regulations

The FLSA requires employees who are not exempt to be paid both a minimum hourly wage (currently $7.25 per hour) and, if they work more than 40 hours in a given week, to receive "time and a half" for all hours worked above the 40-hour threshold. While coverage under the Act is broad, millions of employees fall under one or more of the 30-plus statutory exemptions, which include: administrative, executive and professional employees; agricultural employees; criminal investigators; fishermen; movie theater employees; railroad workers and truckers; small-town radio announcers; and, taxi drivers. (See Table A-1.) While there does not appear to be a clearly articulated unifying principle behind the various statutory exemptions, simple observation suggests that Congress has chosen to exempt occupations where long or irregular hours are the norm (e.g. criminal investigators, fishermen, truck drivers), or where compensation is based on performance or "piecework" rather than hours worked (e.g., agricultural employees, taxi drivers).

The Companion Care Exemption and the Live-in Exemption were enacted as part of the 1974 FLSA Amendments, which extended coverage under FLSA to "domestic service workers," including those who worked directly for a private household,[20] but at the same time carved out exemptions for employees who "provide companionship services for individuals who (because of age or infirmity) are unable to care for themselves" (Sec. 13(a)(15)) and (with respect to overtime only) any employee "in domestic service in a household and who resides in such household." (Sec. 15(b)(21)). Subsequently, the Department determined that these exemptions apply both to those who are employed directly and those who work for third party employers. The Department's decision on this front was reviewed and approved by the Supreme Court.[21]

The proposed regulations would change the regulations implementing the Companion Care and Live-in Exemptions in several important ways.

First, the NPRM would repeal altogether both the companion-care and live-in exemptions for workers employed by third-party employers. A large proportion of companion care is provided through third-party employers, who would now be required to pay both minimum wage and overtime to employees providing these services.

Second, the NPRM would substantially narrow the companion care exemption even for families which employ companion care providers directly. The current regulations (29 CFR §552.6) define companionship care as follows:

> As used in section 13(a)(15) of the Act, the term companionship services shall mean those services which provide fellowship, care, and protection for a person who, because of advanced age or physical or mental infirmity, cannot care for his or her own needs. Such services may include household work related to the care of the aged or infirm person such as meal preparation, bed making, washing of clothes, and other similar services. They may also include the performance of general household work: Provided, however, that such work is incidental, i.e., does not exceed 20 percent of the total weekly hours worked. 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.

Thus, the effect of the current rules is to exempt from minimum wage and overtime coverage those providing "fellowship, care and protection," including "work related to the care of the aged or infirm" (such as meal preparation) and even "general household work," so long as the latter does not exceed 20 percent of total weekly hours. Services which can only be performed by trained personnel are not "companionship services."

The proposed rules would eliminate altogether the list of incidental activities (such as meal preparation) which can be provided without specific limitation, while prescribing in detail a limited set of activities that would be subject to the "not more than 20 percent" limitation. The new rules would provide specifically that directly-employed companion care providers could spend up to 20 percent of their time each week providing the following services:

> (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.[22]

Under the proposal, if during any week the companion care provider's performance of these activities accounts for more than 20 percent of the employee's time during that week, "then the exemption may not be claimed for that week and workers must be paid minimum wage and overtime."[23] Presumably, companion care providers and/or those being cared for would be responsible for tracking the number of hours spent each week changing diapers, placing clothing in the laundry, assisting with brushing of teeth, and so forth, in order to ensure compliance with the 20 percent threshold.

Importantly, any performance of tasks not explicitly listed as exempt would also subject the companion care provider's time during to minimum wage and overtime rules. For example, "[t]he 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."[24] Thus, if a companion provider were to prepare a meal and leave the worksite before it was consumed, the exemption would be invalidated and all time during that week would become subject to minimum wage and overtime. The proposal also repeals the exemption for general household work altogether: Any vacuuming, washing windows or dusting would invalidate the exemption.[25]

Taken together, these provisions would appear not only to significantly limit the types of activities in which companions can engage while remaining exempt, but also to impose on direct employers (i.e., the elderly and infirm, members of their families, and/or their caretakers), substantial compliance burdens in the form of monitoring and tracking the types of activities performed by companion care providers, ensuring that they do not exceed the permissible boundaries, and, should they do so in any given week, making appropriate adjustments to payrolls, withholding, unemployment insurance, and so forth.

Third, the NPRM also proposes to restructure the contractual relationship between direct and third-party employers and live-in companions by requiring employers to maintain precise records of hours worked. Under the current regulations (29 CFR §552.102(a)), live-in domestic service employees are exempt from overtime but not from the minimum wage requirement. However, under the current regulations:

> In determining the number of hours worked by a live-in worker, the employee and the employer may exclude, by agreement between themselves, the amount of sleeping time, meal time and other periods of complete freedom from all duties when the employee may either leave the premises or stay on the premises for purely personal pursuits.[26]

Furthermore, and importantly, the current regulations (29 CFR §552.102(b)) allow the agreement to "be used to establish the employee's hours of work in lieu of maintaining precise records of the hours actually worked," thus relieving employers of the requirement to precisely track "working" versus "leisure" hours for live-in employees. The NPRM would repeal this accommodation:

> 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.[27]

To summarize, the proposed regulations would eliminate altogether the minimum wage and overtime exemptions for companion-care providers and live-in workers employed by third parties, circumscribe the definition of exempt companion-care services as applied to direct employers, and impose substantial new recordkeeping requirements and compliance burdens on direct and third party employers of both companion-care and live-in workers.

C. Economic Impact

The guidelines for conducting benefit-cost analysis of major Federal regulations are contained in a series of Circulars and other guidance from the Office of Management and Budget (OMB). Most importantly, they are described in detail on OMB Circular A-4 and a variety of successor documents (OMB Guidelines).[28] As explained below, by failing to provide a meaningful "evaluation of the benefits and costs – quantitative and qualitative – of the proposed action,"[29] the PRIA fails to comply with the OMB Guidelines.

The PRIA's economic analysis consists of a two-step process. First, the PRIA estimates various compliance costs associated with the proposed rules, finding that total compliance costs would represent less than one percent of current market wages. Second, the PRIA applies these estimates to a standard "supply-and-demand"

model of the labor market, based on assumed values for the elasticity of labor supply and labor demand, which yields an estimate of the deadweight loss associated with the proposed rules.

For the first step, the PRIA quantifies four types of compliance costs: Minimum wage costs, overtime payments, travel wage costs, and regulatory familiarization costs. With respect to the minimum wage, the PRIA estimates that 31,000 agency employees and 7,500 independent providers earn less than the federal minimum wage, and that minimum wage provisions would increase labor costs by $16.1 million in the first year of implementation only.[30] The PRIA assumes that the costs associated with minimum wage requirements would be negligible in all future years.[31]

The proposed regulations would affect the number of hours worked by subjecting time companion care providers spend in travel from location to location to the minimum wage rules and by forcing travel hours to be counted in calculating total hours for overtime purposes.

With respect to overtime wages, the PRIA assumes that ten percent of the workforce works five hours of overtime (i.e., a 45-hour week), and that two percent works 12.5 hours of overtime (i.e., a 52.5-hour week), while the remaining 88 percent works 40 hours per week (or fewer).[32] Based on these assumptions, total overtime costs are estimated at $139.3 million assuming no adjustment in the employment/hours mix, and at one-half this amount ($69.7 million), assuming that existing overtime hours are halved in response to the new regulations.[33] (As discussed below, the latter estimate assumes away any quasi-fixed costs that would be incurred when additional workers are hired). The PRIA also considers a third scenario in which employers pay no overtime costs whatsoever, based on the assumption that employers would "increase staffing to ensure no employee works more than 40 hours per week," and that "additional staff can be hired at the current going wage rate."[34]

With respect to regulatory familiarization costs, the PRIA assumes that home health care establishments would require two hours of mid-level staff time to read and review the new regulations, and implement all necessary changes to payroll systems, employee handbooks, and so on.[35] When combined with an estimated "mid-level HR wage" of $26.79 per hour, the PRIA arrives at an estimate of approximately $54 per establishment, for a total of approximately $3.9 million in regulatory familiarization costs for agencies.[36] The PRIA assumes that families employing independent providers would spend only one hour on regulatory familiarization, which, when valued at the national average hourly wage ($29.07), yields a total of approximately $6 million in regulatory familiarization costs.[37] Accordingly, total regulatory familiarization costs are estimated at $9.9 million. The PRIA assumes that there are no ongoing compliance costs for either agencies or direct employers (though it does include small ongoing costs for familiarization to reflect turnover among both agencies and direct employers).[38]

The proposed regulations would affect the number of hours worked by subjecting time companion care providers spend in travel from location to location to the minimum wage rules and by forcing travel hours to be counted in calculating total hours for overtime purposes. The PRIA estimates travel costs based on an amicus brief filed by the City of New York and New York State Association of Counties in *Long Island Care at Home, Inc. v. Coke*.[39] Based on the *Coke* amicus brief, the PRIA estimates that travel costs would represent 19.2 percent of total overtime costs, or approximately $26.7 million, based on the PRIA's overtime cost estimates.[40]

Combining these four categories, the PRIA estimates total first-year compliance costs to be $16.1M + $69.7M + $9.9M + $26.7M = $122.4 million.[41] When combined with the PRIA's estimate of 737,761 potentially affected workers, this yields an estimate of $166 per worker, less than one percent of current market wages.[42]

For the second step, the PRIA applies a supply-and-demand model of the labor market to estimate the effect of its compliance costs on employment and economic welfare in the labor market. Specifically, the PRIA assumes that the elasticity of demand for labor is -0.15, and that the elasticity of labor supply is 0.14. These assumptions imply that the average hourly wage in the industry would increase by $0.044, causing a small contraction in the demand for labor, leading to the disemployment of 505 workers, with an accompanying deadweight loss of $420,000 in the first year of implementation. This translates into an increase of 0.45 percent over the average HHA hourly wage of $9.85, and an increase of 0.47 percent over the average PCA wage of $9.46. In the PRIA's analysis, the total compliance cost burden is effectively shared between the supply and demand side and the supply side of the labor market. Because the PRIA assumes that the relative elasticities of supply and demand are roughly equal, each side of the market is assumed to share roughly half of the total compliance cost burden. The PRIA reaches very similar conclusions when analyzing subsequent years.[43]

To very briefly summarize what follows, we conclude that the PRIA's economic analysis suffers from a number of severe shortcomings, which fall into three main categories. First, the PRIA assumes away or understates several important types of compliance costs, both by assigning a value of zero cost to those categories that it is unable to quantify (including "quasi-fixed" costs, such as search costs, hiring costs, health benefits, and training costs), and by systematically underestimating those costs that it does attempt to quantify (assuming, for example, that employers would incur one-time costs of just $54 in adapting their payroll systems and human resources policies to comply with the new regulations). Perhaps most significantly, the PRIA ignores altogether the disproportionate costs that would be imposed on the market for live-in care: Despite the likelihood that live-in care industry would bear a substantially greater burden with respect to, e.g., overtime and recordkeeping costs, and despite the PRIA's admitted inability to gauge the size of the live-in industry, the PRIA simply assumes that there would be no differential impact on the market for live-in care.

