All states must set higher wage benchmarks for home health care workers

Report • By Cassandra Robertson, Marokey Sawo, and David Cooper • June 2, 2022

What this report finds: In every state, an undervalued home health care workforce—overwhelmingly composed of women, workers of color, and immigrants—is paid extremely low wages to perform vital work for the nation's older adults and people with disabilities. In the lowest-paying states, home health care workers typically make less than $12 an hour. Even in the highest-paying states, average wages top out below $18 per hour. If these workers were appropriately compensated for their labor, their average wages would range from $19.58 per hour in West Virginia to $28.98 in Massachusetts. New state-by-state estimates of what home health care workers should be paid can help states bolster their home care workforce to meet the growing demand for in home care.

Why it matters: The more than 1 million additional home health care workers needed by 2029 will add to a system already straining under worker shortages. At the same time, 1 in 6 home health care workers lives below the poverty line, in many cases using government safety net benefits to make ends meet. Raising pay for home health care work to a livable wage would make home health care jobs more attractive and decrease reliance of these workers on the social safety net. Studies also suggest that stabilizing the home health care workforce could improve the quality of care, strengthen economic growth, and allow family members of individuals needing care to return to the workforce.

What can be done about it: Congress can include additional funds for the Medicaid-based Home and Community Based Services

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(HCBS) program in legislation, as has been done twice in recent years. Lawmakers and the Biden administration could provide additional guidance on how these dollars could be spent that prioritizes higher pay for home health care workers. State officials could increase reimbursement rates to HCBS-funded home health care providers and encourage them to use the additional funding to raise pay for frontline caregiving staff to be more in line with the benchmark wage rates presented in this report.

Introduction

Home health care workers across the country help older adults and people with disabilities remain in their homes and communities. They assist with activities of daily living (ADLs), helping their clients with such actions as bathing, dressing, eating and drinking, and using the bathroom. This is intimate and important work that requires a high degree of trust and professionalism.

Home health care workers are often paid extremely low wages. State median wages for home health care workers in 2021 ranged from $8.76 per hour in Louisiana to $17.45 per hour in Massachusetts, with a national median of $14.15 (BLS 2021). (The median is the wage at the exact middle of the wage distribution—meaning that half of all home health care workers in these states make less than this amount.) Home health care workers are paid by those they serve or their immediate family, private long-term care insurance, or through Medicare or Medicaid's Home and Community Based Services waiver program (HCBS).

The majority of home care workers are paid through the HCBS waiver program, which is administered at the state level through a federal waiver program (KFF 2022). Although HCBS is funded through a combination of state and federal dollars, each state chooses what services to offer under the program and how much providers will be reimbursed for HCBS services, which means states play a crucial role in setting wages for this workforce.

Because state Medicaid agencies set reimbursement rates and pay for many of these workers, states have the opportunity and responsibility to improve outcomes for home care workers and the families they serve by ensuring that the home health care workforce is supported by sustainable wages.

Many states already recognize that they need to raise home care worker wages to ensure that there are enough workers to serve current clients and to expand services to every person who needs them. As of 2020, nearly 700,000 families eligible for care sit on waiting lists, according to the Kaiser Family Foundation (KFF 2020). However, there are no current state-by-state estimates of what appropriate wages for this workforce would be. Building on the Economic Policy Institute's previous work in this area, documented in Banerjee, Gould, and Sawo (2021), this report outlines state-level wages that would ensure home health care workers are appropriately compensated for their valuable labor. These

new estimates can help states seeking to bolster their home care workforce moving forward.

Who are home health care workers and how do trends affect their occupation?

The home health care workers who help the nation's older adults and people with disabilities remain in their homes and communities are an important national resource. This section provides a snapshot not only of who these workers are and what they do but also the structures and trends that shape the occupation now and in the future.

Who they are and what they do

Home health care workers are disproportionately women; disproportionately Black, Hispanic, and Asian American/Pacific Islander women; and in many cases, immigrant women. These workers who are vastly overrepresented in the home health care workforce compared with their numbers in the general workforce are also workers who face discrimination across multiple identities. This discrimination is central to understanding the devaluation of care work as a profession and the low wages these workers are paid.

Goubert, Cai, and Appelbaum (2021) note that 46.9% of all workers in America are women, and report that nearly double that percentage—88.6%—of home health care workers are women. Additionally, Asian, Latinx, and Black women represent almost 60% of this workforce, compared with 17% in the U.S. labor force (Goubert, Cai, and Appelbaum 2021). Finally, Banerjee, Gould, and Sawo (2021) note that 26.5% of workers in this industry are immigrants, compared with 7.3% of the workforce overall.

There is great variation in the type of work home health care workers do on a daily basis. Some workers specialize in hospice care, while others work with those needing rehabilitation from an injury, or with those with ongoing needs. Some home care workers have a years-long relationship with clients. They may walk the dog, clean up the house, monitor catheters, or bathe a client. This is physically and emotionally demanding work that helps people who are not able to live independently to stay in their homes and communities.

