No. 11-681

In the Supreme Court of the United States

PAMELA HARRIS, ET AL.,

Petitioners,

v.

PAT QUINN, GOVERNOR OF ILLINOIS, ET AL.,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

BRIEF FOR *AMICI CURIAE* HOMECARE HISTORIANS IN SUPPORT OF RESPONDENTS

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Amici are scholars who have researched and written extensively on the history of homecare.

Eileen Boris holds the Hull Endowed Professorship and is Chair of the Department of Feminist Studies and Professor of History, Black Studies, and Global Studies at the University of California, Santa Barbara. She is a historian of women's work and the history of social and labor policy and has had fellowships from the Danforth Foundation, the National Endowment for the Humanities, the Smithsonian Institution, the Woodrow Wilson Center, the Fulbright Foundation (Bicentennial Chair in American Studies, University of Helsinki), and the Rockefeller Foundation, among others. For over 30 years she has specialized on the home as a workplace. Among her books are *Home to Work: Motherhood and the Politics of Industrial Homework in the United States* (1994), winner of the 1995 Philip Taft Prize for the best book in Labor History; the co-edited *Intimate Labors: Cultures, Technologies, and the Politics of Care* (2010); and, with Jennifer Klein, *Caring for America: Home Health Workers in the Shadow of the Welfare State* (2012), winner of the Sara Whaley Prize for the best book on women and work from the National Women's Studies Association.

Jennifer Klein is Professor of History at Yale University, specializing in twentieth century U.S. history. She is the author of *For All These Rights: Business, Labor, and the Shaping of America's Public-Private Welfare State* (2003), which was awarded the Ellis W. Hawley Prize in Political Histo-

ry/Political Economy from the Organization of American Historians and the Hagley Prize in Business History from the Business History Conference. She is co-author with Eileen Boris of *Caring For America*. Professor Klein has been a fellow of the Brookings Institution, the Robert Wood Johnson Foundation, and the National Endowment for the Humanities. A historian of twentieth century U.S. political economy, her research and teaching stand at the intersection of work and the welfare state. She has written numerous articles on the history of healthcare policy, Social Security, pensions, collective bargaining, New Deal liberalism, and homecare work and policy.

As the first scholars to write the history of homecare over the course of the twentieth century, *amici* submit this brief in the belief that the historical record illuminates the questions now under consideration by this Court.

SUMMARY OF ARGUMENT

Petitioners' argument in this case is premised on a basic misunderstanding of the history and evolution of homecare work. Petitioners and their *amici* portray homecare workers as good Samaritans who receive public benefits for tending to family members they would care for anyway even without compensation, rather than as a growing workforce that performs a service of central importance to the State; deny that Illinois is the employer of that State's homecare workers in any real respect; and contend that collective bargaining by home healthcare workers does not advance any substantial state or public interest. The history and current status of the homecare profession, however, belie each of these contentions. In fact, States historically have directed, supervised, and controlled the economic terms gov-

erning the provision of homecare and its increasingly skilled workforce in crucial ways—and continue to do so to this day. At the same time, the extension of collective bargaining rights to state homecare workers has provided vitally important benefits to States, to the beneficiaries of homecare services, and to homecare workers themselves.

A. Homecare workers provide essential services to elderly Americans, to those struggling with chronic illnesses, and to people with disabilities. Although the jobs of homecare workers vary widely, these employees often tend to tasks such as supervising medication, monitoring vital signs, dressing, bathing, cooking, and attending to client hygiene.

For much of American history, this type of care work was handled at the periphery of the economy. But, since the early part of the twentieth century, government at every level has become increasingly involved in organizing, regulating, and directly managing the job of homecare. These efforts began with modest programs that dispatched "substitute mothers" and "housekeeping aides" to needy homes. The government's role in homecare began during the New Deal, with President Roosevelt and other reformers viewing homecare work as both a vehicle for increasing employment and a workable alternative to institutionalization. During and after World War II, these workers became employees of public welfare and health departments in a number of jurisdictions. By the 1960s, all levels of American government—local, state, and federal—were intimately involved with the homecare labor force. These governments set wages and hours, provided training programs, determined who could be a compensated homecare

worker, dictated the tasks to be accomplished, and regulated how those tasks would be performed.

B. This history, together with an on-the-ground recognition of what care workers actually do on an everyday basis, makes it clear that the tasks performed by homecare workers are undoubtedly "work" of a sort that one would expect to see undertaken by employees of the State. Despite petitioners' facile suggestion to the contrary, the vast bulk of care workers do not incidentally receive government benefits for work they would otherwise do anyway. Rather, they hold jobs performed under government supervision in exchange for government wages. Indeed, the tasks carried out by state-compensated homecare workers are often identical to the tasks performed by care workers who are employed by private agencies, either in the home or in an institutional setting. Given the similarities between some kinds of nursing and homecare, it is no surprise that many care workers have moved along a continuum of jobs that has included nursing homes, hospitals, and various group homes. The "work" of homecare has now been recognized by the federal government, which recently acknowledged that consumers (as disability activists prefer designating the receivers of this labor) often jointly employ homecare workers with both public and private employers. The government further provided that such jointly-employed homecare workers are not exempt from the protections of the Fair Labor Standards Act.