Second, the PRIA understates deadweight loss (a) by assuming, explicitly and incorrectly, that the elasticity of demand for companionship *labor* is extremely low; and (b) by implicitly and incorrectly assuming that the elasticity of demand for companionship care *services* is zero (perfectly inelastic).

With respect to (a), the PRIA's assumed labor demand elasticity is taken wholly out of context from the economic literature, and then arbitrarily halved. The PRIA's assumed elasticity misrepresents the relevant literature by relying on studies designed solely to estimate the *substitution effects* associated with a change in the wage rate, which measure the degree of substitutability between labor and capital, and ignoring entirely the *scale effect*, which captures the extent to which an increase in labor costs forces firms to "scale back" (or even shut down) their operations. In Section IV, we report the results of our econometric analysis of the demand for companion care labor, which indicates that labor demand is far more elastic than what the PRIA assumes.

Despite the likelihood that live-in care industry would bear a substantially greater burden with respect to, e.g., overtime and recordkeeping costs, the PRIA simply assumes that there would be no differential impact on the market for live-in care.

With respect to (b), the PRIA's implicit assumption of perfectly inelastic demand for companionship services, which is the foundation for its finding of low deadweight losses from the proposed rule, arises from the notion that public and private payers would fully and instantaneously accommodate the increased costs of companion care that would result from the proposed rules. This assumption directly contradicts a substantial body of evidence showing

Table 2 — Unfounded Assumptions and Omissions In PRIA's Economic Analysis

Category	PRIA Estimate	Comments/Findings
Compliance Costs		
Overtime Costs	$0 – $139.3M	Assumes low level of OT hours in contradiction with other studies; ignores OT costs for independent providers; ignores disproportionate OT costs for live-in care; ignores possible changes to collective bargaining agreement in California.
Minimum Wage Costs	$16.1M	Assumes federal minimum wage remains fixed at $7.25 in perpetuity.
Travel Costs	$26.7M	Derived from under-estimate of overtime costs; ignores high travel costs in rural areas.
Quasi-Fixed Costs	$0	Ignores costs of hiring, training, health benefits, etc. Ignores empirical evidence that quasi-fixed costs make up 19% of labor costs on average.[44]
Regulatory Familiarization and Recordkeeping Costs	$9.9M	Assumes cost of adaptations to payroll policies, software, staffing plans, etc. would come to only $54 per business and only $27 per family employer. Ignores new recordkeeping burdens for live-in care. Ignores recordkeeping burden of "20 percent" threshold for incidental activities.
Disproportionate Impact on Costs in Live-In Care Industry	$0	Acknowledges absence of reliable data on number of live-in employees and prevalence of overtime in live-in care industry; ignores these deficiencies in economic analysis.
Economic Distortions/Deadweight Loss		
Elasticity of Demand: Companion Care Labor	0.15	Assumes extremely low elasticity of demand for companionship labor. Relies on mischaracterization of economic literature; relies on labor/capital substitution effects, holding output constant; ignores scale effects. Navigant's econometric analysis of industry data finds far more elastic labor demand.
Elasticity of Demand: Companion Care Services	0	Assumes perfectly inelastic demand for companionship care services; assumes public/private payers completely insensitive to cost increases, despite evidence to the contrary. Inconsistent with labor market analysis.
Deadweight Loss: Labor Market	$0.008M – $0.103M	Based on systematic under-estimates of (1) compliance costs; (2) labor demand elasticity.
Deadweight Loss: Companion Care Services Market	$0	Based on assumption of perfectly inelastic demand for services. Inconsistent with labor market analysis.
Disemployment	218 – 793	Based on systematic under-estimates of (1) compliance costs; (2) labor demand elasticity.

that existing federal programs have increasingly moved towards cost control measures in response to increases in home health care expenditures over the last decade; that shortages already exist in the public sector, even at current prices for companionship care services; and, that the private payer market is also sensitive to cost increases. The PRIA's assumption of zero demand elasticity for companionship care services is also contradicted by our econometric estimate of the demand for companionship care labor (showing demand to be elastic), since the demand for labor (like any input to production), is a "derived demand," which ultimately depends on the demand for the final product.

Table 2 below presents a summary of key unsupported assumptions and omissions underlying the PRIA's economic analysis:

To summarize, the PRIA errs in three primary respects. First, it understates the direct costs of the proposed rule in terms of increased wages and various other compliance costs. Second, it understates the effect of those costs on the demand for companion care labor by assuming an unrealistically low elasticity of demand, which translates directly into unrealistically low estimates of the employment effects of the proposed rules. Third, and most egregiously, it assumes that the proposed rules would have essentially *no* impact in the market for companionship care itself – that is, virtually no elderly person or individual with special needs would forego companion care, or be forced into a nursing home, as a result of the rule. This assumption is both unjustified and incorrect.

III. Compliance Costs

A. Overtime and Minimum Wage Costs

The PRIA estimates overtime costs based on the assumption that 12 percent of the workforce currently works more than 40 hours per week, and that no significant fraction of the workforce currently works more than 52.5 hours per week. Specifically, the PRIA assumes that ten percent of the workforce works five hours of overtime (i.e., a 45-hour week), and that two percent work 12.5 hours of overtime (i.e., a 52.5-hour week), while the remaining 88 percent works 40 hours per week (or fewer).[45] This assumed distribution of overtime hours is based on an analysis performed by the Paraprofessional Healthcare Institute (PHI) of the Current Population Survey's Annual Social and Economic Supplement (ASEC).[46] Based on these assumptions, total overtime costs are estimated at $139.3 million assuming no adjustment in the employment/hours mix, and at one-half this amount ($69.7 million), assuming that existing overtime hours are halved in response to the new regulations.[47]

The PRIA understates overtime costs for several reasons. For example, the PRIA ignores overtime costs altogether for independent providers.[48] According to the PRIA's own estimates, approximately 12 percent of the labor market "can reasonably be described as independent providers that directly provide caregiver services to families, perhaps through informal arrangements."[49] The PRIA proceeds on the assumption 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."[50] The PRIA provides no data or analysis to support this assumption. In any case, by dismissing overtime hours altogether, the PRIA can only understate the true number of independent provider overtime hours that would be subject to the proposed rules.

The hypothesis that hours worked may be systematically under-reported to the CPS is supported by evidence from a 2007 study by the Department of Health and Human Services.

The PRIA's economic analysis also understates overtime costs by ignoring the sensitivity of its estimates to state-level factors. For example, the PRIA acknowledges that its overtime cost estimate would increase by more than 50 percent (by $75 million) in the event that approximately 367,000 companion care workers in California lose overtime coverage due to a change in the terms of a collective bargaining agreement.[51] Yet the PRIA fails to account for these costs when conducting its economic analysis.

The PRIA's assumptions also ignore the impact of the proposed rules on live-in workers. By its very nature, the live-in companionship care industry is disproportionately likely to incur extended periods of pay at the overtime wage under the proposed rules. For example, a two-aide rotation would result in a total of 18 weekly overtime hours, assuming a 14-hour workday. With an hourly wage of $10, total weekly labor costs would be $98*10=$980 without overtime, but $80*10 + 18*$15 = $1,070 with overtime - an increase of over nine percent.[52] For any given base wage, labor costs would increase by the same percentage. Of course, the percentage increase in labor costs would be greater to the extent that the workday exceeds 14 hours: As the PRIA anticipates, "[a]ttending 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)."[53]

In contrast, the PRIA estimates that *total* compliance costs (inclusive of overtime costs and all other cost categories) would represent less than one percent of current wages,[54] and that overtime costs would represent a bit over one half of one percent of current wages.[55] Based on the example above, the PRIA's failure to distinguish between live-in care and hourly care would cause it to underestimate the overtime cost burden for the live-in care industry by roughly a factor of eighteen.[56]

As noted previously, the PRIA takes the position that any overtime hours incurred by live-in workers should be reflected in the CPS data on which it relies. However, this assumes that CPS respondents report hours worked in a manner consistent with that required by the proposed rules. It is unlikely that work hours reported to the CPS would fully reflect, e.g., the "precise records of the hours actually worked"[57] and "bona fide sleep periods"[58] required by the proposed rules.

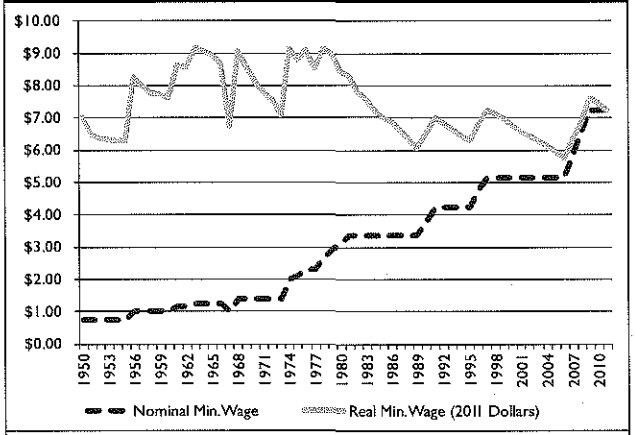
The hypothesis that hours worked may be systematically under-reported to the CPS is supported by evidence from a 2007 study by the Department of Health and Human Services (DHHS). In that study, home health aides worked an average of approximately 32 to 35 hours per week, with a standard deviation of approximately 18 to 19 hours.[59] If one assumes that hours are approximately normally distributed, this implies that approximately 25 to 30 percent of aides worked more than 40 hours per week, and that over 15 percent worked more than 50 hours per week. Similarly, a recent study by IHS Global Insight finds that, among companion care businesses that operate as franchises, approximately 27 percent of employees work more than 40 hours per week.[60]

With respect the minimum wage, the PRIA estimates that only a small number of workers (31,000 agency employees and 7,500 independent providers) would be affected, with the remainder already earning in excess of the federal minimum.[61] In the first year, minimum wage provisions are estimated to increase labor costs by $16.1 million. In all subsequent years, the PRIA assumes that minimum wage requirements will not affect labor costs; future increases in market wages would are assumed to make the minimum wage irrelevant in the future.[62]

To the extent that future increases in the minimum wage would violate this assumption, the PRIA understates the costs of minimum wage requirements. As seen in Figure 1 below, the history of the minimum wage involves a series of abrupt nominal adjustments, which translate into a jagged up-and-down time series when the data are adjusted for inflation.

It is not possible to predict exactly when or by how much the federal minimum wage will next be adjusted. Nevertheless, it is clear that abrupt upward adjustments have occurred regularly in the past and that future increases could affect companion care labor costs significantly. For example, in 2010, the national median hourly wage for HHAs was $9.89, the twenty-fifth percentile was $8.61, and the tenth percentile was $7.84.[63] Because the federal minimum wage is currently $7.25, an increase in the federal minimum wage of $0.59 would affect one tenth of all HHAs, an increase of $1.36 would affect one quarter of all HHAs, and an increase of $2.64 would affect half of all HHAs. Increases of this magnitude are not unprecedented. To illustrate, from 2006 to 2009, the federal minimum wage increased by $2.10, from $5.15 to $7.25.