The increasing demand for home health care workers

The demand for home care is growing quickly. According to AARP (2021), 77% of people ages 50 and older say they want to age in place—a trend that has been reinforced by the COVID-19 pandemic, which has highlighted how institutional care increases dangerous

exposures to infectious diseases for patients (and the resulting isolation from the outside world). This increasing interest in receiving care at home indicates a shift over previous decades, as home health care has become a larger and more effective means of caring for those who need assistance than institutional care, such as nursing homes and assisted living facilities.

As the preference for home health care increases, the population that will need care is also expanding. Johnson (2019) estimates that 70% of people who reach age 65 will need long-term care, and the U.S. Census Bureau projects that the number of people ages 65 and older will increase by 44% (or roughly 25 million) by 2040 (Vespa, Medina, and Armstrong 2020). With these trends, demand will only grow. By 2040, 1 in 5 Americans will be older than 65 (Urban Institute 2022).

There are currently 2.3 million home health care workers serving seniors and people with disabilities, and it is estimated that more than 1 million more home health care workers will be needed by 2029 (PHI 2019; McCall 2021). In fact, over the next several years, the Bureau of Labor Statistics projects more openings in home health care than in any other industry (BLS 2021), yet states already are facing a shortage of these critical workers (Graham 2022).

When home health care workers are not available, individuals need to find other ways to get their needs met, such as moving into nursing homes and other institutional settings, instead of remaining in their homes. This is not only contrary to what individuals want, but also puts additional strain on state budgets. The monthly median cost of home health care is $4,576, compared with $7,908 for a semi-private room in a nursing home (Genworth 2021). This additional cost is covered by Medicaid. More than 665,015 people are on waitlists for Medicaid-funded HCBS services, increasing unnecessary costs to public programs and putting a heavy strain on families and seniors going without care (KFF 2020).

How home health care work is funded

The majority of home health care workers are paid through the HCBS program, which is administered at the state level through Medicaid (KFF 2022). It is funded using both state and federal dollars. Every state's program is slightly different, as states have discretion over what types of services they offer (for example, Colorado allows family caregivers to receive payments, while Massachusetts does not). As a result, the precise services vary across states.

Because most of these workers are paid through the Medicaid program, state Medicaid agencies set payment rates for care providers. When a physician determines that an individual is eligible for home care services, that individual is assigned a certain number of hours of care. Those hours are reimbursed by Medicaid at a rate set by the state Medicaid agency. If the rates are low, the wages paid to care providers are typically low. Conversely, reimbursing for services at a higher rate will often translate to a higher wage for these workers. (Home care agencies do receive payment for overhead and some of the increase

in rates can also go to overhead.) State policy therefore has a powerful impact on home health care workers' wages. In some states, such as Washington, the state Medicaid agency negotiates with worker unions to set rates at more adequate levels and increase reimbursement rates at set intervals. Other states, such as Arkansas and Louisiana, have far lower rates for their workers (Lieberman et al. 2021).

Why do wages matter?

Wages for home health care workers matter, not just to ensure that these workers earn a living wage, but also to decrease their reliance on the social safety net, improve quality of care, and attract more people to this rapidly growing industry. Also, by stabilizing the formal paid care work workforce, likely more women currently providing informal unpaid care would be able to return to the labor force as their family members receive services from home care workers.

Worker economic security

As of 2021, state median wages for home health care workers ranged from $8.76 to $17.45 per hour, with a national median of $14.15 (BLS 2021). This is significantly less than the national median wage of $22.00, and few of these workers receive benefits (OEWS 2021). A 2020 report on working conditions of direct care workers (working in residential care settings as well as homes) found that although direct care workers work an average of 36 hours per week for 46.4 weeks a year, their average yearly income is only $23,263 (Weller et al. 2020).

Weller et al. (2020) also note that almost half of all direct care workers earn below a living wage, and therefore cannot afford basic necessities.[1] Many have wages so low that they are entitled to public benefits, with 1 in 6 home care workers living below the poverty line despite their essential work (Bedlin 2021). No worker should be paid so little that they cannot make ends meet without relying on public assistance. Yet it is particularly troubling—and woefully inefficient—to have government policy set pay so low for a group of workers they must then turn back to the government for aid to afford their basic needs.

Quality of care

Higher wages for care workers would likely have significant impacts on patient safety and health. For example, in a study of nursing homes, the cost of increased wages were partially offset by improvements in care, such as fewer pressure ulcers and urinary tract infections, and the cost was completely offset when the social value of longevity is considered (Ruffini 2020). Additionally, after a care recipient returns from a hospital stay, access to home care can reduce their probability of readmission to the hospital (Carnahan et al. 2017).

Furthermore, people with disabilities often have close relationships with their care

providers, and experience lower quality of care when turnover is high. By improving wages to decrease turnover, those receiving care would experience better outcomes for what is difficult and skilled work (IOM 2008).

Sustainability of the workforce and cost savings

Higher wages would reduce staffing shortages while also saving billions of dollars across government programs and tax credits that supplement the income of low-wage workers. According to the LeadingAge LTSS Center at UMass Boston, which studies long-term services and supports for the aging population, improved pay would attract more people into direct care work, improve consistency of care, and lead to workers working more hours (Weller et al. 2020). This not only would improve the sustainability of the workforce, but also lead to higher-quality experiences for both workers and those who need care.