In fact, homecare is an occupation—and one that is expanding rapidly. Homecare is among the fastest growing job fields in America. Some two-and-a-half million Americans are employed in homecare, a figure that is expected to double over the next decade.

Care work is a critical component of the modern healthcare system, providing both a cost-effective alternative to institutionalization and a framework for achieving a higher quality and quantity of healthcare for everyday Americans. In these circumstances, there is no basis for differentiating care workers who perform state-defined and compensated services in the home as joint employees of individual consumers and the State or a private agency, from those who perform such services for the same compensation in an institutional setting.

C. The development of homecare as a distinct occupation has not been accompanied by a corresponding increase in worker wages, job stability, or training. As a consequence, many modern homecare workers must deal with extraordinarily difficult circumstances both in their workplaces and in their own homes. Although they navigate intimate personal and medical situations on an everyday basis, many homecare workers have not received sufficient training. Others are paid poverty wages. Many homecare workers lack healthcare themselves, which is especially problematic given the dangers involved with some care work and the threat that a sick care provider poses to vulnerable consumers. Together, these problems have led to unsustainable rates of turnover among unrepresented homecare workers, which in turn has reduced the quality and dependability of care available to some consumers.

Care workers began organizing in earnest during the 1960s, when workers' frustration with low wages and poor working conditions reached intolerably high levels. Realizing that representation might improve their lives, many workers began exploring collective bargaining as a means of negotiating with their em-

ployers concerning training, stabilizing hours of work, wages and benefits, and coordination of placements. In some cases, homecare unions emerged as independent locals or as part of public sector organizing during the 1960s. In other instances, homecare workers sought out unions of hospital workers or nursing-home attendants, who perform identical or very similar tasks. Recognizing that permitting homecare workers to engage in collective bargaining with government officials about their employment terms could improve the quality and raise the standards of care, many States—including Illinois—have chosen to protect their own interests and those of individuals in need of homecare by extending to homecare workers the right to choose a representative and engage in collective bargaining.

On the whole, care workers' collective bargaining has helped achieve better outcomes for the workers, for homecare clients, and for the States as employers. Of particular importance for present purposes, the extension of the right to bargain collectively to homecare workers has facilitated labor peace, while encouraging development of a more stable and productive workforce that provides an increasing level of service for an aging population. That reality has ensured that millions of Americans have access to well-trained homecare employees.

ARGUMENT

To appreciate the current status and nature of the State's role as employer of homecare workers, it is helpful to begin with a look at the history and evolution of the home healthcare occupation. Government at all levels has been instrumental in creating that occupation, setting its standards, paying for its services, and supervising its performance—that is,

the essential things that an employer is expected to do. In fact, government policies played a direct role in "shap[ing] the structure of the industry and the terms of conditions of work" and continue to do so today. Eileen Boris & Jennifer Klein, *Organizing Home Care: Low-Waged Workers in the Welfare State*, 34 Pol. & Soc'y 81, 83 (2006). When homecare services are provided by workers who are paid by and substantially responsible to the State, collective bargaining with the State is a valuable means of setting critical terms of the employment relationship.

A. Homecare has long been closely supervised and managed by the state.

1. In one sense, care work has been part of the American economy since the Founding. Historically, the household was the locus of care for elderly and disabled Americans. State-run and private institutions, now thought to be major care providers for older citizens, originally focused on serving the severely ill, the disabled, and the kinless poor. Eileen Boris & Jennifer Klein, *Caring for America: Home Health Workers in the Shadow of the Welfare State* 20-21 (2012).

In the first decades of the twentieth century, however, private agencies, such as the Jewish and Catholic Family Services, began hiring homemakers to care for incapacitated mothers and their children. The conditions of these workers, though, remained largely outside the public eye. Maud Morlock, *Homemaker Services History & Bibliography* 1-4 (1964).

2. The nature of the occupation, if not the work actually performed, changed significantly with the advent of the New Deal and, subsequently, with the

expansion of state responsibility for medical and related services in the 1960s and 1970s. At those times, governments at all levels—federal, state, and local—began and then accelerated the development of a state-employed homecare workforce.

During the Great Depression, government began shaping the homecare labor market. In 1935, Congress funded the Works Progress Administration ("WPA") to employ people on projects that included health and social services. Nick Taylor, *American-Made: The Enduring Legacy of the WPA: When FDR Put the Nation to Work* (2008).