Figure 1 — Federal Minimum Wage, 1950 – Present



Sources: Department of Labor, Wage and Hours Division; Bureau of Labor Statistics.

B. Quasi-Fixed Costs

While the PRIA acknowledges that the proposed regulations might increase what are known as *quasi-fixed costs* of employment, it incorrectly attaches a zero value to this effect.

Quasi-fixed costs arise when employers incur costs that vary with the number of workers hired, rather than the number of hours worked.[64] In general, quasi-fixed costs can be categorized as either (a) investments in the workforce, such as hiring and training costs; or, (b) direct employee benefits, such as health benefits and paid vacation. Labor economists have estimated that such costs may comprise nearly one-fifth of total compensation.[65] Although the PRIA acknowledges the existence of "additional managerial costs to

agencies [that] might occur as a result of changes in staffing,"[66] it claims that they can be safely ignored because, "the Department has no basis for estimating these costs, but believes they are relatively small."[67]

The PRIA's assumption that quasi-fixed costs can be dismissed is unfounded, as is its decision to ignore these costs altogether in its economic analysis. For instance, the 2007 National Home Health Aide Survey indicates that 38 percent of home health aides have employer-sponsored health insurance.[68] More generally, there is evidence that employers in this industry incur a variety of quasi-fixed costs. As the agency Partners in Care reported to the *New York Times* in 2008, employees receive a variety of benefits, the net effect of which is to decrease turnover:

> All of our aides are eligible for individual health benefits, including vision, dental and prescription drug coverage, at no cost to them. We also offer our aides pension benefits, paid vacations and sick time, and we provide uniforms as well...all of our aides are offered continuing education and have career advancement opportunities...All of these things account for our success in keeping home health aides working with us for years."[69]

Indeed, the fact that overtime hours are observed at all in this industry is itself evidence that quasi-fixed costs are economically significant, as labor economists have recognized:

> Firms using overtime before [an overtime requirement] could have increased their workforce and reduced their use of overtime earlier; the fact that they did not suggests that the quasi-fixed costs of hiring made that a more costly option. If they now eliminate overtime and hire more workers at the same base wage rate, their labor costs will clearly rise.[70]

Moreover, as the PRIA acknowledges, there is evidence that workers react to overtime requirements, and the concomitant reduction in hours, by seeking out hours at multiple agencies:

> 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. 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.[71]

Under this scenario, there is no net additional hiring by employers, while workers receive no benefits whatsoever from the new overtime requirement (since they do not receive overtime pay on hours after forty). On the other hand, quasi-fixed costs clearly increase in the aggregate, as each agency now "shares" employees that used to work exclusively for only one agency.[72] The PRIA fails to quantify this cost category – which is estimated, overall, to account for 19 percent of total labor costs in the U.S. economy – and thus effectively assigns it a value of zero by default.

C. Regulatory Familiarization and Recordkeeping Costs

Recognizing that "[e]ach establishment will spend resources to familiarize itself with the requirements of the rule and ensure it is in compliance," the PRIA incorporates an estimate for the costs of "regulatory familiarization" into its economic analysis.[73] Specifically, the PRIA assumes that "[e]ach 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 handbooks and make any needed changes to the payroll systems."[74] Combining this with an estimated "mid-level HR wage" of $26.79 per hour, the PRIA arrives at an estimate of approximately $54 per establishment, for a total of approximately $4 million in regulatory familiarization costs for agencies.[75] With respect to independent providers, the PRIA assumes that the families which employ them would spend only one hour on regula-

tory familiarization, which, when valued at the national average hourly wage ($29.07), yields a total of approximately $6 million in regulatory familiarization costs for families.[76]

The PRIA's assumptions regarding regulatory familiarization costs are unfounded for several reasons. With respect to family employers, the PRIA provides no basis for its assumption that a single hour would be sufficient for regulatory familiarization, nor does it account for the ongoing need for family employers to keep track of weekly hours and overtime and to adjust overtime compensation in a manner consistent with the proposed rules. The PRIA also ignores the recordkeeping burden associated with complying with the "20 percent" threshold for incidental activities, which, as noted above, would require employers to draw fine distinctions and to keep careful records of, e.g., the amount of time that companion care workers spend doing laundry, driving to the store to pick up groceries, and so on.

With respect to agencies, the PRIA's assumption that regulatory familiarization would require only two hours of mid-level human resources time is unsupported, as is its implicit assumption that a computerized payroll system previously designed solely for straight-time pay could be adapted to accommodate overtime pay without expending time and resources on, e.g., technical support personnel, overtime tracking software, and so forth. The PRIA also ignores the likelihood that adapting to a fundamental shift in a firm's compensation structure would require at least some mid- to upper-level management resources.

More fundamentally, while the PRIA's economic analysis assumes that employers are most likely to respond to the proposed rules by altering the mix between employment and hours worked, the PRIA's regulatory familiarization cost estimates make no allowance for the time and resources that would be required to make such an adjustment. To the extent that employers respond to the proposed rule, as the PRIA predicts, by "hiring some additional staff or increasing hours to part-time workers,"[77] this adjustment process would cause employers to incur costs in the course of adapting to the new regulations. In determining the extent to which workloads should be rebalanced, agencies would need to weigh the costs of overtime against the costs of, e.g., new staffing arrangements that increase the ratio of employees to customers: As the PRIA observes, "the time spent reorganizing staffing plans is not costless."[78] Yet for purposes of assessing economic impact, the PRIA assumes the cost to be zero.

Finally, regulatory familiarization and adaptation costs are likely to be particularly high for employers of live-in workers. As noted previously, employers would no longer permitted to "maintain a simplified set of records for live-in domestic employees who work a fixed schedule,"[79] and would instead be obligated to "maintain records showing the exact number of hours worked by the live-in domestic employee."[80] Yet despite acknowledging the fundamental transformation of payroll and recordkeeping systems that the proposed rules imply, the PRIA ignores these costs in its economic analysis.[81] Once again, by assuming a default value of zero, the PRIA continues its pattern of systematically understating compliance costs.

D. Travel Costs

The proposed rules would require that companion care workers traveling between worksites be compensated for travel time. After noting that "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,"[82] the PRIA settles on a travel cost estimate based on amicus brief filed in *Long Island Care at Home, Inc. v. Coke* (the same brief which the PRIA disregards for purposes of estimating overtime costs).[83] Based on the *Coke* amicus brief, the PRIA estimates that travel costs would represent 19.2 percent of total overtime costs, or approximately $26.7 million.[84]

The PRIA's travel cost estimate is likely understated for two primary reasons. First, the PRIA's travel cost estimate is, by construction, based on its own estimate of overtime costs, which is understated for a variety of reasons discussed herein. Second, the PRIA's estimate is based on travel patterns specific to New York City. As the PRIA observes, "home health care workers in rural areas might have to travel further between

clients,"[85] which would increase travel costs as a proportion of overtime costs. The potential for high travel costs in rural areas is corroborated by evidence cited in the PRIA,[86] as well as evidence that the industry is sensitive to fuel prices in rural areas.[87] Yet the PRIA justifies its reliance on the New York City estimate based on the absence of other evidence, continuing a pattern of adopting assumptions that have the effect of systematically understating compliance costs.[88]

E. The Disproportionate Impact on Live-in Care

Finally and perhaps most significantly, the PRIA ignores altogether the disproportionate impact of the repeal on the market for live-in care. As noted previously, under the proposed rules, third-party employers of live-in domestic workers would become subject to minimum wage and overtime requirements. Although the PRIA acknowledges that "[a] significant overtime pay issue in this industry is associated with overtime pay for the care of patients requiring 24-hour services,"[89] and that recordkeeping costs would increase for employers no longer permitted to "maintain a simplified set of records for live-in domestic employees who work a fixed schedule,"[90] and instead required to "maintain records showing the exact number of hours worked by the live-in domestic employee,"[91] these qualitative acknowledgments do not find their way into the PRIA's quantitative analysis of the economic impact of the proposed rules. Instead, the PRIA makes no distinction whatsoever between live-in care and hourly care, assuming equal economic impacts across these two very different segments of the industry.

The obvious flaw in this logic is that there is no reason to expect that CPS respondents would report hours worked in a manner consistent with that required by the proposed rules.

The PRIA acknowledges that it lacks reliable data on both the number of employees and the prevalence of overtime in the live-in care industry, yet proceeds to ignore these informational deficiencies when performing its economic analysis. With respect to the number of live-in workers, the PRIA acknowledges that it was not able to "identify current data to estimate the number of live-in domestic workers employed by third-party agencies," and that its only data source for the number of live-in domestic workers is a 1979 study of domestic service employees, which itself relied on 1974 data. The PRIA does not incorporate data specific to live-in domestic employees into its economic analysis, and instead specifically solicits comments and data on the number of live-in domestic workers and their employers.[92] Yet the PRIA still manages to conclude that "based on historical data, we do not expect the impact of the proposed change concerning third-party employment [of live-in domestic workers] to be substantial."[93] The PRIA's reliance on a three-decades-old dataset in forming its expectations is particularly puzzling given that the PRIA justifies the proposed rules in large part based on the growth in demand for in-home care that has accompanied the aging of the U.S. population since the mid-1970s, as well as the rising cost of traditional institutional care.[94]

With respect to the prevalence of overtime among live-in domestic workers, the PRIA again acknowledges that it lacks access to reliable data, and then proceeds to ignore the likely biases that this informational deficiency introduces into its economic analysis. Specifically, the PRIA notes that current regulations allow employers to maintain a copy of the agreement of hours to be worked, instead of requiring the employer to maintain an accurate record of hours actually worked by the live-in domestic worker, and expresses concern that "that not all hours worked are actually captured by such agreement,"[95] and that "[t]he 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."[96] Yet despite this concern that live-in hours may be systematically underreported, the PRIA makes no allowance for

such underreporting when estimating the extent of overtime hours worked in the industry, and therefore the likely overtime costs. Instead, the PRIA relies upon hours reported by respondents to the Current Population Survey (CPS), asserting that such data "should reflect all hours worked, including that of home health care workers caring for patients requiring 24-hour care."[97]

The obvious flaw in this logic is that there is no reason to expect that CPS respondents would report hours worked in a manner consistent with that required by the proposed rules. For example, if the hours worked by live-in domestic workers are captured in a formal agreement with the employer, as is permitted under current rules, there is nothing to prevent a survey respondent from reporting this "formal" number of hours to the CPS, as opposed to the (higher) number that would be calculated under the proposed rules.

To illustrate, under the proposed rules, "[a]ttending staff may be eligible for pay up to 16 of every 24 hours or even more."[98] Rather than reporting a workday of 16 hours (or more) to the CPS, the most likely response may well be to indicate the number of hours captured by the respondent's formal agreement with his or her employer: There is no reason to believe that work hours reported to the CPS would fully reflect the "precise records of the hours actually worked"[99] and "bona fide sleep periods"[100] required by the proposed rules. Thus, after expressing concern that overtime hours are underreported, the PRIA then proceeds to rely on data subject to this same downward bias when estimating overtime costs.