A true living wage would also decrease reliance of these workers on the social safety net. For example, Currently, 16.8% of direct care workers (those in homes as well as residential facilities) rely on safety net programs. An increase to a living wage (according to their state) would lead to $556 million worth of savings in Medicaid payments alone, as well as $1.6 billion in savings across all benefit programs and tax credits (Weller et al. 2020).

These data demonstrate that not only are workers in the direct and home health care settings, and those receiving care, hurt by low wages, but that the government already pays more for these workers than just what it spends in wage reimbursements due to higher safety net costs. Federal and state dollars would thus be better spent on increasing wages than on compensating for those same low wages with social safety net programs.

Macroeconomic impacts

Investing in home health care and increasing workers' wages would potentially lead to significant macroeconomic effects. Moody's Analytics found that investing in home health care has an economic multiplier greater than one, meaning that every dollar spent boosts the economy by more than a dollar (Zandi and Yaros 2021). Raising wages and increasing the number of workers in this field would therefore lead to stronger economic growth.

Additionally, if higher wages were to stabilize the HCBS workforce and increase the number of people eligible to participate, labor force participation would likely increase overall. Shen (2021) finds that because seniors who are eligible for home health care but not able to access the program often receive informal care from family members, for every three older individuals who receive care, an average of one additional woman is able to return to the labor force. This suggests that a lack of access to care means families are "making do" with informal and unpaid care arrangements that preclude formal labor market participation, and that women are able to return to the labor force when their family members receive services from home health care workers.

Overall, investing in home health care would support stronger economic growth, as well as increase the number of women in the labor force. This is particularly important given how

many women have left the formal labor force due to care responsibilities during the pandemic (Kohler, Odiase, and Forden 2021).

What are current wages of home health workers by state—and why are they so low?

The prevalence of low wages in the home health care workforce spans the entire country and is particularly stark in some states. **Figure A** details current average wages at the state level. It accounts for the fact that the sample of home health care workers in the Current Population Survey (CPS)—the data source used for much of the analysis in this report—is relatively small in some states. To ensure an accurate assessment of current home health care wages, we present current average wages as a range between the average home health care wage estimates calculated from the CPS and the average home health care wage estimate calculated from the Occupational Employment and Wage Statistics (OEWS) published by the Bureau of Labor Statistics. The map in Figure A is shaded by the average of the values from the two data sets. (See Appendices A and B for more details on the data sources, and our methodology for estimating recommended wage levels, as outlined in the last section of the report before the conclusion.)

Figure A shades states based on the average value of these two wage estimates. Based on the estimated value resulting from averaging the two range values presented, current average hourly wages are lowest in Louisiana, West Virginia, Texas, Mississippi, and Oklahoma. In these states, home health care workers typically make less than $12 an hour. At the national level, the average hourly wage for these workers is about $13.50. The places where home health care workers are currently paid the highest hourly wages are Massachusetts, North Dakota, Alaska, Washington state, and Colorado. Average wages in these states range from $14.59–$17.70 per hour.

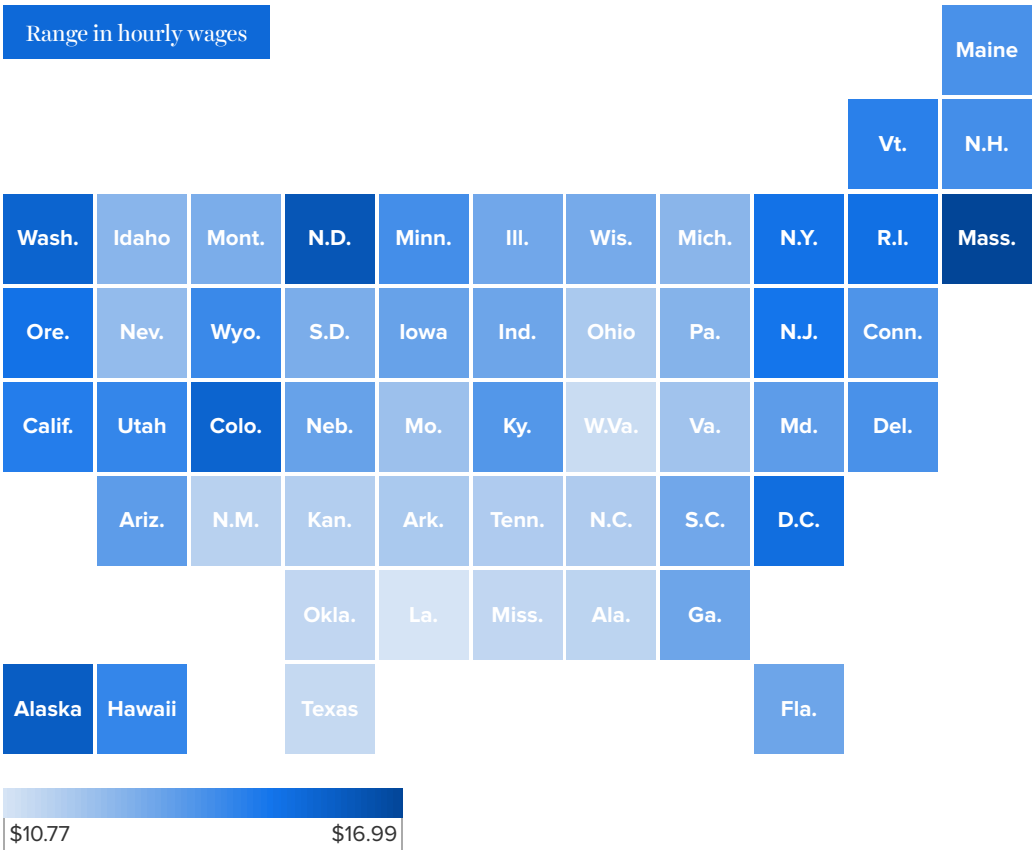
As our analysis asserts, home health care workers are severely underpaid. The underpayment of this workforce is due to the explicit lack of labor protections available to these workers, the undervaluing of care work in our economy, and the discrimination faced by the (often immigrant) Black, Latinx, and Asian women who have historically and continue to make up the majority of the home health care workforce.