The WPA's involvement in the provision of homecare was extensive. The agency's "visiting housekeepers" program, for example, was designed to aid families with incapacitated mothers. This program was also a source of care for chronically ill and elderly people, enabling them to be returned from public hospitals to their homes and relieving the fiscal stress on public hospitals from having to house people with chronic conditions. Marta Fraenkel, *Housekeeping Service for Chronic Patients* (1942); The Hosp. Council of Greater N.Y., *Organized Home Medical Care in New York City: A Study of Nineteen Programs* 35-37 (1956). During the New Deal and the decades that followed, the federal government thus became directly involved with the most important details of homecare employment: who could provide care, who could receive it, how it would be provided, and what the providers would be paid. *Report on the First Year's Work of WPA Project*, Mary C. Jarrett Papers, Sophia Smith Collection, Smith College (Feb. 15, 1937); Div. of Women's & Prof'l Projects, Works Progress Admin., *Housekeeping Service for Home Care of Chronic Patients*, Report on Official

Project No. 165-97-7002 (Dec. 1938); Fraenkel, *Housekeeping for Chronic Patients*, *supra*.[1]

By the time the WPA was dissolved in 1943, the program had employed over 38,000 housekeeping aides in 45 States and the District of Columbia. Boris & Klein, *Caring for America*, *supra*, at 23.

3. With the assistance of federal funds, States also became deeply involved in the provision of homecare. The particular manner in which States chose to organize such care, however, differed in light of the varied ways in which these governments organized social welfare services and assistance.

One model often chosen by state and local government involved the public employment of care workers. Illinois offered an early example of such a regime. Just as the WPA created a "housekeeping-aide" program during the New Deal, the City of Chicago adopted a "homemaker" program through which recipients of state aid could receive home services. Boris & Klein, *Caring for America*, *supra*, at 49. Like their national counterparts, Chicago's homecare initiatives steadily expanded in the years following the Great Depression. By 1940, the City of Chicago Wel-

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[1] In an effort to reduce reliance on welfare programs, the federal government subsequently pursued policies that further expanded its involvement in homecare. Through the Office of Economic Opportunity and other federal programs, government at the federal and state levels helped train poor, single mothers to become homecare workers. These women, in turn, no longer needed to seek welfare benefits through Aid to Families with Dependent Children. U.S. Office of Econ. Opportunity, *A Nation Aroused: 1st Annual Report* 41 (1965), *microformed on* "The War on Poverty, 1964-1968," Part I: The White House Central Files, Reel 9, Box 125, University Publications of America.

fare Department provided homemakers for families on Aid to Dependent Children when mothers were incapacitated. Beginning in 1947, the Public Assistance Division of the Cook County Department of Welfare began to provide housekeeping services. That agency controlled homecare workers' wages and hours, as well as the amount and type of services that could be provided. Even with this extensive level of government involvement, some clients complained that lack of direct state supervision of workers was resulting in a reduction in service quality. Thus, in 1952, Cook County established a Homemaker Service Department within the Department of Welfare. This program provided field supervisors, maintained time schedules, centralized payroll data, and recruited homecare workers to become government employees. Div. of Pub. Health Methods, U.S. Dep't of Health, Educ. & Welfare, Pub. Health Serv. Publ'n No. 645, *Homemaker Services in the United States, 1958: Twelve Statements Describing Different Types of Homemaker Services* 10-15 (1958) ("*1958 Report*").

After World War II, responsibility for homecare programs shifted into state and local welfare departments. To carry out the service, Illinois joined a number of other States in using federal dollars to expand homecare service. Boris & Klein, *Caring for America*, *supra*, at 50. In 1951, Illinois submitted an application for funds under all the categorical aid programs of Social Security to pay for homecare services.[2] Cook County then developed training pro-

[2] "Submittal for Commissioner's Consideration; Subject: Homemaker Service—Illinois and New York," Bureau of Public Assistance to the Deputy Commissioner, September

grams for the County's homecare workers. This training included practical work in household skills, home nursing, and care for the bedridden. Homemakers were full-time public employees and had their wages increased after a probationary period. They received reimbursement for transportation, vacation, sick leave, disability, and retirement benefits like all other Cook County Department of Welfare employees. These homecare workers were not only employees of the government, but were also members of public employee unions and engaged in collective bargaining. See Div. of Pub. Health Methods, U.S. Dep't of Health, Educ. & Welfare, Pub. Health Serv. Publ'n No. 746, *Homemaker Services in the United States: Report of the 1959 Conference* (1960); *1958 Report*, *supra*, at 10-15.

During this period, homecare workers were employees of the government and became members of public employee unions who engaged in collective bargaining. In New York, they were first represented by an independent union, the Social Service Employees Union, and then by the American Federation of State, County, and Municipal Employees ("AFSCME") in the 1960s. Boris & Klein, *Caring for America*, *supra*, at 81-82, 89-91. In Illinois, AFSCME represented homecare workers prior to 1980. See Russell K. Schutt, Organization in a Changing Environment: Unionization of Welfare Employees 90 (1986).