With respect to the recordkeeping costs, the proposed rules would require employers of live-in domestic workers to keep detailed records of reflecting the number of hours worked, as opposed to maintaining a copy of an agreement covering hours of work.[101] The PRIA recognizes that this requirement imposes additional costs on employers, and estimates the cost to live-in employers at over $22.5 million.[102] This estimate was produced to comply with the Paperwork Reduction Act (PRA), which requires the Department to consider the impact of paperwork and other information collection burdens.[103] However, the PRIA omits these recordkeeping costs from its economic analysis, noting that its recordkeeping cost estimate relies on the same dated study of domestic service employees noted above.[104] Thus, after making use of three-decades-old data to estimate recordkeeping costs (and thus to comply with the letter of the Paperwork Reduction Act), the PRIA then disavows its estimate for purposes of analyzing the economic impact of the proposed rules, thereby assuming by default that these employers incur no additional recordkeeping costs whatsoever.

IV. The Deadweight Loss from Repeal

As explained below, the PRIA systematically understates deadweight loss by assuming, based on a misrepresentation of the economic literature, that the elasticity of demand for companionship *labor* is extremely low. The PRIA also incorrectly assumes that the elasticity of demand for companionship care *services* is zero (perfectly inelastic), based on the assumption that public and private payers are willing and able to fully and instantaneously accommodate cost increases. As a consequence, the PRIA makes no attempt whatsoever to quantify the deadweight loss associated with foregone companionship services to elderly and special needs populations, assigning a default value of zero.

A. The Demand for Companion Care Labor

The elasticity of demand for companionship labor is central to assessing the impact of the DOL's proposal. Unfortunately, the PRIA fails to properly or meaningfully assess the likely magnitude of this critical parameter, and instead simply assumes an unrealistically low value that is taken wholly out of context from the economic literature – and then arbitrarily chopped in half. In so doing, the PRIA fails to consider the crucial issue of budget constraints on public sector funding for companionship care services, as well as the likely constraints on private sector expenditures. Simply put, the PRIA fails to consider whether the agencies and individuals who ultimately pay for companionship care would be capable of absorbing the costs associated with its proposal.

The PRIA acknowledges the absence of empirical estimates of the elasticity of demand for companionship labor.[105] As an alternative, it relies on what it characterizes as "the national average price elasticity of demand for all workers," drawn from the labor economics literature, which is estimated to be -0.30,[106] meaning that a one percent increase in wages is estimated to decrease the amount of labor demanded by 0.3 percent. Without basis in the economics literature or elsewhere – beyond the PRIA's own assertion that "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" – the original estimate then is reduced by half.[107] By this logic, the PRIA ultimately assumes that the elasticity of demand for companionship care labor is -0.15, and proceeds to rely on this estimate (and only this estimate) to inform its impact analysis.

The PRIA's assumed labor demand elasticity is misleading and taken out of context from the economic literature. The source of the elasticity estimate is a well-known book by the labor economist Daniel Hamermesh, which surveys a large number of empirical studies of labor demand, and, based on the results of these studies, computes -0.30 as a point estimate for the elasticity and [–0.15, –0.75] as a reasonable confidence interval.[108]

Even if these studies were relevant to the PRIA's analysis of this industry (as explained below, they are not), the existence of this confidence interval indicates that the elasticity could be more than twice as high as what DOL assumes. Yet the PRIA makes no allowance for this non-trivial source of uncertainty in its analysis. As Professor Hamermesh points out, adopting the PRIA's approach of relying on a single point estimate is "not a good idea."[109]

More fundamentally, the measure of elasticity relied upon by the PRIA is itself the incorrect measure, as it captures only the effect of substitution between capital and labor, assuming output remains constant.

Specifically, the studies cited by Hamermesh in arriving at the point estimate of -0.30 are designed to estimate the *substitution effects* associated with a change in the wage rate, also referred to as the *constant-output labor-demand elasticity.*[110] These studies are used assess the degree of substitutability between labor and capital (or other factors of production). Technically, they measure the curvature of the isoquants that define firms' production technologies.

Because it captures only the substitution effect, the PRIA's assumed elasticity ignores entirely the *scale effect*, defined as the percentage decrease in employment associated with a one percent increase in wage rates (or labor costs), holding production technology constant. The scale effect is the result of cost increases being passed on in the form of higher prices, which reduces demand for the final product, and thus employment levels. Thus, the scale effect captures the extent to which an increase in labor costs forces firms to "scale back" (or even shut down) their operations.

Increases in labor costs lead to greater scale effects when labor represents a larger share of total costs, since any given increase in variable costs per worker translates into higher prices. Scale effects are also more pronounced in industries where demand for the final product or service is relatively elastic, because any given increase in the price of the final product causes a greater contraction in the equilibrium quantity demanded of the final product. These effects are also larger in the long run than in the short run, because demand for the final product is more elastic in the long run, during which consumers are better able to seek out substitutes.[111] Finally, scale effects are greater when demand for the final product is subject to significant *income effects*, because demand for the final product is more elastic when the final product comprises a larger share of consumers' income. (To illustrate, an increase in the price of housing may make an individual significantly "poorer" (causing the individual to purchase a smaller house), whereas even a relatively large increase in the price of (say) candy bars would not typically result in material income effects (although there could well be substitution effects).

By ignoring the scale effect altogether, the PRIA *assumes away* contractions in employment

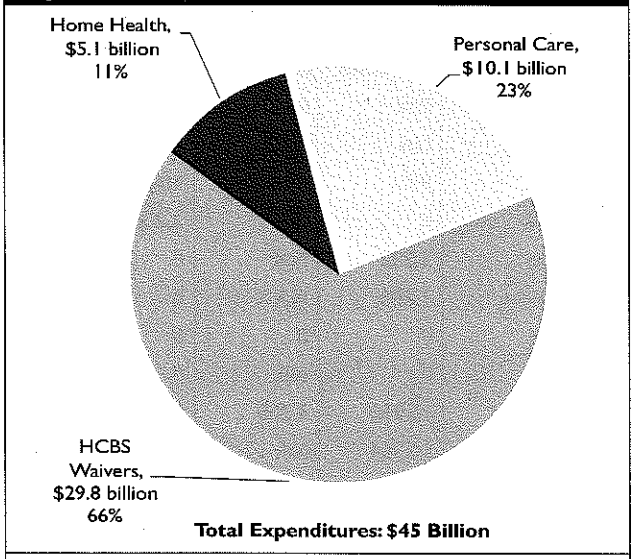
driven by the inability of those who ultimately pay for companionship care services to absorb additional cost increases – i.e., it assumes away the primary source of deadweight losses from the rule. In economic terms, the PRIA ignores the fact that the demand for labor (like any input to production), is "derived demand," which depends on the demand for the final product. As discussed below, these effects are likely to be quite large in both the public sector and the private sector.

B. The Demand for Companion Care Services

A central assumption of the PRIA's economic analysis is that the payers for companionship services, particularly public payers, are insensitive to cost increases, such that "[t]he Department anticipates that the proposed rule will have relatively little effect on the provision of companionship services."[112] In fact, the PRIA makes no attempt whatsoever to quantify the deadweight loss associated with foregone companionship services, thereby assigning a value of zero due to a "lack of information."[113] Accordingly, the department ignores the losses associated with the denial of companion care to current and future consumers, and the special needs populations they represent (see Section V.C).

Thus, embedded throughout the PRIA's economic analysis is the assumption that public and private payers are willing and able to fully and instantaneously accommodate cost increases into their budgets. As explained below, these assumptions are unfounded. In fact, the evidence shows that existing federal programs have increasingly moved towards cost control measures in response to substantial increases in home health care expenditures over the last decade; that the extent of existing public sector coverage of companionship services is more limited than what the PRIA implies; that shortages already exist in the public sector, even at current prices for companionship care services; and, that the private payer market is also likely to be sensitive to cost increases (as the PRIA itself acknowledges). These findings are confirmed by our econometric analysis, which indicates that labor demand in these markets is elastic.

Figure 2 — Medicaid Home Health Expenditures, 2008



Source: Kaiser Commission on Medicaid and the Uninsured and UCSF analysis of CMS Form 372 data and program surveys.

According to the PRIA, "the demand for companionship services probably has two distinct components: Patients covered by Medicare and Medicaid, and out-of-pocket payers. Medicare and Medicaid accounted for 35 and 41 percent, respectively, of total spending on home health in 2008."[114] Statistics such as these form the basis of the PRIA's maintained assumption that demand for companionship care is highly inelastic, due to funding from government programs.[115] None of these figures is specific to companion care services. In fact, the PRIA provides no data on federal home health care expenditures for companionship care *per se*; it appears that such data do not exist.

With respect to Medicaid, home health expenditures totaled approximately $45 billion in 2008, as seen in Figure 2. (The fraction of these expenditures allotted to companionship care is unknown). As Figure 2 illustrates, home health care under Medicaid is provided through Medicaid Home Health, the State Plan Personal Care Option, and Medicaid Home and Community-based Services (HCBS). Home health care spending under HCBS is administered through state-specific waivers, and accounts for the majority of expenditures (approximately 66 percent in 2008).

From 1999 to 2008, aggregate expenditures across these three categories increased

Table 3 — Waiting Lists for Medicaid 1915(c) Home and Community-Based (HCBS) Waivers, 2010