The historical exclusion of home care workers from federal labor law has led to fewer protections for this workforce and lower wages. Home care workers were left out of the groundbreaking 1938 Fair Labor Standards Act, a bedrock of the New Deal that "establishes minimum wage, overtime pay, recordkeeping, and youth employment standards affecting employees in the private sector and in Federal, State, and local governments" (U.S. DOL n.d.). The racism, sexism, and xenophobia embedded in this law when it was created structured the treatment of this workforce for decades (Dixon 2021; Banerjee, Gould, and Sawo 2021). It wasn't until 2013, during the Obama administration, that home care workers became entitled to the same protections as other workers, such

Figure A

Current wages for home health care workers are low nationwide and vary greatly across states

Average hourly wages for home health care workers by state



Notes: Average wage presented as a range between Current Population Survey (CPS) and Occupational Employment and Wage Statistics (OEWS) wage data. The figure is shaded based on the average of CPS and OEWS values for each state. All figures are in 2020 dollars.

Source: Economic Policy Institute (EPI) analysis of 2016–2020 Current Population Survey Outgoing Rotation Group microdata, EPI Current Population Survey Extracts, Version 1.0.28 (EPI 2022) and OEWS (2021).

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as minimum wage and overtime rules. More recently, lawmakers in some states have begun to introduce a Domestic Workers Bill of Rights (NDWA 2022), which would further reform labor laws and include such benefits as paid time off. However, a federal version introduced in both the House and Senate appears to be stalled (Office of Rep. Pramila Jayapal 2021), and there is still a long way to go to ensure labor protections and fair wages for this workforce (NDWA 2022).

Additionally, a large body of research has established that care workers face a pay penalty for performing this type of work (England, Budig, and Folbre 2002; Budig, Hodges, and England 2019; Wolfe et al. 2020). The most recent estimates place the value of the home care penalty at 27% to 36%, meaning that home care workers receive approximately one-third less compensation compared with similar workers who are not in care jobs (Wolfe et

al. 2020). Therefore, appropriately compensating workers for their labor would ensure there is not a penalty for choosing to enter this field.

Turning to demographic characteristics, these workers are underpaid because those who perform home care work are undervalued in our society and economy. As described above, home care workers are frequently discriminated against and marginalized because of their gender, race, and citizenship status (Banerjee, Gould, and Sawo 2021). This means that any fair wage should account for how the economy has systematically discriminated against and undervalued these workers.

Finally, in most states, few home health care workers are unionized and thus do not receive the pay premium that union status typically confers. Unions can have a powerful impact on wages across sectors. Overall, union members are paid 10.2% more than workers in the same industry who are not union members, demonstrating how powerful unionization can be as a tool to demand higher wages (EPI 2021). Unionized home care workers receive significantly higher wages and benefits (for example, Washington state home care workers receive paid time off). And patients cared for by unionized workers typically experienced superior health outcomes during the pandemic (Dean, Venkataramani, and Kimmel 2020).

What should home health care wages be in each state?

The opportunity to raise home health care wages to more effective levels arose when Congress passed the first COVID-19 response legislation under the Coronavirus Aid, Relief, and Economic Security (CARES) Act. States received increases in the federal match of Medicaid dollars for their state programs. Some states recognized the home health care industry was in crisis and used these resources to increase wages for these workers.

However, increases were temporary, and so more federal investment was needed. In early 2021, Congress passed the American Rescue Plan Act (ARPA), which provided an additional $12 billion in funding to the HCBS program. Each state had to submit a plan for how to allocate its funds, and 46 states and Washington, D.C., used ARPA dollars to improve wages, provide hazard pay, and award bonuses.

Unfortunately, the federal dollars from ARPA also were temporary, so most states instituted only temporary wage increases. This demonstrates that there is a need for further interventions, such as the inclusion of the HCBS program in the next iteration of any reconciliation package or domestic spending legislation. However, because HCBS is administered at the state level, each state will be responsible for setting its own rates, meaning that wages will continue to vary across the nation. Yet, even with such variance, state agencies can more consistently set wages at levels that appropriately value home care work and the workers who perform it. The following state-level wage benchmarks provide a starting point for state policymakers who seek to use future dollars to invest in this workforce and ensure adequate access to home-based care in the future.