As the federal government offered the States new funding for old age, health, and disability services in the 1960s and 1970s, Illinois sought to meet an ex-

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12, 1952, CF 1949-52, box 412 (or 416), RG102, National Archives and Records Administration, College Park, MD.

panded demand by reorganizing the delivery of homecare. In 1979, Illinois established programs to pay for homecare through its general revenues. Using this mechanism, the State provided basic homecare services for the disabled through state employees characterized as "[h]omemaker[s]"; it also provided "[i]ndividual housekeepers" for persons over the age of 60. See *State of Ill., Dep't of Cent. Mgmt. Servs. & Dep't of Rehabilitation Servs.*, No. S-RC-115, 2 Pub. Emp. Rep. for Ill. ¶ 2007, 1985 WL 1144994 (Dec. 18, 1985).

In 1981, Congress agreed to let States use Medicaid funds more flexibly through federally approved waivers. In 1983, Illinois (like other States) applied for a Medicaid waiver, which would allow the State to adopt its own means of providing homecare service. Illinois used one waiver to provide homecare to the elderly through state contracts with vendors and another waiver to allow disabled persons to avoid institutionalization. Boris & Klein, *Caring for America*, *supra*, at 163.

In its current iteration, for reasons of efficacy and economy, Illinois has delegated some of its authority over homecare workers to consumers themselves, such that the individual recipient of care generally is entitled to select and terminate the homecare worker within state-defined limits, but the State sets the requirements for service, writes the employment contract, develops each consumer's service plan, and establishes and pays worker wages and benefits. See Ill. Admin. Code tit. 89, §§ 676.10-.200. Illinois moved to this model at least in part due to its experience in the 1980s, when the State had a long waiting list for people needing homecare but could not attract a reliable labor force; the instability

of worker schedules and hours made the homecare labor market chaotic. Boris & Klein, *Caring for America*, *supra*, at 162-163.

4. The state interest in supervising the activity of homecare workers, reflected in this history of homecare work in Illinois, has become increasingly urgent as homecare has assumed a greater role both in public health and in the economy as a whole—and as the status of home healthcare as a profession has solidified. There can be no dispute on these points: Homecare is now one of the fastest growing professions in America. Together, personal care aides and homecare aides are projected as the top two job growth categories from 2010-2020. See Bureau of Labor Statistics, Economic News Release tbl.5 (Dec. 19, 2013), http://tinyurl.com/no6zau5. Although there are already two-and-a-half million homecare workers in the United States, that number is expected to double by 2018. Eileen Boris & Jennifer Klein, *Home-Care Workers Aren't Just 'Companions'*, N.Y. Times, July 1, 2012. See also Michele Ochsner, Carrie Leana, & Eileen Applebaum, *Improving Direct Care Work: Integrating Theory, Research and Practice*, Alfred P. Sloan Foundation White Paper, at 4 (July 23, 2009) (noting that the Bureau of Labor Statistics "estimates that the demand for personal and home care aides will increase by 51% and that the demand for home health aides will increase by 49% between 2006 and 2016").

This trend is certain to continue as the U.S. population ages: "Approximately 1.2 million elderly and 300,000 younger chronically ill or disabled individuals live in the nation's 17,000 nursing homes, and nearly 900,000 elders reside in assisted living facilities." Ochsner et al., *supra*, at 3. Experts predict that

the number of older Americans in need of hired care workers will be well over five million by 2040—a two-fold increase from only 40 years earlier. *Id*. at 4. And it is more than the aging of the population that has increased homecare needs; after 1980, changes to Medicare and the transformation of the hospital industry sent people home sooner and with greater post-hospital care needs. Boris & Klein, *Caring for America*, *supra*, at 14.

Without the alternative of homecare, the American economy would be strained by the enormous cost of caring for a huge number of elderly or disabled persons in hospitals, nursing homes, or other institutions. Indeed, in 2006 alone, governments spent about twice as much on nursing-home care ($125 billion) as they did on homecare ($53 billion). Ochsner et al., *supra*, at 3. In these circumstances, it is critically important that the States not be deprived of the labor relations tools necessary to respond to local circumstances with the requisite flexibility.

B. Homecare workers perform work equivalent to that of other public and private sector healthcare employees under terms and limits set by the State.

1. This history of homecare's increasing development as a distinct occupation—and the consistent recognition of state governments that they are responsible for the continued availability of quality homecare—belies the assumption that seems to underlie much of petitioners' argument: that many homecare providers are best characterized as volunteers "caring for a disabled family member so that he or she may live at home" (Pet. Br. 38), rather than as members of a critically important and sophisticated government workforce. So long as providers receive

government pay and work under government supervision, the fact that their labor takes place in a home and can affect members of their own families does nothing to alter their employment status or transform their wages into "public benefits." On the contrary, the situation of modern home healthcare workers is fundamentally similar to that of other healthcare and public sector employees.

Viewing homecare as family service rather than regular employment requires discarding common understandings of what "work" and "employment" mean. In ordinary usage, "work" is "the labor, task, or duty that is one's accustomed means of livelihood," and an "employee" is "one employed by another usually for wages or salary." Merriam Webster's Collegiate Dictionary 408, 1442 (11th ed. 2003). These definitions highlight an intuitive truth—that persons earning their primary wages from providing care services perform "work" and are "employees" of the entity paying them, no matter where this labor takes place or what the workers' relationships to their consumers look like.