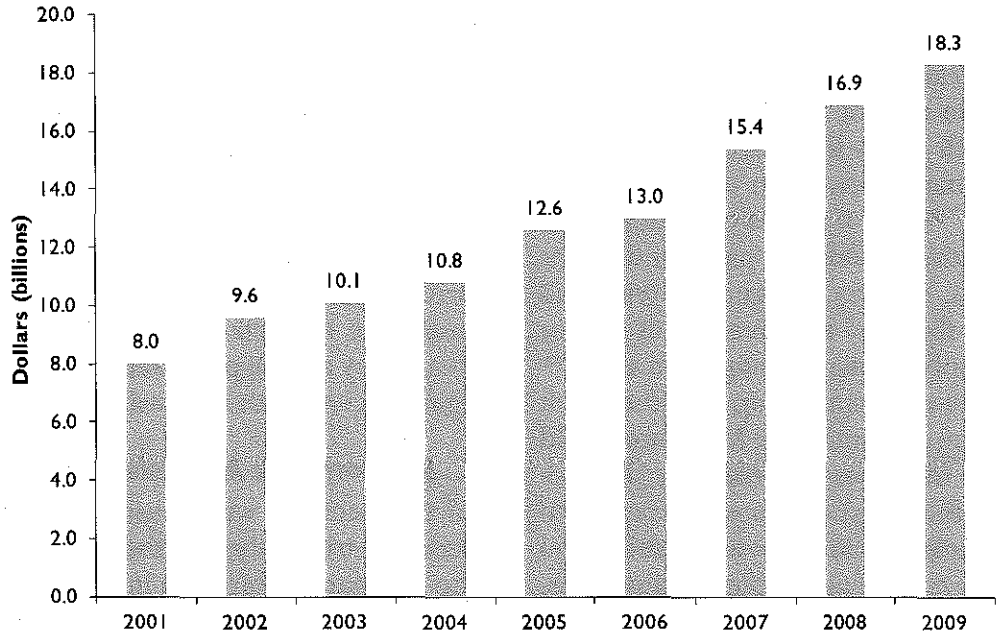
State	ID/DD	Aged	Aged and Disabled	Physically Disabled	Children	HIV/ AIDS	Mental Health	TBI/SCI	Total
Alabama	Unknown	NA	3,500	250	NA	0	NA	NA	3,750
Alaska	982	0	NA	0	0	NA	NA	NA	982
Arizona	NA	NA	NA	NA	NA	NA	NA	NA	NA
Arkansas	991	0	NA	0	NA	NA	NA	NA	991
California	0	NA	1,200	830	NA	0	NA	NA	2,030
Colorado	3,232	NA	0	NA	1,075	0	0	0	4,307
Connecticut	1,846	NA	0	71	NA	NA	NA	0	1,917
Delaware	0	0	0	NA	NA	0	NA	0	0
DC	0	NA	0	NA	NA	0	NA	NA	0
Florida	18,960	4,200	8,985	0	2	0	NA	606	32,753
Georgia	10,364	NA	763	NA	0	NA	NA	115	11,242
Hawaii	0	NA	100	NA	0	0	NA	NA	100
Idaho	0	NA	0	NA	NA	NA	NA	NA	0
Illinois	33,114	0	0	0	0	0	NA	0	33,114
Indiana	29,303	NA	2,946	NA	NA	NA	NA	106	32,355
Iowa	108	0	NA	1,566	482	7	NA	697	2,860
Kansas	2,414	0	NA	2,771	260	NA	NA	0	5,445
Kentucky	0	NA	0	0	NA	NA	NA	0	0
Louisiana	4,572	NA	14,163	NA	5,104	NA	NA	NA	23,839
Maine	98	NA	0	107	NA	NA	NA	NA	205
Maryland	3,210	20,000	NA	1,200	3,361	NA	NA	39	27,810
Massachusetts	0	0	NA	NA	0	NA	NA	0	0
Michigan	0	NA	3,404	NA	65	NA	NA	NA	3,469
Minnesota	Unknown	Unknown	NA	Unknown	NA	NA	NA	Unknown	Unknown
Mississippi	0	NA	5,945	1,992	NA	NA	NA	46	7,983
Missouri	Unknown	NA	Unknown	Unknown	169	Unknown	NA	NA	169
Montana	810	NA	508	NA	52	NA	10	NA	1,380
Nebraska	2,390	NA	0	NA	NA	NA	NA	0	2,390
Nevada	126	181	NA	112	NA	NA	NA	NA	419
New Hampshire	NA	0	NA	NA	NA	NA	NA	NA	0
New Jersey	0	NA	0	NA	NA	0	NA	50	50
New Mexico	1,141	NA	5,000	NA	130	0	NA	NA	6,271
New York	0	NA	0	NA	Unknown	NA	NA	0	Unknown
North Carolina	Unknown	NA	3,647	NA	106	0	NA	NA	3,753
North Dakota	0	NA	0	NA	NA	NA	NA	NA	0
Ohio	43,793	NA	500	NA	NA	NA	NA	NA	44,293
Oklahoma	5,754	NA	0	NA	NA	NA	NA	NA	5,754
Oregon	0	NA	0	NA	0	NA	NA	NA	0
Pennsylvania	20,460	0	NA	0	0	0	NA	0	20,460
Rhode Island	0	0	99	12	NA	NA	NA	NA	111
South Carolina	1,296	NA	3,883	0	404	0	NA	224	5,807
South Dakota	23	0	NA	NA	NA	NA	NA	NA	23

Table 3 — Waiting Lists for Medicaid 1915(c) Home and Community-Based (HCBS) Waivers, 2010 (Continued)

State	ID/DD	Aged	Aged and Disabled	Physically Disabled	Children	HIV/ AIDS	Mental Health	TBI/SCI	Total
Tennessee	2,316	NA	350	NA	NA	NA	NA	NA	2,666
Texas	70,113	NA	40,925	NA	14,347	NA	NA	NA	125,385
Utah	1,847	72	NA	62	51	NA	NA	70	2,102
Vermont	NA	NA	NA	NA	NA	NA	NA	NA	NA
Virginia	6,798	NA	0	0	NA	0	NA	NA	6,798
Washington	829	NA	0	NA	Unknown	NA	NA	NA	829
West Virginia	409	NA	0	NA	NA	NA	NA	NA	409
Wisconsin	675	NA	675	NA	1,938	NA	NA	675	3,963
Wyoming	246	NA	103	NA	NA	NA	NA	38	387
United States	**268,220**	**24,453**	**96,696**	**8,973**	**27,546**	**7**	**10**	**2,666**	**428,571**

Definitions: NA: No waiver offered. ID/DD: Intellectual Disability and Developmental Disabilities. This waiver type is referred to as MR/DD by CMS and was formerly titled as such in this table.TBI/SCI: Traumatic Brain and Spinal Cord Injury Sources: The Kaiser Commission on Medicaid and the Uninsured (KCMU) and The University of California at San Francisco's (UCSF) analysis based on The Centers for Medicare & Medicaid Services (CMS) Form 372, December 2011, Table 11. "Medicaid 1915(c) Home and Community-Based Service Programs: Data Update" available at http://www.kff.org/medicaid/upload/7720-05.pdf

Figure 3 — Medicare Home Health Care Expenditures, 2001 – 2009



Source: Medpac, "A Data Book: Healthcare Spending and the Medicare Program" (June 2010) at 139.

by 165 percent, (from an initial level of $17 billion), with most of the increase accounted for by HCBS waivers.[116] In response, states have adopted various cost control measures. For example, of those states offering the State Plan Personal Care Option, more than half (56 percent) used service or cost limits in 2010 to control expenditures.[117] With respect to HCBS waivers, in 2010 all states reported "using mechanisms to control costs in HCBS waivers such as restrictive financial and functional eligibility standards, enrollment limits, and waiting lists."[118] As shown in Table 3, a total of 39 states reported waiver wait lists totaling 428,571 individuals. The average time spent by individuals on wait lists ranged from six to 36 months.[119]

With respect to Medicare, as seen in Figure 3, expenditures on home health care services totaled $18.3 billion in 2009, approximately four percent of total outlays.[120] Under the Prospective Payment System (PPS) adopted in October 2000, home health care expenditures more than doubled from 2001 to 2009.[121] Presumably in response to trends such as these, President Obama's recently released budget plan calls for $364 billion in healthcare savings over the next ten years, part of which would come in the form of reduced Medicare payments to healthcare providers and beneficiary copayments for home healthcare.[122]

Although the fraction of these expenditures accounted for by companionship care is unknown, official Medicare documentation states clearly that home health aide services are covered by Medicare only on a "a part-time or intermittent basis," and only if necessary "as support services for skilled nursing care."[123] Medicare defines care as "intermittent" when administered fewer than 7 days per week or less than 8 hours per day over a maximum period of 21 days.[124] Medicare does not cover live-in care or "[p]ersonal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care you need."[125] All of this is consistent with the assessment that "Medicare pays for doctors, hospitalizations, surgery, diagnostic tests and medication for those 65-and-over – but not for what is commonly known as long-term care."[126]

Even for those companionship services that it covers, there is no guarantee that Medicare would absorb the cost increases generated by the proposed rules, as the PRIA assumes. According to the PRIA, "[b]ecause 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."[127] In other words, the PRIA cannot point to any rule that would require Medicare to cover minimum wage and travel cost increases, and can only speculate that it would. The PRIA cannot even provide a speculative basis for the assumption that Medicare would absorb increased overtime costs, which, according to the PRIA's own economic analysis, would represent the single largest cost increase under the proposed rules.[128] The PRIA states only that "[t]he impact of overtime pay on reimbursement rates is more uncertain."[129]

With respect to the private pay market, the available evidence is consistent with the commonsense notion that private payers are sensitive to increases in the cost of companionship care, in part because such services may represent a substantial share of household income. For example, live-in care "can cost upwards of $150,000 a year for someone who needs 24/7 assistance that is custodial, rather than medical, and thus not covered by Medicare...."[130] Although private health insurance policies generally provide some coverage for skilled home care services, companionship services are generally not covered over the long term. As the Congressional Budget Office observed in a 2004 report:

> [H]ealth insurers cover certain long-term care services, such as home health care, to aid beneficiaries in recovering from specific medical events. But they generally do not cover LTC services that are needed because of either nonspecific causes related to old age or as a result of chronic, or "long-term," impairment.[131]

In economic terms, the reason for this is clear: Live-in and/or long-term care expenses are not driven by the type of rare and costly events that insurance markets typically insure against. Instead, they are the predictable consequence of an aging society with increasing life expectancy.[132]

C. Econometric Analysis of Industry Data

In this section, we present the results of our econometric analysis of the demand for labor in the companionship care industry. As explained below, the analysis indicates that employment in the industry is far more responsive to changes in labor costs than the PRIA assumes. Specifically, the demand for companionship care workers is found to be elastic, implying that a one percent increase in labor costs causes employment to decline by more than one percent, causing aggregate worker compensation to decline.

We utilize a state-level panel data set to analyze the relationship between companion care wages and companion care employment across states

and over time, while controlling for other factors that may affect the demand for companion care labor. Due to the potential for wage endogeneity, the econometric model is estimated via two-stage least squares. In the first stage, state-level variation in the companion care minimum wage is exploited to produce exogenous variation in wages. As explained below, we also use state-level variation in the cost of living (as proxied by a home price index) to instrument for wages in the first stage. The second stage then examines the effect of this variation on employment levels in the companion care industry.

The dependent variable in the econometric model is the natural log of aggregate employment of Home Health Aides (HHAs) and Personal Care Aides (PCAs) in a given state in a given year. The key independent variable of interest is the natural log of the average hourly wage received by HHAs and PCAs in a given state in a given year.[133]

The model is estimated using a state-level panel dataset spanning 2001-2009, and includes several additional right-hand-side variables to control for other factors that may affect employment levels. (Note that 2009 is the most recent year for which all variables are available). The econometric model can be written as follows:

$$\ln(TOT\_EMP_{st}) = \beta_0 + \beta_1 \ln(WAGE_{st}) + \beta_2 \ln(AGED\_POP_{st}) + \ldots$$
$$\ldots + \beta_5 \ln(MEDICAID\_HHC_{st}) + \beta_6 T + \varepsilon_{st}$$

Variables incorporated into the regression model are adjusted for inflation where applicable, using the Consumer Price Index (CPI). Above, TOT_EMP_{st} represents total PCA and HHA employment in state s and year t, and $WAGE_{st}$ represents the average hourly wage of PCA and HHA workers in state s and year t. The remaining right-hand-side variables are defined as follows:

- $AGED\_POP_{st}$ is the population over the age of 65 in state s and year t.[134]
- $MEDICAID\_HHC_{st}$ is Medicaid spending on home health care in state s and year t.[135]
- T is a linear time trend.
- Finally, ε_{st} is a stochastic error term.