Results

The hourly wages presented below build upon the work of Banerjee, Gould, and Sawo (2021), who estimated national-level care worker wage benchmarks that accounted for 1) the wage penalty associated with care work; 2) the wage penalties associated with the gender, race/ethnicity, and citizenship of large portions of the care workforce, and 3) the wage premium that comes from unionization. In other words, the hourly wages recommended here represent what home health care workers' wages would be if the factors that depress wages were reduced and these workers received the wage boost that typically comes from unionization (which has a wage equalizing effect by gender and race/ethnicity). This report uses a series of methods detailed in **Appendix A** to regionalize Banerjee, Gould, and Sawo's national wage values to every state.

Table 1 details the hourly wage level for home health care workers that we are proposing for each state. Our proposed wages range from a low of $19.58 per hour in West Virginia to a high of $33.87 per hour in Washington, D.C. Out of the 51 proposed wages, 37 of them fall between $20 and $25 per hour. The D.C. number is an outlier because of its unique city-level status, in which economywide average wages are significantly higher than statewide averages in each of the 50 states. The D.C. average hourly wage of $40.62 compares with a national average of $26.69. Excluding D.C., the next highest proposed wage is about $5 less—$28.98 in Massachusetts.

In every state, current home health care wages do not meet the more appropriate levels proposed in this analysis. **Figure B** depicts both the proposed wage for each state and how far away current home health care wages are from our proposed wage benchmarks. (For the gap ranges and averages by state behind the map, see Appendix Table 2.) Based on the estimated value resulting from averaging the two estimates for current home health care workers at the state level presented in Figure A, the states for which current wages are closest to our proposals are South Dakota, Vermont, Idaho, Montana, and Iowa. For these states, current wages are about $6 – $9 less than the average hourly wages proposed for those states. Excluding Washington, D.C., current wages are furthest away from our benchmarks in Virginia, Maryland, Massachusetts, New Jersey, and Colorado. In these states, current wages range from about $11–14 less than our proposals. As discussed above, the proposal for D.C. is an outlier because of its unique status and how high economywide wages are there. At the national level, the average home health care wage is about $8.70 less than our proposed benchmark.

Conclusion

As policymakers seek to address the rising demand for in-home care, and to ensure both high-quality care and the sustainability of the home health care workforce, these estimates provide a yardstick for what appropriate wages for this workforce would be in every state. Our proposed wages range from a low of $19.58 per hour in West Virginia to a high of $28.98 in Massachusetts (with $33.87 per hour in Washington, D.C.). These are wages that more accurately reflect the value of home health care work and would ensure more livable

Table 1

Proposed wages for home health care workers by state

State	Wage	State	Wage
Alabama	$20.95	*Montana*	$20.69
Alaska	$24.56	*North Carolina*	$20.96
Arkansas	$20.07	*North Dakota*	$26.54
Arizona	$22.13	*Nebraska*	$22.03
California	$25.04	*New Hampshire*	$23.31
Colorado	$27.25	*New Jersey*	$26.67
Connecticut	$25.12	*New Mexico*	$20.38
Washington, D.C.	$33.87	*Nevada*	$21.60
Delaware	$25.48	*New York*	$24.53
Florida	$23.14	*Ohio*	$20.41
Georgia	$22.17	*Oklahoma*	$20.33
Hawaii	$24.93	*Oregon*	$24.99
Iowa	$21.16	*Pennsylvania*	$21.72
Idaho	$20.30	*Rhode Island*	$25.34
Illinois	$23.24	*South Carolina*	$24.23
Indiana	$23.39	*South Dakota*	$20.37
Kansas	$20.56	*Tennessee*	$20.51
Kentucky	$23.29	*Texas*	$22.16
Louisiana	$20.64	*Utah*	$24.21
Massachusetts	$28.98	*Virginia*	$25.14
Maryland	$26.22	*Vermont*	$22.11
Maine	$22.16	*Washington*	$25.39
Michigan	$21.12	*Wisconsin*	$21.96
Minnesota	$23.29	*West Virginia*	$19.58
Missouri	$20.59	*Wyoming*	$23.82
Mississippi	$19.90		

Note: All figures are in 2020 dollars.

Source: Economic Policy Institute (EPI) analysis of 2020 Bureau of Economic Analysis State and Metro Areas Regional Price Parities by state, and 2016–2020 Current Population Survey Outgoing Rotation Group microdata, EPI Current Population Survey Extracts, Version 1.0.28 (EPI 2022).