That homecare workers are paid to perform tasks that they or others might, in a different context, do for free is immaterial. Firefighting, for example, was once, and still often is, an uncompensated, volunteer-based community service. See *National Fire Protection Association (NFPA) Estimates*, U.S. Fire Admin. (2012), http://tinyurl.com/ngxpb8y (noting that about 70% of America's 1.1 million firefighters are volunteers). Yet no one would suggest that full-time professional firefighters are good Samaritans who incidentally receive a public assistance benefit, or that they are lobbying on a matter of public policy when they bargain for increased wages for doing their job.

Rather, they are employees performing paid work who seek compensation for that work from their employer. See, *e.g.*, *Ricci* v. *DeStefano*, 557 U.S. 557, 563 (2009) (characterizing the City of New Haven as the "employer" of municipal firefighters); *id.* at 608 (describing firefighting as a "profession").

Similarly, any suggestion that services traditionally performed in the home by family members cannot constitute work falls apart under scrutiny. Consider, for example, basic housekeeping services: if a family hired a housekeeping agency to provide the cleaning services that once fell to a mother or a wife, no one would doubt that these services constituted "work" and that the housekeeper is a bona fide "employee" of the agency, even if family members directed the housekeeper while he or she was in their home. Indeed, homecare workers employed by private agencies work in the homes of (and are supervised on a day-to-day basis by) the disabled people they serve, providing exactly the same types of services as the workers here; such workers have long been organized under the NLRA. See, *e.g.*, *Metrocare Home Servs., Inc.*, 332 NLRB 1570, 1570-71 (2000); *People Care, Inc.*, 299 NLRB 875, 875, 877 (1990); *Human Dev. Ass'n*, 293 NLRB 1228, 1228 (1989); *ANKH Servs., Inc.*, 243 NLRB 478-80 (1979); *Visiting Nurses Ass'n of Sacramento*, 187 NLRB 731, 731-32 (1971).

Moreover, the idea that homecare workers simply receive a state benefit for labor they would otherwise provide for free is wholly out of touch with the realities of modern homecare. Although some homecare workers do enter the field to care for family members, many of these individuals stay on to become career homecare aides, and their decisions to

remain in the workforce (rather than returning to other jobs) are influenced as much by compensation as by commitment to caring for families. Candace Howes, *Upgrading California's Home Care Workforce* 78 (2004). Homecare workers' labor-market behavior thus depends on a number of factors, including wages, benefits, job flexibility, and employment rights—and this is true for both relatives and non-relatives of consumers. Candace Howes, *Love, Money, or Flexibility: What Motivates People to Work in Consumer-Directed Home Care?*, 48 Gerontologist 46, 58 (2008). Without adequate compensation from the State, many homecare providers would not stay in this line of work, as studies have found a direct relationship between wage levels and worker retention and reduction of turnover rates. See Candace Howes, *Living Wages and Retention of Homecare Workers in San Francisco*, 44 Indus. Rel. 139, 140 (2005) ("Howes, *San Francisco*"). It is therefore clear that homecare workers respond to many of the same incentives as employees in other fields. The low wages and stigmatization of care work as intimate labor fuels a chaotic labor market that the State has an interest in regularizing and that workers have an interest in improving through collective bargaining.

2. The actual work performed by homecare employees reinforces their similarity to other public healthcare workers. Homecare aides often serve in roles that are functionally indistinguishable from those their counterparts play in hospitals, nursing homes, and other healthcare facilities. See Comm'n on Long-Term Care, *Report to Congress* 19 (2013) ("Home health aides perform tasks similar to those of nursing aides, but in the home and community."). The Bureau of Labor Statistics includes both those who work in the home and those who labor elsewhere

under the classification of personal attendants. Indeed, some workers do the same exact things in their day jobs at hospitals and their night jobs in private homecare. See, *e.g.*, The Fair Home Health Care Act: Hearing on H.R. 3582 Before the Subcomm. on Workforce Protections of the H. Comm. on Educ. & Labor, 110th Cong. (2007) (statement of homecare worker Manuela Butler) (noting that, under the then-governing legal framework, homecare workers "would get time and half pay for [their] overtime hours for performing the same tasks for Mrs. G. if she was in a nursing home facility").

For this reason, homecare workers have long joined unions alongside hospital aides and other support workers who labor in hospitals, nursing homes, and group homes for the developmentally disabled. Starting in the 1970s, workers at both public and private hospitals and nursing homes sought to bring homecare employees into their unions, precisely because all of these workers perform identical or substantially similar tasks. See Boris & Klein, *Caring for America*, *supra*, at 124 (describing how "[h]ospital unions further discovered housekeeping and health aids doing the same tasks as their members during weekends or evenings, but in the private setting of the home, and they too began to organize such workers"). As services provided by certified nursing assistants and other personnel in institutional settings unquestionably constitute work, identical services performed by homecare workers in private homes should not be viewed any differently.

