SELECTED ISSUES IN WORK-FAMILY POLICY; A BRIEF OVERVIEW

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FOREWORD

This study was prepared in response to Senate Concurrent Resolution No. 13 (2006). The Concurrent Resolution requested the Legislative Reference Bureau to study other states' laws and practices identified as promoting good work-family policy. This study presents a brief overview of other states' approaches to selected family and medical leave, caregiver support and child care issues.

The Bureau extends its appreciation to the staffs of the Department of Human Services, Executive Office on Aging, Department of Labor and Industrial Relations, University of Hawaii, and the City and County of Honolulu and to various child care professionals who assisted the Bureau in this study.

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TABLE OF CONTENTS

FACT SHEET

In responding to Senate Concurrent Resolution No. 13 (2006), the Bureau briefly surveyed what other states are doing in three work-family policy areas: family leave and medical leave, caregiver support, and child care. The salient findings of the survey are highlighted below:

I. Family, Medical, and Maternity Disability Leaves

- Hawaii is among five states that use a more expansive definition of "parent" than the federal Family and Medical Leave Act's definition of a parent for whose illness an employee may take family leave. Hawaii defines "parent" as a "biological, foster, or adoptive parent, a parent-in-law, a stepparent, a legal guardian, a grandparent, or a grandparent-in-law."

- Hawaii and several states include what in Hawaii are referred to as reciprocal beneficiaries, but Hawaii is the only state that includes grandparents and grandparents-in-law in its definition of family member for the purposes of family leave.

- At least 40 states, including Hawaii, have laws or regulations allowing public sector employees to use sick leave to care for certain ill family members. However, significantly fewer states require private sector employers to allow substitution of sick leave for family leave. Hawaii is among at least six other states that have laws requiring private sector employers to allow workers to use their sick leave to care for certain ill family members.

- Five states (Hawaii, California, New York, New Jersey, and Rhode Island) and Puerto Rico have state-administered temporary disability programs to provide partial wage replacement for employees who are temporarily disabled for medical reasons, including pregnancy and childbirth.

- In 2002, California became the first state in the nation to provide paid family leave by establishing the Paid Family Leave Insurance Program, where an employee is allowed to use his or her own temporary disability insurance to care for a family member with a serious health condition. No other state offers this option of paid family leave to provide non-maternity related care for a family member.

- Hawaii's family, medical, maternity, maternity disability, and parental leave polices appear to be among the most generous when compared to other states.

II. Caregiver Support

- Employed caregivers make personal, economic, and career sacrifices that affect their families, employers, and communities. They experience increased absenteeism, decreased physical well-being, diminished earnings, and loss of savings due to caregiving expenses. They also report needing flexibility and support at work.

- The growth of America's older population (60 years of age and older) and the significant increase of women in the workforce will continue to have major impacts on employed caregivers and their employers.

- States receive funds through the federal National Family and Caregiver Support Program (NFCSP) to provide support services to: family caregivers of elderly persons; older individuals providing care to persons with developmental disabilities; and grandparents and other relatives who provide care for children 18 years of age and under.

- Like other states that did not already have well-developed caregiver support programs in place prior to the implementation of the NFCSP in 2000, Hawaii faces limited funding sources and workforce shortages of trained long-term care providers, such as social workers, nurses, and personal care workers.

- Some states have continued to fund their own state-funded programs to complement the NFCSP. At least six states use alternative funding sources, such as lottery or tobacco settlement funds, to support family caregivers. State revenues have been used to provide convenient and thorough access to information sources, establish public/private partnerships, and provide respite care.

- Labor union-sponsored assistance to caregivers and private sector initiatives in caregiving have helped to mitigate the multi-faceted needs of employed caregivers.

III. Child Care

- For many families, market rate child care costs are out of reach. Federal child care subsidy programs can help income eligible parents pursue job training, employment opportunities, and economic self-sufficiency. State funded child care programs also help eligible families access child care in a variety of settings.

- Hawaii's child care assistance policies for subsidized child care programs have kept pace with other states in the areas of income eligibility limits, waiting lists of eligible families, co-payments, and reimbursement rates to families for child care fees. Hawaii is generally doing well in helping low income families with

accessing child care. However, families who do not quality for subsidized child care have limited options.

- Federal and state tax provisions for child and dependent care can offer some financial assistance for families with their child care expenses. A family may be able to reduce its federal income tax bill by claiming the federal child and dependent care tax credit, which is not refundable. Hawaii's child and dependent care tax credit is viewed as generous, when compared to other states, because it is refundable.

- Best practice models in child care can be found in the public and private sectors. The Department of Defense child care program used a systemic approach to providing child care by simultaneously addressing quality, affordability, and availability. Some states in the civilian sector have made gains in emulating the Department of Defense's core strategies, but have suffered setbacks due to federal and state funding constraints.

- Private sector initiatives in child care range from on-site care, extended care, back up care, financial assistance with child care, and flexible work arrangements to before- and after- school care.