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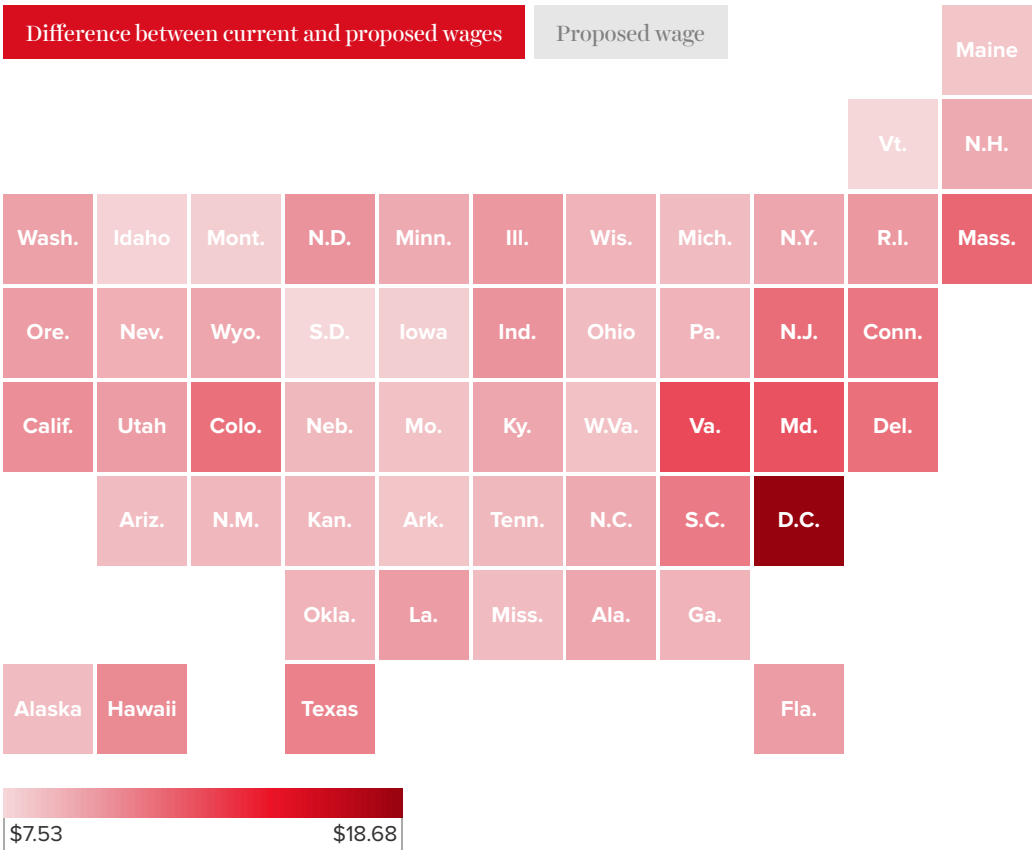
earnings for home health care workers. As this diverse workforce grows over the next decade, this industry could provide economic security and mobility, or it could trap these

Figure B

There are no states where home health workers wages meet our proposals

Difference between current and proposed hourly wages (in dollars) and proposed hourly wage, by state



Notes: Wage gap is presented as how much higher in dollars the proposed wage is than the current wage range between Current Population Survey (CPS) and Occupational Employment and Wage Statistics (OEWS) wage data. The figure is shaded based on the difference between the average of CPS and OEWS values for the current wage in each state and the proposed wage. The national gap between the average wage range and the proposed wage is $8.67–$8.77. All figures are in 2020 dollars.

Source: Economic Policy Institute (EPI) analysis of 2020 Bureau of Economic Analysis State and Metro Areas Regional Price Parities by state (BEA 2021), and 2016–2020 Current Population Survey Outgoing Rotation Group microdata, EPI Current Population Survey Extracts, Version 1.0.28 (EPI 2022).

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workers in low-wage jobs that have little room for growth.

Workers, care recipients, and the economy overall would benefit from this important investment in home health care work. Not only would more workers be able to enter this profession and provide for their families, but those receiving care would enjoy better outcomes and more stability of care. States would be able to save money on safety net programs while also enjoying greater economic growth. These are workers whose wages are in most cases paid with state and federal dollars, and they should be paid enough to enjoy a living wage that benefits everyone.

Appendix A: Methodology

The state-level home health care worker wage benchmarks presented in this report rely heavily on the methodology developed in Banerjee, Gould, and Sawo (2021), which lays out a detailed examination of the state of home health care and child care workers in the United States at the national level. The 2021 report proposes several wage benchmarks that would redress many of the wage inequities direct care workers endure. In this report, we generate state-level versions of the national proposed wage of $22.26 per hour for home health care workers from Banerjee, Gould, and Sawo (2021) as a base. That proposed wage was developed through consideration of three key factors:

- the estimated cost in lost wages workers face simply for being care workers (the care penalty as estimated in Budig, Hodges, and England 2019, where the penalty is how much less care workers make than workers in other occupations with similar education and experience)
- the estimate of the wage penalties workers face in the labor market based on their gender, race/ethnicity, and citizenship status
- the estimated boost to wages that results from increased unionization and harnessing the power of collective bargaining

Data sources and definition of home health care workers

The main data source used to generate our state-level proposed home health care (HHC) wages is the Current Population Survey Outgoing Rotation Group microdata (CPS-ORG) collected and harmonized by the Economic Policy Institute (EPI 2022). To ensure adequate sample sizes for state-level estimates, the CPS-ORG data used are pooled microdata for 2016–2020. All numbers presented are in 2020 dollars.

We use the definition of home health care workers specified in Banerjee, Gould, and Sawo (2021). Following the methodology laid out in that study, we identify these workers by their relevant industry and occupational category combination.[2] Home health care workers are identified in the CPS by the following occupations: nursing, psychiatric, and home health aides; personal and home care aides; home health aides; personal care aides; nursing assistants; orderlies; and psychiatric aides. These are combined with the following industry specifications: private households, home health care services, and individual and family services.