3. The importance of this work for the health and well-being of millions of Americans has given the homecare workforce a vital role in America's healthcare system. Without the services of millions

of homecare workers, many consumers would be forced into institutionalization, which is considerably more expensive and less desirable for most patients. See National Consumer Voice for Quality Long-Term Care, *Consumer Perspectives on Quality Home Care* 7-8, 16 (2012) ("Consumer Voice").

In recognition of the critical part that homecare workers play in the multitrillion dollar healthcare industry, States and the federal government have moved to expressly recognize that homecare employees are ordinary employees who deserve corresponding labor law protections even when jointly employed by consumers. In September 2013, the Department of Labor ("DOL") eliminated the decades-old exemption of many homecare workers jointly employed by consumers and a third-party such as a state agency under the Fair Labor Standards Act ("FLSA"). Application of the Fair Labor Standards Act to Domestic Service, 78 Fed. Reg. 60,453 (Oct. 1, 2013) ("Homecare Rule"). In its final Rule, DOL specifically noted that direct care workers are not mere "elder sitters" or companions. *Id*. at 60,455. Modern homecare work is not only "far more skilled and professional" than it once was, but it also often includes "medical care, such as managing the consumer's medications or performing tracheotomy care, that was previously almost exclusively provided in hospitals, nursing homes, or other institutional settings and by trained nurses." *Id*. at 60,458.

Of particular relevance here, the new Rule rejected an argument similar to the one promoted by the petitioners in this case—that homecare aides are "effectively employed" by their patients rather than by the entities that pay for and regulate their services. 78 Fed. Reg. 60,455. Indeed, DOL noted that

"[d]irect care workers and consumers explained that a variety of care arrangements have been developed in order to provide homecare, many involving potential joint employment relationships." *Id.* at 60,483. The Department explained that, under long-settled principles, "an individual who hires a direct care worker or live-in domestic service worker to provide services pursuant to a Medicaid-funded consumer directed program may be a joint employer with the state agency that administers the program." *Ibid.* And while explaining that both joint employers are responsible for complying with the FLSA in most instances, under the new rule only the state agency or other third-party joint employer carries the obligation of paying the minimum wage and required overtime compensation. *Ibid.*; 29 C.F.R. § 552.109(c).

The federal government's decision to recognize the employment status of homecare workers in this manner follows in the footsteps of a number of States and municipalities that have recognized homecare aides as public employees and, for this reason, have accorded them the right to engage in collective bargaining, just like other public employees. Between 1990 and today, nine states have recognized homecare workers' right to bargain over their wages and benefits. Resp. SEIU Br. 51 n.14. See also Dorie Seavey & Abby Marquand, PHI International, *Caring in America: A Comprehensive Analysis of the Nation's Fastest-Growing Jobs* 28-29 (2011) ("PHI"). In each of these situations, homecare workers were doing the same things in the home that had long been done in hospitals and nursing homes. And, in each of these cases, governments that controlled the economic terms of homecare workers' employment recognized that it served their interests to give homecare

workers the same collective bargaining rights as those accorded other public employees.

In sum, in light of homecare's new and central role in the healthcare market, States have recognized that, even while delegating some authority to consumers, they must retain the central authority of employers—setting and paying wages and benefits, determining hours, regulating procedures, dictating the substantive work done by homecare aides, and bargaining over employment terms—to ensure that critical homecare services are provided adequately.

C. The extension of collective bargaining rights to state-employed homecare workers affords substantial benefits to those workers, to homecare consumers, and to the States.

Extending collective bargaining rights to publicly employed homecare workers offers a rational way for States to respond to the dynamics of this burgeoning field. Collective bargaining helps combat many of the problems posed by homecare, while also encouraging the further professionalization of the workforce.

1. The development of homecare—and the increasing importance of homecare to the economy—has not been accompanied by a corresponding increase in worker wages, benefits, stability, or training. See Homecare Rule, 78 Fed. Reg. 60,458. Instead, the industry has been characterized by low pay, high turnover, frequent workplace injuries, and a lack of formalized standards or training programs. See Nari Rhee & Carol Zabin, *The Social Benefits of Unionization in the Long-Term Care Sector*, in Academics on Employee Free Choice: Multidisciplinary Approaches to Labor Law Reform 83, 84 (John Logan

ed., 2009). This reality contributes to a shortage of homecare workers that will only grow worse as the population ages. See Inst. of Med., *Retooling for an Aging America: Building the Health Care Workforce* 5 (2008).

Many homecare workers in America are at the vulnerable intersection of racial, gender, and socioeconomic disadvantage. On the whole, these workers are disproportionately women of color: Around 90% are women; 50% are African-American; 25% are Hispanic. Eileen Appelbaum & Carrie Leana, *Improving Job Quality: Direct Care Workers in the U.S.*, at 1 tbl.1 (2011). "Compared to other direct care workers in hospitals and nursing homes, they are more likely to be foreign born, Hispanic, Latina, or Asian, and non citizen today than forty years ago when African Americans dominated the job." Boris & Klein, *Caring for America*, *supra*, at 4.