The wage variable is potentially endogenous; that is, wages may be correlated with unobserved factors that also shift the demand for labor. (Durbin and Wu-Hausman tests reject the null hypothesis of exogeneity of the wage variable). Accordingly, the model is estimated using two-stage least squares. In the first stage regression, we predict $\ln(MEAN\_WAGE_{st})$ using the exogenous right-hand-side variables listed above, and two instruments. The first instrument is the state-level companionship care minimum wage (if any); the second instrument is a housing price index, which provides a proxy for differences in the cost of living. Both variables are expected to shift the observed wage in a manner uncorrelated with labor demand. The first stage regression model can be written as follows:

$$\ln(WAGE_{st}) = \lambda_0 + \sum_{i=1}^{5} \lambda_i x_{ist} + \lambda_6 COMP\_MINWAGE_s + \lambda_7 ATI_{st} + u_{st}$$

Table 4 — Summary Statistics for Regression Variables

Variable	Obs	Mean	Std Dev	Min	Max
TOT_EMP	457	26,742	39,832	560	241,429
WAGE	457	$10.38	$1.18	$7.44	$14.53
AGED_POP	457	728,025	778,627	37,815	4,164,048
COMP_MINWAGE	457	$3.11	$3.72	$0.00	$8.67
ATI	457	323.97	112.69	153.96	714.40
MEDICAID_HHC ($ Millions)	457	$339.73	$838.20	$1.13	$6,324.31
T	457	5	3	1	9

Note: Monetary variables expressed in constant 2010 dollars.

Table 5 — Second-Stage Regression Results (Dependent Variable = Natural Log of PCA + HHA Employment)

Independent Variable	Coefficient	Standard Error	t-Statistic	p>|t|
ln(WAGE)	-1.176	0.389	-3.030	0.002
ln(AGED_POP)	0.700	0.041	16.870	0.000
ln(MEDICAID_HHC)	0.235	0.026	9.210	0.000
T	0.035	0.009	3.760	0.000
Constant	1.921	1.229	1.560	0.118
Obs: 457				
R-Squared: 83.72%				

Above, the x_{ist} represent the five exogenous variables defined above, the instrument $COMP\_MINWAGE_{st}$ is the companionship care minimum wage in state s, the instrument ATI_{st} represents the all-transactions house price index in state s and year t, and u_{st} is a random error term.[136]

Our panel data set contains 51 observations for each year (50 states and the District of Columbia) for a total of 457 observations.[137] Summary statistics for the variables used in both stages of the regression analysis are shown in Table 4.

The regression results of the labor demand equation defined above are reported in Table 5. The results of the second stage regression are presented in Table 1. The coefficients on both instruments in first stage regression are positive and statistically significant. The positive and statistically significant coefficient on COMP_MIN_WAGE indicates that, controlling for other factors, a higher state-level companionship care minimum wage leads to a higher observed hourly wage. The positive and statistically significant coefficient for ATI indicates that higher costs of living lead to higher wages for companion workers. Sargan and Basmann tests of overidentifying restrictions accept the null hypothesis that the instrumental variables used in the first stage are exogenous. The model explains 83.7 percent of the variation in companionship care employment.

The size of the aged population has a positive and statistically significant effect on total employment in the industry; older populations are associated with greater demand for companionship care workers. Given that it is defined as the population over 65 years of age, *AGED_POP* also subsumes the effect of Medicare enrollment. Medicaid expenditures on home health care also have a positive and significant effect on employment, as expected. The estimated coefficient on the linear time trend suggests an annual growth in total employment of approximately 3.5 percent, after controlling for other factors.

Most significantly for present purposes, the elasticity of demand for companionship care labor is estimated to be highly statistically significant and elastic: A one percent increase in labor costs is associated with a decrease in employment of 1.18 percent. This differs dramatically (by more than a factor of seven) from the PRIA's assumed labor demand elasticity of -0.15.

Because it is unlikely that employers are able to substitute capital (or other inputs) for labor in the face of a wage increase, our empirical results suggest that scale effects are quite substantial in this industry. This in turn implies that the PRIA, in relying on a mischaracterization of the relevant economic literature, drastically overstates the ability of public and private payers to absorb increases in the cost of companionship care services. Simply put, the effect of the regulations would be to substantially reduce the amount of companion care services provided, with effects likely to be manifested in much the same way as past cost control efforts (enrollment limits, waiting lists, financial/functional eligibility restrictions, and so on).

V. Additional Issues

In addition to the shortcomings catalogued above, there are a variety of other problems with the PRIA which cause it to understate the cost of the proposed regulations and fail to meet the standards for regulatory impact analyses prescribed in OMB Circular A-4.

A. The Likely Effect of Repeal on the Quality of Companion Care

The PRIA recognizes that "although the hours of care received by patients might be unaffected by the increased costs of care, the quality of that care might suffer."[138] As we have demonstrated above, the PRIA's conclusion that the hours of care patients receive would be unaffected is unsupportable and certainly incorrect: It is based on DOL's incorrect assumption that the demand for companion care is perfectly inelastic. Hence, in that sense at least, the quality of care provided would certainly suffer. (Similarly, the PRIA's assumption that demand for companion care is completely unaffected by prices causes it to ignore the impact of increased companion care prices on the propensity of consumers to utilize so-called "grey-market" services).[139]

The other primary sources of quality degradation likely to occur under the proposed rules are associated with continuity of care and with the

ability of home health care providers to attract and retain qualified staff.

With respect to continuity of care, the PRIA notes, but then dismisses, concerns that the rule would result in third-party employers substituting multiple companion care providers (each working less than 40 hours per week) for a single companion provided extended care to a single customer. As the NPRM states:

> 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.[140]

Despite this recognition, the PRIA dismisses concerns about continuity of care based on little more than speculation based on studies showing the impact of long hours on medical error rates (data which is arguably irrelevant since companion care services specifically do not include health care services), and because "one of the purposes of the FLSA's overtime pay requirement is to induce more people to work fewer hours each."[141] Thus, the PRIA effectively acknowledges that continuity of care would be negatively affected by the proposed rules, but fails to include the resulting impact on companion care consumers as a cost.[142]

Similarly, the PRIA discusses the potential impact of the proposed rules on employee turnover (and the presumptive indirect effect on quality of care), but argues that retention will be improved by higher wage rates.[143] The implicit assumption is that retention is a function of the wage rate, rather than total income. Yet research by the Department of Health and Human Services (not cited by the PRIA) reaches the opposite conclusion, finding that "aide work hours were the strongest predictor of job retention; the more hours an aide worked per week, the more likely he/she was to remain in the workforce."[144]

B. The Perverse Impact of Repeal on the Demand for Institutionalized Care

Another implication of the PRIA's erroneous assumption of inelastic demand for companion care is its conclusion that no companion care consumers will be forced into institutionalized care (e.g., nursing homes). But as companion care costs rise, waiting lists for HCBS and other Medicaid-financed home care programs grow, and (for private payers) the relative price of companion care rises compared with nursing home care, it is virtually certain that the demand for institutionalized care will increase, perhaps substantially. For example, ANCOR's 2001 comments concluded that:

> In the absence of third-party employment, it is likely that many people now served under the companionship rules will require institutionalization. For older people with dementia or those with mental retardation, third-party employment is imperative to enable these individuals to remain at home. In the years since this exemption was passed, support at home has become recognized and promoted by individuals, families and government alike for its humanitarian aspects as well as its potential for reducing the costs of care. It is far preferred over institutional care by those who are knowledgeable about supports for people who are aging and disabled. Living at home is certainly preferred by persons with disabilities and their families.[145]

As ANCOR suggests, there is a broad consensus that home care is both superior in quality and, at least potentially, significantly less expensive than institutionalized care. For example, with respect to quality, a 2004 Kaiser Foundation report concluded that "quality problems remain in a significant proportion of the nation's nursing homes, and enforcement mechanisms are weak and underutilized in many states,"[146]

while "it is generally assumed that the quality of home and community-based care is better than nursing home quality because clients have greater control over services, have family and other community supports, are less isolated than residents of nursing homes, and tend to be more satisfied with the services they receive."[147]

There is also a substantial body of evidence suggesting that home care is ultimately less expensive than institutionalized care. A 2010 Prudential Research Report, for example, found that the average daily rate for a private nursing home room ($247) exceeds the average cost of home health care ($190) by 30 percent.[148] Thus, the proposed rules would have the effect not only of forcing long-term care consumers into a less-preferred form of care, but at the same time increasing costs for both public and private payers.

C. The Disproportionate Effect of Repeal on Special Needs Populations

The PRIA fails to recognize, let alone take into account, the fact that the burden of the proposed regulations would fall on special needs populations – elderly and special needs Americans, many of whom are sufficiently economically distressed to qualify for Medicaid. As ANCOR's 2001 comments stated:

> Since the 1970s, the field of mental retardation and developmental disabilities has promoted the provision of services in the least restrictive environment. Whenever possible, it is believed that this should be in the home of the person with a disability. Experience has demonstrated that the smaller the site and more individualized the supports, the greater the progress and satisfaction level of the person served. In increasing numbers, people with disabilities are living with roommates or by themselves with the aid of a companion.[149]

OMB Circular A-4 specifically directs agencies to be alert for "situations in which regulatory alternatives result in significant changes in treatment or outcomes for different groups."[150] Yet the PRIA makes no mention of the potential effect of the proposed repeal on the primary consumers of companion care, who are virtually all elderly and/or have special needs, and many of whom are lacking financial resources.

D. The Need To Consider Regulatory Alternatives

Finally, the PRIA fails, as specifically required by OMB Circular A-4, to examine regulatory alternatives, which include (a) continuing to allow states to regulate minimum wage and overtime provisions as they apply to companion care providers and (b) pausing to gather the data necessary to demonstrate, if the Department believes it can be demonstrated, that the benefits of repeal exceed the costs.

OMB Circular A-4 clearly directs agencies to consider leaving regulatory issues to the states:

> The advantages of leaving regulatory issues to State and local authorities can be substantial. If public values and preferences differ by region, those differences can be reflected in varying State and local regulatory policies. Moreover, States and localities can serve as a testing ground for experimentation with alternative regulatory policies. One State can learn from another's experience while local jurisdictions may compete with each other to establish the best regulatory policies. You should examine the proper extent of State and local discretion in your rulemaking context.[151]

In this case, the fact that the primary payer for the services at issue, Medicaid, is a state-run program, with substantial deviation across states in how companion care services are organized, provided and paid for, should suggest to DOL that Federal preemption of minimum wage and overtime regulation in the market for companion care labor is both unnecessary and unwise, especially since 17 states have shown their willingness and ability to act independently to impose minimum wage and/or overtime provisions designed to match conditions in their specific markets.