Generating state-level wage benchmarks

The proposed national hourly care worker wage benchmark from Banerjee, Gould, and Sawo (2021) that we use as a starting point is $22.26 per hour. Using this number as a base, we explore three methods for adjusting it to the state level. In the first method, we scale the national wage benchmark for home health care workers using Regional Price

Parity (RPP) data from the Bureau of Economic Analysis (BEA) on the variation in cost of living across the 50 U.S. states and Washington, D.C. Each state has an RPP measure expressed as a percentage of the national overall price level. Using BEA's latest estimates for 2020, we multiply each state's RPP by the national base wage of $22.26 to get a price-adjusted state-level proposed care wage.

Our second method uses variability in existing home health care wages at the state level to scale the national proposed wage for these workers. We first calculate average hourly wages for home health care (HHC) workers at the state level using the CPS-ORG data. We then express these state-level HHC wages as a share of the national average HHC hourly wage (estimated under our analysis as $13.59) by dividing them by the national estimate. The resulting ratio for each state is then multiplied by the national HHC wage benchmark to scale it to the state level. This method effectively establishes a home health care wage benchmark that reflects the existing variation in home care wages across the states.

Our third method accounts for variation in economywide wages at the state level. We begin by calculating the economywide mean hourly wage across all workers in each state using CPS-ORG data. We then express these state-level economywide wages as a share of the national average economywide wage across all workers in the United States (estimated as $26.69) by dividing them by the latter. The resulting ratio for each state is then multiplied by the proposed national HHC wage to scale it to the state level. This produces a wage benchmark that accounts for broader differences in economic and labor market conditions across states.

For each state, we select a final wage benchmark for home health care workers based on the maximum resulting estimate from the three methods described above. We select the maximum of these three methods because each method reflects a different dimension of wage adequacy, none of which can be ignored when setting appropriate wage levels—namely, variations in the cost of living, the wage distribution within home health care, and the wage distribution of all workers in the state, respectively. In states where the cost of living is particularly high relative to the average cost of living across the country, home health care worker pay should reflect these higher costs. In states where the existing wages of home health care workers in that state are high relative to the national average, wages should continue to reflect whatever premium the state market for these jobs currently exhibits. In states where economywide wages are high relative to the national average, care worker wages will need to reflect these broader labor market trends to remain competitive. Whichever of these methodologies is highest will necessarily satisfy the aims of all three.

Generating state-level current wages and gaps between current and benchmark wages

To estimate current average wages in each state we use two data sets. From the Current Population Survey we compute an average wage using pooled 2016–2020 Outgoing Rotation Group wage microdata for the following occupations: nursing, psychiatric, and home health aides; personal and home care aides; home health aides; personal care

aides; nursing assistants; orderlies; and psychiatric aides. These are combined with the following industry specifications: private households, home health care services, and individual and family services. From the Occupational Employment and Wage Statistics, we compute an average wage using May 2021 data for the following occupation: home health and personal care (HHPC) workers (see more on this data set in Appendix B). We express the current wage as the range between the two averages. The gaps between the wage range and benchmark wages are the wage gaps.

Appendix B: Supplemental set of proposed wages

In **Appendix Table 1** we provide a second set of proposed wages that relies on published data from the May 2020 Occupational Employment and Wage Statistics survey data (OEWS 2021) instead of our own calculations of wages using the Current Population Survey Outgoing Rotation Group microdata (CPS-ORG). We use the CPS-ORG data in order to remain consistent with the data source used in Banerjee, Gould, and Sawo (2021)—the source of our national base wage. However, similar home care worker and economywide wage scaling can be done using government-published data from the OEWS. We include below a supplemental set of state-scaled wages derived using these government-published OEWS data.

We arrive at this second set of estimates using the same methodology described earlier in this report. In particular, we calculate another set of estimates of the latter two scaling methods described above using OEWS data in lieu of CPS-ORG data. The first scaling method described earlier remains the same, since it is based on BEA price parities data. For the second method, we use the May 2020 OEWS state-level data for the average hourly wage for home health and personal care (HHPC) workers. These state level wages are divided by the national average HHPC wage of $13.59. The resulting ratio for each state is then multiplied by the proposed national wage to scale $22.26 to the state level. For the third scaling method, we use the May 2020 OEWS state-level data for the average hourly wage for workers across occupations. These state economywide wages are then divided by the OEWS estimate for the national average hourly wage across all occupations of $27.07. The resulting ratio for each state is then multiplied by the proposed national wage to scale it to the state level. The final proposed wage for each state is the maximum resulting number across these three estimates.