Historically, these workers have been paid very low wages, and conditions have not uniformly improved in the intervening decades. "In 2005, the median hourly wage for direct care workers was $9.56 as compared to a median hourly wage of $14.15 for all U.S workers." Ochsner et al., *supra*, at 4.[3] As of 2006, one-quarter of homecare workers had annual family incomes below $10,000, and one-third of homecare workers lived below the poverty line. Boris & Klein, *Organizing Home Care*, *supra*, at 82. These vulnerable workers historically not only have labored for poverty wages, but have also lacked any employ-

[3] In 2005, nursing home aides made approximately $22,000 per year, home health aides made approximately $19,500 per year, and homecare aides made approximately $17,700 per year. Ochsner et al., *supra*, at 4.

ment security or fringe benefits. Boris & Klein, *Caring for America*, *supra*, at 6.

On the whole, homecare workers receive wages well below the national average, are more likely to live in poverty and lack health insurance than are other workers, and experience high levels of workplace injury. Inst. of Med., *supra*, at 200-201. Many are also poorly trained. *Id.* at 214-215. Indeed, consumers cite additional training as one of the principal requests for homecare employees. Consumer Voice, *supra*, at 21.

2. These characteristics of homecare employment have led the industry to experience shockingly high levels of turnover, which according to some estimates may run in excess of 70% per year. Rhee & Zabin, *supra*, at 84. Retention of new employees is correspondingly dismal. One study found that 40% to 60% of homecare workers leave after a single year on the job, and 80% to 90% leave after two years. *Id*. at 84-85. This constant state of flux creates a major impediment to the effective delivery of care. When turnover is high, the chances that a consumer will be injured increase, as new workers may be poorly trained, less familiar with the customer's needs and home, and more likely to act negligently. See Eileen Boris & Jennifer Klein, *We Were the Invisible Workforce: Unionizing Horne Care*, *in* The Sex of Class: Women and America's New Labor Movement 177 (Sue Cobble ed., 2007). Accordingly, studies have found a direct association between high turnover rates and low quality of care. See Inst. of Med., *supra*, at 213.

3. Poor conditions and a decentralized workforce have also produced a history of fractious labor relations, characterized both by workers protesting their

treatment and by disputes between unions seeking to represent these employees.

In New York, for example, some 12,000 homecare workers went on strike in 2004. Steven Greenhouse, *Thousands of Home Aides Begin a Strike*, N.Y. Times, June 8, 2004. The workers demanded an increase in their extremely low wages, which were then set at about $7 per hour. Jennifer Steinhauer, *Labor Demands Cast a Rich Mayor in a Miserly Light*, N.Y. Times, June 10, 2004.

Three years later, another group of homecare workers went on strike in New York, protesting their uniform lack of health insurance and their low wages (which were then set at below $8 per hour). These workers demanded a new contract, hoping to win wages that were on par with other state employees who were represented. Caroline E. Ruse, *Home Health Care Workers Strike*, Newsday, Aug. 14, 2007. Many striking homecare workers reported that, without a collective bargaining agreement, they had no way of enforcing promises that had been made to them by their employer when they were hired. Luann Dallojacono, *Aides Demand Contracts*, The Long Islander, Aug. 16, 2007 (noting that Premier Healthcare promised various benefits to new hires but never followed through).

This same kind of contention existed in other States. See, *e.g.*, Boris & Klein, *Caring for America*, *supra*, at 164-175 (describing protests in Illinois). And this unrest is not an artifact of history: Major labor unrest is *currently* occurring in Ontario, where more than 4,500 homecare workers are on strike. See, *e.g.*, Hillary Caton, *Personal Support Workers Across Ontario on Strike*, Burlington Post, Dec. 10, 2013.

These strikes hit homecare *consumers* especially hard, as they may lose all access to healthcare during labor strife. Even when replacement workers can be located, those workers often stay with the client for less time and provide less satisfying or competent care than did the striking employee. See, *e.g.*, Dallojacono, *supra*, at A14 (discussing consumer complaints stemming from labor unrest in New York in 2007 that "replacement workers will [not] give the same standard of care"). During the 2007 New York strike, for example, the recipients of homecare service received either no care or lower-quality care during the strike, and replacement workers made mistakes that endangered the health of the patients. Caroline E. Ruse, *Amid Premier Strike, Patients Suffer*, Newsday, Aug. 18, 2007. Such disruptions also burden the State, which may be forced to make expensive alternative care arrangements—possibly including institutionalization—in response to labor disruption.