Similarly, the PRIA fails to consider the obvious alternative, in the face of the absence of reliable data on even the most basic elements of the markets at issue (e.g., How many companion

care providers would be affected by the rule?), of pausing to gather more data. Again, OMB Circular A-4 provides clear guidance:

> When uncertainty has significant effects on the final conclusion about net benefits, your agency should consider additional research prior to rulemaking. The costs of being wrong may outweigh the benefits of a faster decision.... For example, when the uncertainty is due to a lack of data, you might consider deferring the decision, as an explicit regulatory alternative, pending further study to obtain sufficient data.[152]

At a very minimum, the PRIA demonstrates that DOL lacks the information necessary to analyze the effects of the proposed repeal, and that it should pause long enough to gather the data necessary to demonstrate, if it is true, that the benefits exceed the costs.

VI. Conclusions

The proposed repeal of the Companion Care Exemption and the Live-in Exemption to the FLSA would likely create substantial disruptions in the market for home health care, increasing the costs of companion care and reducing its availability. The Department of Labor's PRIA understates the costs of the rule in important ways, including minimizing or ignoring a variety of compliance costs, underestimating the elasticity of demand for labor, and assuming incorrectly that demand for companion care is completely inelastic. Our analysis of the data indicates that the demand for companion care labor (and, by implication, the demand for companion care services), is elastic, and therefore quite sensitive to increases in the cost of labor. The compliance costs associated with repealing these exemptions would therefore cause aggregate worker compensation in the industry to decline, reduce the availability of companionship care services to the special needs populations that typically require them, and have other adverse effects. More generally, our case study suggests that efforts to expand the FLSA's minimum wage and overtime provisions to previously exempt occupations may result in unintended. harm to both workers in the industry and others. ■

Table A-1 — Overtime and Minimum Wage Provisions Under the FLSA

Exemption	FLS Section	Exempt From	Summary
Executive, administrative, professional employees; salesmen	213(a)(1)	Minimum Wage and Overtime Requirements	Provides exemption for employees employed "in a bona fide executive, administrative, or professional capacity...or in the capacity of outside salesman" given that they meet certain criteria regarding job duties and compensation.
Seasonal amusement park/camp/ religious or non-profit workers	213(a)(3)	Minimum Wage and Overtime Requirements	Provides exemption for employees "employed by an establishment which is an amusement or recreational establishment, organized camp, or religious or non-profit educational conference center" for establishments that operate for seven or fewer months of the year.
Fishermen	213(a)(5)	Minimum Wage and Overtime Requirements	Provides exemption for "any employee employed in the catching, taking, propagating, harvesting, cultivating, or farming of any kind of fish, shellfish, crustacea, sponges, seaweeds, or other aquatic forms of animal and vegetable life, or in the first processing, canning or packing such marine products at sea as an incident to, or in conjunction with, such fishing operations, including the going to and returning from work and loading and unloading when performed by any such employee".
Agricultural employees	213(a)(6)	Minimum Wage and Overtime Requirements	Provides exemption for employees in the field of agriculture for seasonal employment, or those workers employed by family members, or certain hand harvest employees, or certain employees engaged in production of livestock.

Table A-1 — Overtime and Minimum Wage Provisions Under the FLSA (Continued)

Exemption	FLS Section	Exempt From	Summary
Those given special exemption under Section 214	213(a)(7); 214	Minimum Wage and Overtime Requirements	Provides exemption for "any employee to the extent that such employee is exempted by regulations, order, or certificate of the Secretary issued under section 214 of this title". Section 214 provides for the employment of certain workers under special certificates issued by the Department of Labor. Section 214(c), for example, authorizes exemption for workers who have disabilities to be paid at special minimum wages that are less than the Federal minimum wage.
Employees involved with small newspaper publications	213(a)(8)	Minimum Wage and Overtime Requirements	Provides exemption for "any employee employed in connection with the publication of any weekly, semiweekly, or daily newspaper with a circulation of less than four thousand the major part of which circulation is within the county where published or counties contiguous thereto".
Small, independently owned public telephone company switchboard operators	213(a)(10)	Minimum Wage and Overtime Requirements	Provides exemption for "any switchboard operator employed by an independently owned public telephone company which has not more than seven hundred and fifty stations".
Seamen on non-American vessels	213(a)(12)	Minimum Wage and Overtime Requirements	Provides exemption for "any employee employed as a seaman on a vessel other than an American vessel".
Babysitters and companion care workers	213(a)(15)	Minimum Wage and Overtime Requirements	Provides exemption for "any employee employed on a casual basis in domestic service employment to provide babysitting services or any employee employed in domestic service employment to provide companionship services for individuals who (because of age or infirmity) are unable to care for themselves (as such terms are defined and delimited by regulations of the Secretary)".
Criminal Investigators	213(a)(16)	Minimum Wage and Overtime Requirements	Provides exemption for "a criminal investigator who is paid availability pay under section 5545a of Title 5".
Computer systems analysts, computer programmers, software engineers, or similarly skilled workers	213(a)(17)	Minimum Wage and Overtime Requirements	Provides exemption for "any employee who is a computer systems analyst, computer programmer, software engineer, or other similarly skilled worker" whose meet certain criteria regarding primary work responsibilities and compensation.
Employees deemed exempt by the Secretary of Transportation	213(b)(1)	Overtime Requirements	Provides exemption for "any employee with respect to whom the Secretary of Transportation has power to establish qualifications and maximum hours of service pursuant to the provisions of section 31502 of Title 49".
Rail carrier operators	213(b)(2)	Overtime Requirements	Provides exemption for "any employee of an employer engaged in the operation of a rail carrier subject to part A of subtitle IV of Title 49".
Employees of a "carrier by air" per the Railway Labor Act	213(b)(3)	Overtime Requirements	Provides exemption for "any employee of a carrier by air subject to the provisions of title II of the Railway Labor Act".
Outside buyers of raw poultry or dairy products	213(b)(5)	Overtime Requirements	Provides exemption for "any individual employed as an outside buyer of poultry, eggs, cream, or milk, in their raw or natural state"
Seamen	213(b)(6)	Overtime Requirements	Provides exemption for "any employee employed as a seaman".
Small-town radio or television announcers	213(b)(9)	Overtime Requirements	Provides exemption for "any employee employed as an announcer, news editor, or chief engineer by a radio or television station" for major studios located in small cities and towns that meet certain population and location criteria.

Table A-1 — Overtime and Minimum Wage Provisions Under the FLSA (Continued)

Exemption	FLS Section	Exempt From	Summary
Automobile, trucks, farm implements, trailers, boats, and aircraft salesmen	213(b)(10)	Overtime Requirements	Provides exemption for automobile, trucks, farm implements, trailers, boats, and aircraft salesmen employed by nonmanufacturing establishments.
Local delivery drivers	213(b)(11)	Overtime Requirements	Provides exemption for "any employee employed as a driver or driver's helper making local deliveries, who is compensated for such employment on the basis of trip rates, or other delivery payment plan, if the Secretary shall find that such plan has the general purpose and effect of reducing hours worked by such employees to, or below, the maximum workweek applicable to them under section 207(a) of this title".
Agricultural employees or those employed in connection with agricultural irrigation maintenance and/or operation	213(b)(12)	Overtime Requirements	Provides exemption for "any employee employed in agriculture or in connection with the operation or maintenance of ditches, canals, reservoirs, or waterways, not owned or operated for profit, or operated on a sharecrop basis, and which are used exclusively for supply and storing of water, at least 90 percent of which was ultimately delivered for agricultural purposes during the preceding calendar year".
Farm employees	213(b)(13)	Overtime Requirements	Provides exemption for "any employee with respect to his employment in agriculture by a farmer, notwithstanding other employment of such employee in connection with livestock auction operations in which such farmer is engaged as an adjunct to the raising of livestock, either on his own account or in conjunction with other farmers" given that employee meets certain criteria in regards to weekly employment and wages.
Small "country elevator" production employees	213(b)(14)	Overtime Requirements	Provides exemption for "any employee employed within the area of production (as defined by the Secretary) by an establishment commonly recognized as a country elevator, including such an establishment which sells products and services used in the operation of a farm, if no more than five employees are employed in the establishment in such operations".
Maple syrup/sugar processing employees	213(b)(15)	Overtime Requirements	Provides exemption for "any employee engaged in the processing of maple sap into sugar (other than refined sugar) or syrup".
Fruit and vegetable transportation and preparation employees	213(b)(16)	Overtime Requirements	Provides exemption for employees engaged in the "transportation and preparation for transportation of fruits or vegetables" or the transportation of workers who harvest fruits and vegetables.
Taxi drivers	213(b)(17)	Overtime Requirements	Provides exemption for "any driver employed by an employer engaged in the business of operating taxicabs".
Law enforcement and fire fighters employed by small public agencies	213(b)(20)	Overtime Requirements	Provides exemption for "any employee of a public agency who in any workweek is employed in fire protection activities or any employee of a public agency who in any workweek is employed in law enforcement activities (including security personnel in correctional institutions), if the public agency employs during the workweek less than 5 employees in fire protection or law enforcement activities, as the case may be".
Live-in domestic service employees	213(b)(21)	Overtime Requirements	Provides exemption for "any employee who is employed in domestic service in a household and who resides in such household".
Foster parents	213(b)(24)	Overtime Requirements	Provides exemption for "any employee who is employed with his spouse by a nonprofit educational institution to serve as the parents of children" who are orphans or are enrolled in the institution while the children are in residence there, given annual compensation not less than $10,000.

Table A-1 — Overtime and Minimum Wage Provisions Under the FLSA (Continued)

Exemption	FLS Section	Exempt From	Summary
Movie theater employees	213(b)(27)	Overtime Requirements	Provides exemption for "any employee employed by an establishment which is a motion picture theater".
Forestry/lumbering employees for small companies	213(b)(28)	Overtime Requirements	Provides exemption for "any employee employed in planting or tending trees, cruising, surveying, or felling timber, or in preparing or transporting logs or other forestry products to the mill, processing plant, railroad, or other transportation terminal ,if the number of employees employed by his employer in such forestry or lumbering operations does not exceed eight".
National park or forest amusement or recreational establishment employees	213(b)(29)	Overtime Requirements	Provides exemption for "any employee of an amusement or recreational establishment located in a national park or national forest or on land in the National Wildlife Refuge System" for employees of private entities with certain government contracts that also meet certain compensation criteria.
Criminal Investigators	213(b)(30)	Overtime Requirements	Provides exemption for "a criminal investigator who is paid availability pay under section 5545a of Title 5".