Appendix Table 1

Alternative set of proposed home health care wage benchmarks using Occupational Employment and Wage Statistics data

State	Wage	State	Wage
Alabama	$19.87	*Montana*	$21.48
Alaska	$28.05	*North Carolina*	$20.44
Arkansas	$19.85	*North Dakota*	$27.00
Arizona	$22.05	*Nebraska*	$21.52
California	$25.99	*New Hampshire*	$23.09
Colorado	$24.08	*New Jersey*	$25.18
Connecticut	$25.87	*New Mexico*	$20.38
Washington, D.C.	$37.69	*Nevada*	$21.60
Delaware	$22.42	*New York*	$26.82
Florida	$22.42	*Ohio*	$20.41
Georgia	$21.10	*Oklahoma*	$20.33
Hawaii	$24.93	*Oregon*	$24.39
Iowa	$22.57	*Pennsylvania*	$21.72
Idaho	$22.06	*Rhode Island*	$24.42
Illinois	$22.96	*South Carolina*	$20.40
Indiana	$20.59	*South Dakota*	$22.06
Kansas	$20.56	*Tennessee*	$20.51
Kentucky	$21.67	*Texas*	$22.16
Louisiana	$20.64	*Utah*	$22.89
Massachusetts	$27.68	*Virginia*	$23.78
Maryland	$25.15	*Vermont*	$26.83
Maine	$23.35	*Washington*	$26.44
Michigan	$21.11	*Wisconsin*	$20.74
Minnesota	$23.27	*West Virginia*	$19.58
Missouri	$20.59	*Wyoming*	$22.85
Mississippi	$19.54		

Note: All figures are in 2020 dollars.

Source: Economic Policy Institute (EPI) analysis of 2020 Bureau of Economic Analysis SARPP Regional Price Parities by state (BEA 2021), and May 2020 Occupational Employment and Wage Statistics survey data (OEWS 2021).

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Appendix Table 2

Difference between current hourly wages and proposed hourly wages and proposed hourly wage by state

State	Difference between current wage range and proposed wage	Proposed wage
Alabama	$8.16–$10.87	$20.95
Alaska	$7.56–$9.57	$24.56
Arizona	$8.62–$8.80	$22.13
Arkansas	$7.82–$8.77	$20.07
California	$10.00–$10.87	$25.04
Colorado	$10.61–$12.66	$27.25
Connecticut	$10.96–$11.75	$25.12
Delaware	$9.92–$13.29	$25.48
Washington D.C.	$18.58–$18.79	$33.87
Florida	$9.01–$10.92	$23.14
Georgia	$8.63–$9.38	$22.17
Hawaii	$10.36–$10.97	$24.93
Idaho	$6.93–$8.54	$20.30
Illinois	$9.66–$10.63	$23.24
Indiana	$9.11–$11.36	$23.39
Iowa	$7.48–$8.24	$21.16
Kansas	$8.60–$9.25	$20.56
Kentucky	$9.07–$10.16	$23.29
Louisiana	$8.62–$11.12	$20.64
Maine	$8.01–$8.63	$22.16
Maryland	$12.51–$12.99	$26.22
Massachusetts	$11.29–$12.69	$28.98
Michigan	$8.52–$8.72	$21.12
Minnesota	$9.19–$9.41	$23.29
Mississippi	$7.75–$9.55	$19.90
Missouri	$8.17–$8.68	$20.59
Montana	$7.67–$8.06	$20.69
Nebraska	$8.58–$8.99	$22.03
Nevada	$9.19–$9.27	$21.60
New Hampshire	$9.24–$9.44	$23.31
New Jersey	$10.80–$12.79	$26.67

Appendix Table 2 (cont.)

State	Difference between current wage range and proposed wage	Proposed wage
New Mexico	$8.91–$8.91	$20.38
New York	$9.08–$9.99	$24.53
North Carolina	$8.66–$9.94	$20.96
North Dakota	$10.18–$10.34	$26.54
Ohio	$8.55–$8.74	$20.41
Oklahoma	$8.40–$9.60	$20.33
Oregon	$9.73–$10.21	$24.99
Pennsylvania	$8.97–$9.17	$21.72
Rhode Island	$9.87–$10.54	$25.34
South Carolina	$9.44–$12.90	$24.23
South Dakota	$7.00–$8.05	$20.37
Tennessee	$8.16–$9.39	$20.51
Texas	$10.27–$11.71	$22.16
Utah	$9.43–$10.34	$24.21
Vermont	$5.85–$9.28	$22.11
Virginia	$12.26–$13.91	$25.14
Washington	$9.59–$9.89	$25.39
West Virginia	$7.85–$9.13	$19.58
Wisconsin	$8.55–$9.39	$21.96
Wyoming	$9.28–$9.97	$23.82

Notes: Wage difference is presented as how much higher in dollars the proposed wage is than the current wage, where the current wage is a wage range between Current Population Survey (CPS) and Occupational Employment and Wage Statistics (OEWS) wage data. All figures are in 2020 dollars.

Source: Economic Policy Institute (EPI) analysis of 2016–2020 Current Population Survey Outgoing Rotation Group microdata, EPI Current Population Survey Extracts, Version 1.0.28 (2022) and OEWS (2021).

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Endnotes

1. Here, a living wage is defined by state using MIT's living wage calculator. This calculator is similar in concept and values to the Economic Policy Institute (EPI)'s Family Budget Calculator, which would describe the earnings required to achieve a modest but adequate standard of living (https://www.epi.org/resources/budget/).

2. Given a change in the industry and occupation categories in 2020 within the Current Population Survey (CPS) data, we combined disaggregated categories for 2020 data to be consistent with the earlier definitions on which data for earlier years we use are based.

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