Disputes between workers and their state employer have not been the only source of confusion and contention in this context: unions have competed to represent homecare workers. In New York in the late 1970s and 1980s, AFSCME, Local 1199 Hospital, Nursing Home, and Allied Health Services Union, and SEIU competed against each other. In California throughout the 1990s, United Domestic Workers of America, AFSCME, and SEIU sought to represent the same workers. In the first decade of the twenty-first century, AFSCME and SEIU competed against each other in Michigan, while the Communications Workers of America (CWA) joined the competition in New Jersey. See, *e.g.*, J.A. 26 ¶ 32 (competition between two unions to represent Illinois homecare workers); Alicia Freese, *Formerly Allies, Two Unions*

Now Compete for Home-care Worker Votes, VT Digger, May 30, 2013; Rob Mitchell, *National Unions in Tussle To Represent Home Care Workers*, Rutland Herald, June 25, 2013. Disputes of this kind pose the danger of disruptive "conflicting demands from different unions" or "attack[s] [on labor agreements] from rival labor organizations" that may be avoided by exclusive collective bargaining representation. *Abood* v. *Detroit Bd. of Educ.*, 431 U.S. 209, 220-221 (1977).

2. Collective bargaining has proven to be one of the most effective ways of addressing these problems in the chaotic homecare market: it has improved homecare workers' wages, benefits, training, and job stability; avoided work stoppages and the confusion caused by inter-union disputes; and accordingly enhanced the quality of patient care.

First, collective bargaining has dramatically increased homecare workers' compensation and improved their quality of life. See Boris & Klein, *Organizing Home Care*, *supra*, at 81 (documenting improved compensation attributable to collective bargaining in California and Oregon). Collective bargaining also has led to a significant expansion in health coverage and other benefits for homecare workers. Before California passed legislation that enabled collective bargaining, almost no homecare workers in that State had health benefits; now a majority of them do. Rhee & Zabin, *supra*, at 88. Similarly, homecare workers in Washington State and Oregon have secured significant increases in benefits through selecting a single representative and subsequent collective bargaining. *Id*. at 88-89.

Second, the gains from collective bargaining have not been confined to homecare workers themselves.

Rather, the rationalization of the homecare labor market through collective bargaining creates a more efficient and reliable care-provision model for consumers and a less contentious negotiating environment for States.

In particular, wage and benefits improvements embodied in collective bargaining agreements have helped combat the industry's major problems with turnover and retention. In her landmark study of the San Francisco homecare market, economist Candace Howes found that improvements in compensation resulting from collective bargaining between 1996 and 2002 led to a dramatic 89 percent improvement in retention. Howes, *San Francisco*, *supra*, at 140. Similar results have also been observed in other States. Rhee & Zabin, *supra*, at 87. In addition, bargaining has been an important catalyst in securing better training for homecare workers, which has reduced medical costs and the number of mistakes. Better training also has improved worker retention, as dissatisfaction with training is a major cause of worker attrition. *Id*. at 83-84.

Finally, in a regime of collective bargaining, the parties will work to secure a contract on terms that satisfy both workers and the public. See Rhee & Zabin, *supra*, at 87 (observing that homecare workers in union states have typically been able to negotiate contracts that improve wages, standards, and quality of service within a year). This helps ensure that employees will be satisfied with their working conditions, which in turn results in fewer labor stoppages. See Eileen Boris & Jennifer Klein, *Labor on the Home Front: Unionizing Home-Based Care Workers*, 17 New Lab. F. 32 (2008) (noting that representation improves workplace stability and helps to

avoid turmoil and work stoppages). Moreover, the existence of a union provides an avenue for workers to grieve complaints with management, allowing issues to be resolved instead of festering until workers quit or engage in disruptive protests such as strikes. Without such an intermediary, the process of resolving grievances is hopelessly disorganized and disaggregated.

In general, then, the extension of collective bargaining rights to homecare workers has helped provide stable and competent care to millions of Americans, which in turn has prevented States from having to shoulder the costs of these consumers' institutionalization. It has offered an effective way for States to make a chaotic, and increasingly crucial, market more rational. Moreover, in each of these places, the mechanics and limits of collective bargaining have been tailored to conform with how States have chosen to serve their elderly and disabled populations.

3. The Illinois experience itself shows how extending collective bargaining rights to state-employed homecare workers is a workable way to advance all of these interests. Under the current regime, Illinois has adopted a rational labor relations policy that has reduced costs, promoted labor peace, and increased the quality and quantity of care provided. Collective bargaining in Illinois has led to health benefits, paid training, paid orientations, a dispute resolution procedure, a health and safety committee, and other changes to make work within the program more attractive. Resp. Ill. Br. 7; Resp. SEIU Br. 6-7. Studies predict that these new measures will reduce workforce turnover by 33 percent. See Elizabeth T. Powers & Nicholas J. Powers,

Should Government Subsidize Caregiver Wages? Some Evidence on Worker Turnover and the Cost of Long-Term Care, 21 J. Disability Pol'y Stud. 195, 202 (2011).

Illinois's approach thus reflects its considered judgment that offering its state-employed homecare workforce the right to bargain collectively is the best way to handle this increasingly important area of state services. This Court should hesitate to strike down such a successful regime. See *New State Ice Co.* v. *Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting) (States may "try novel social and economic experiments without risk to the rest of the country. This Court has the power to prevent an experiment. * * * But, in the exercise of this high power, [it] must be ever on our guard, lest [it] erect [its] prejudices into legal principles.").

CONCLUSION

The judgment for the court of appeals should be affirmed.

Respectfully submitted.

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