ENDNOTES

1 See 29 U.S.C. 213(a)(15).
2 See 29 U.S.C. 213(b)(21).
3 See 29 CFR part 552, 40 FR 7404 (February 25, 1975).
4 See 76 FR 81190-81245 (December 27, 2011). Hereafter "NRPM."
5 NPRM at 81228
6 NPRM at 81207.
7 See generally http://www.bls.gov/oco/ocos326.htm.
8 NPRM at 81208
9 NPRM at 81208.
10 NPRM at 81208.
11 NPRM at 81208.
12 NPRM at 81209-81210.
13 NPRM at 81210.
14 NPRM at 81214.
15 See NPRM Table 3-2.
16 NPRM 81191.
17 "Home Health Aides: Why Hire From an Agency?" *New York Times* (December 23, 2008). Hereafter "NYT HHA."
18 NRPM at 81201.
19 See NPRM at 81212-81213.
20 NPRM at 81190.
21 *See Long Island Care at Home, Ltd. v. Coke*, 551 U.S. 158 (2007).
22 NPRM at 81244.
23 NPRM at 81194.
24 NPRM at 81194.
25 NPRM at 81194.
26 NPRM at 81198.
27 NPRM at 81198.
28 See OMB Circular A-4, "Regulatory Analysis" (September 17, 2003) (available at http://www.whitehouse.gov/sites/default/files/omb/assets/omb/circulars/a004/a-4.pdf); see also "Regulatory Impact Analysis: A Primer" (August 15, 2011) (available at http://www.whitehouse.gov/sites/default/files/omb/ inforeg/regpol/circular-a-4_regulatory-impact-analysis-a-primer.pdf).
29 OMB Circular A-4 at 2.
30 NPRM at 81223.
31 NPRM at 81228.
32 NPRM at 81218.
33 NPRM at 81220, and at 81223.
34 NPRM at 81220.
35 NPRM at 81213-81214.
36 NPRM at 81214.
37 NPRM at 81214.
38 NPRM at 81221.
39 NPRM at 81219.
40 NPRM at 81219.
41 NPRM at Table 4-6. The PRIA also contains two alternative compliance cost scenarios, in which overtime costs are adjusted to reflect varying assumptions regarding the extent to which overtime hours are adjusted. (All other cost categories remain the same). The PRIA's key conclusion of extremely small disemployment and deadweight loss is invariant across the three scenarios.
42 See NPRM at 81224-81226 ("[T]he 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").
43 NPRM at 81227- 81228.
44 See Ronald G. Ehrenberg and Robert S. Smith, *Modern Labor Economics: Theory and Public Policy* (Pearson/Addison Wesley 2008) 10th ed. at 148. Hereafter Ehrenberg and Smith.
45 NPRM at 81218.
46 NPRM at 81217.
47 NPRM at 81220, and at 81223.
48 NPRM at 81216 ("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.")
49 NPRM at 81208.
50 NPRM at 81218.
51 NPRM at 81209, and at 81218.
52 See, e.g., NYT HHA (Providing a typical example of a two-aide weekly rotation for live-in care, with one aide working three days for a total of 14*3 = 42 hours, and a second working four days, for a total of 14*4 = 64 hours).
53 NPRM at 81217.
54 See NPRM at 81224 ("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").
55 The PRIA's estimated overtime costs of $69.7 million represent 57 percent of total compliance costs ($122.4 million).
56 Equal to (9 percent)/(0.5 percent).
57 NPRM at 81198.
58 NPRM at 81217.
59 U.S. Department of Health and Human Services, "Home Health Aide (HHA) Partnering Collaborative Evaluation: Final Report" (September 2007), Table 3A. Hereafter, DHHS Report.
60 IHS Global Insight, "Economic Impact of Eliminating the FLSA Exemption for Companionship Services" (February 2012) at 10.
61 NPRM at 81223.
62 NPRM at 81228.
63 BLS Occupational Employment Statistics, Occupational Employment and Wages for Home Health Aides (May 2010), available at http://www.bls.gov/oes/current/oes311011.htm.
64 Ehrenberg and Smith at 144-148.
65 Ehrenberg and Smith at 148.
66 NPRM at 81220.
67 NPRM at 81220.
68 Dorie Seavey and Abby Marquand, "Caring in America: A Comprehensive Analysis of the Nation's Fastest-Growing Jobs: Home Health and Personal Care Aides," Paraprofessional Healthcare Institute (December 2011), Figure 7.4, citing analysis of the CDC's National Home Health Aide Survey, 2007.
69 See, e.g., NYT HHA.
70 *Ehrenberg and Smith* at 151.
71 NPRM at 81218.
72 Employees may also to incur costs of their own, due to the need to divide time between multiple employers.

[73] NPRM at 81213-81214.
[74] NPRM at 81213-81214.
[75] NPRM at 81214.
[76] NPRM at 81214.
[77] NPRM at 81220.
[78] NPRM at 81218.
[79] NPRM at 81199.
[80] NPRM at 81199.
[81] NPRM at 81220.
[82] NPRM at 81219.
[83] NPRM at 81219.
[84] NPRM at 81219.
[85] NPRM at 81219.
[86] NPRM at 81219, citing a Maine study finding average unreimbursed travel miles of 45 miles per week, and as high as 438 miles per week. See Ashley, Butler, and Fishwick, "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.
[87] Jan Hill, "Rising travel costs hit home health care," *Rapid City Journal* (June 15, 2008).
[88] NPRM at 81219.
[89] NPRM at 81217.
[90] NPRM at 81199.
[91] NPRM at 81199.
[92] NPRM 81220.
[93] NPRM 81220.
[94] NPRM 81191.
[95] NPRM 81233.
[96] NPRM 81233.
[97] NPRM at 81218.
[98] NPRM at 81217.
[99] NPRM at 81198.
[100] NPRM at 81217.
[101] NPRM at 81199.
[102] NPRM at 81219.
[103] NPRM at 81199.
[104] NPRM at 81220.
[105] NPRM at 81223.
[106] NPRM at 81223.
[107] NPRM at 81224.
[108] Daniel Hamermesh, *Labor Demand* (Princeton University Press 1993) at 92, and at 134-35 ("We know that the absolute value of the constant-output elasticity of demand for homogeneous labor for a typical firm, and for the aggregate economy in the long run, is above 0 and below 1. Its value is probably bracketed by the interval [0.15, 0.75], with 0.30 being a good 'best guess.'"). Hereafter, Hamermesh.
[109] Hamermesh at 92 ("If one were to choose a point estimate for this parameter, 0.30 would not be far wrong (though picking a single estimate is *not a good idea*)."). (Emphasis added).
[110] Hamermesh at 92, and at 134-35.
[111] See Ehrenberg and Smith at 97-100. See also P.R.G. Layard and A.A. Walters, *Microeconomic Theory* (McGraw Hill, 1978) at 259-276.
[112] NPRM at 81223
[113] See NPRM at 82130 ("[I]ncreased 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.")
[114] NPRM at 81223.
[115] NPRM at 81223 ("[I]t 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.")
[116] Kaiser Commission on Medicaid and the Uninsured, "Medicaid Home and Community-Based Services Programs: Data Update," (December 2011), at 1.
[117] *Id.* at 11.
[118] *Id.* at 2.
[119] *Id.*
[120] NPRM at 81210.
[121] Medpac, "A Data Book: Healthcare Spending and the Medicare Program," (June 2010), at 139.
[122] See David Morgan, "Obama's '13 budget plan would ramp up healthcare savings," *Reuters* (February 13, 2012), available at http://www.reuters.com/article/2012/02/13/usa-budget-healthcare-idUSL2E8DD75Y20120213; see also Partnership for Quality Home Healthcare, "Medicare Cuts, Copayments for Home Healthcare Beneficiaries Hardest on America's Poorest, Most Vulnerable Seniors," *PR Newswire* (February 13, 2012), available at http://www.prnewswire.com/news-releases/medicare-cuts-copayments-for-home-healthcare-beneficiaries-hardest-on-americas-poorest-most-vulnerable-seniors-139244058.html.
[123] Centers for Medicare & Medicaid Services, *Medicare and Home Health Care*, available at http://www.medicare.gov/publications/pubs/pdf/10969.pdf, at 8.
[124] *Id.* at 6.
[125] *Id.* at 10.
[126] NYT HHA.
[127] NPRM at 81224.
[128] NPRM at 81220.
[129] NPRM at 81224.
[130] NYT HHA.
[131] Congressional Budget Office, "Financing Long-Term Care for the Elderly" (April 2004) at ix.
[132] *Id.* ("The probability of losses in physical functioning increases with age—dramatically so for the population aged 65 and older. About 19 percent of seniors experience some degree of chronic physical impairment. Among the very old, those aged 85 or older, the proportion of people who are impaired and require long-term care (LTC)—the personal assistance that enables impaired people to perform daily routines such as eating, bathing, and dressing— is about 55 percent.")
[133] Wage and employment data for these two occupations were obtained from the Bureau of Labor Statistics' Occupational Employment Statistics (OES) survey. See Bureau of Labor Statistics Occupational Employment Statistics Estimates for SOC codes 39-9021 (Personal Care Aides) and 31-1011 (Home Health Aides), available at http://stats.bls.gov/oes/.
[134] Population data obtained from the U.S. Census Bureau. See U.S. Census Bureau, Population Division, Intercensal Estimates of the Resident Population by Sex and Age for States, available at http://www.census.gov/popest/data/intercensal/state/ST-EST00INT-02.html.
[135] Medicaid home health care expenditure data obtained from the U.S. Centers for Medicare and Medicaid Services (CMS), Health Expenditures by State of Residence, 1991-2009, available at https://www.cms.gov/NationalHealthExpendData/05_NationalHealthAccountsStateHealthAccountsResidence.asp#TopOfPage.
[136] Companion care minimum obtained from the Department of Labor. See U.S. Department of Labor Wage and Hour Division, *State Minimum Wage and Overtime Coverage of Non-Publicly Employed Companions*, available at www.dol.gov/whd/flsa/statemap/#stateDetails. Housing price index obtained from the Federal Housing Finance Agency (FHFA). See FHFA House Price Indexes, available at http://www.fhfa.gov/Default.aspx?Page=87.
[137] Employment data for HHAs and PCAs in Delaware were not available from 2002 – 2003, therefore those years only contain 50 observations for a total sample size of 457 observations.
[138] NPRM at 81228.
[139] See NPRM at 81230.
[140] NPRM at 81229.
[141] NRPM at 81229.
[142] See also IHS Report, Appendix (reporting on companion care providers discussing negative impact of proposed rules on continuity of care).
[143] NPRM at 81229-81230.
[144] See DHHS Report at vi. See also IHS Report at 24.
[145] See "ANCOR Opposes DOL Proposed Changes to Companionship Exemption" (March 19, 2001) (available at http://www2.ancor.org/issues/wageandhour/w&h_companionship_exemption0301.htm.
[146] See e.g., Ellen O'Brien and Risa Elias, *Medicaid and Long-Term* Care, Kaiser Commission on Medicaid and the Uninsured (May 2004) at 17.
[147] See O'Brien and Elias at 18.
[148] See Prudential Research, Long-Term Care Cost Study (2010) at 10 (available at http://www.prudential.com/media/managed/LTCCostStudy.pdf). See also *Genworth 2011 Cost of Care Survey: Home Care Providers, Adult Day Health Care Facilities, Assisted Living Facilities and Nursing Homes* (2011) at 5 ("In contrast to facility-based care, rates charged by home care providers for "non-skilled" services have remained relatively flat over the past six years.") (available at http://www.genworth.com/content/etc/medialib/genworth_v2/pdf/ltc_cost_of_care.Par.14625.File.dat/2010_Cost_of_Care_Survey_Full_Report.pdf).
[149] See ANCOR 2001 Comments.
[150] OMB Circular A-4 at 14.
[151] OMB Circular A-4 at 6.
[152] OMB Circular A-4 at 39.