Chapter 1

INTRODUCTION

Nature of the Study

During the Regular Session of 2006, the Legislature adopted Senate Concurrent Resolution No. 13, entitled "Requesting the Governor to Convene a Work-Family Task Force to Review Hawaii's Work-Family Laws and Policies, and Requesting the Legislative Reference Bureau to Study Other States' Laws and Practices That Promote Good Work-Family Policy." The resolution notes that working families and single parent families must often deal with caring for young children, adults with disabilities, and dependent elders, creating situations that can create work-family tensions. This report responds to the request that the Legislative Reference Bureau review others states' laws and practices identified as promoting good work-family policy. A copy of the resolution is included as Appendix A.

Background

In the past three decades, there has been an increased amount of research devoted to understanding linkages between work and family life. Factors that have contributed to a greater interest in the relationship between work and family life include women entering the workforce in record numbers and an aging population. Balancing work and other responsibilities has become a predominate issue in the workplace.

While work-family programs in the 1980s were geared primarily to support women with children, programs today are less gender-specific and recognize other commitments as well as those of the family.[1] The current research literature has increasingly used the term "work-life" rather than the term "work-family," which was more frequently used in the past. According to the Society for Human Resource Management (SHRM), the phrase "work-life" gives a broader connotation or labeling referring to specific areas of support for employees (e.g. quality of life, flexible work options, life balance, etc).[2]

To that end, there have been significant federal and state legislative efforts, joint public and private sector initiatives, and corporate programs that aim to balance the needs of employees and employers in the context of work-family. Work-family balance from the employee's perspective is defined as "the dilemma of managing work obligations and personal and family responsibilities."[3] Work-family balance from the employer's perspective is defined as "the challenges of creating a supportive company culture where employees can focus on their jobs while at work." For the purposes of this study, "good work-family policy" is defined as laws, policies, benefits, and practices that help employees fulfill both their work and family responsibilities.

Scope and Organization of the Study

Employment issues affecting working families range from increased wages, lost seniority, reduced retirement benefits, financial burdens of taking unpaid leave, and workplace cultures and climates that reflect family- or employee-centered beliefs, to extending opportunities for employee growth and advancement. The scope of this study will be limited to key benefits, policies, and programs in the areas of family leave, support for caregivers who are taking care of the elderly, and child care for working parents. Accordingly, this study will discuss other states' work-family initiatives in the areas of family leave, caregiver support, and child care that have been highlighted as helping employees fulfill both their work and family responsibilities.

The study will focus primarily on publicly-funded and employer-sponsored programs that help working families. It will also look at collaborative efforts between government and employers that increase services available to working families. Finally, the study will highlight model programs that have been considered best practices in promoting good work-family policy.

The remainder of this report is organized as follows:

(1) Chapter 2 discusses other states' laws and policies on family and other types of leave that help families, such as paid and unpaid parental leave, medical leave, maternity disability, and uses of accrued sick leave;

(2) Chapter 3 focuses on issues and needs of employed caregivers, such as information and referral to eldercare services, financial assistance with caregiving expenses, options for respite care, and other available resources for caregiver support; and

(3) Chapter 4 examines child care assistance, such as federal and state child care subsidies, cost and quality of child care, and tax provisions for child and dependent care expenses.

ENDNOTES

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3. Ibid.

Chapter 2

FAMILY AND MEDICAL LEAVE LAWS

Introduction

In 1942, when substantial numbers of women in the United States first entered the labor force, the Women's Bureau of the United States Department of Labor recommended that employed women have six weeks of prenatal leave and two months of leave following childbirth. These proposed polices were never implemented because men returning from military service at the end of World War II replaced most women laborers.[1] It would take the next fifty years for the United States to enact federal legislation in the form of family and medical leave. In Europe, however, public policies providing employment breaks and temporary income to new mothers had been in effect since the early 1900s. Among industrialized countries today, only the United States and Australia do not provide paid leave to mothers.[2]

Family and medical leave legislation in the United States has its roots at the state level. Nine states had enacted paid maternity leave provisions by 1987. In the next two years, another 14 states added maternity or parental leave benefits.[3] Although the first version of a national family leave bill was introduced in Congress in 1985, it did not pass until 1993.

Background

The Pregnancy and Discrimination Act of 1978[4] was the first federal law to protect employment of new parents. The law, which amended Title VII of the Civil Rights Act of 1964, focused on prohibiting discrimination in employment by expanding the terms "because of sex" and "on the basis of sex" to include pregnancy, childbirth, or a related medical condition. The Act made it illegal for employers to fire, refuse to hire, or deny a promotion to a woman because of pregnancy. An employer was required to treat a pregnant woman the same way it would treat any other employee who becomes sick or temporarily disabled. But the Act did not guarantee an employee the right to return to her job or an equivalent job with the same benefits.

However, the Federal Family and Medical Leave Act of 1993[5] (FMLA) does guarantee job-protected leave to an employee. In addition to granting temporary medical leave and family leave to employees for a serious illness or to care for a child, spouse, or parent, the FMLA ensures that employees may return to their former position or a similar position with equivalent benefits, pay, terms, and work conditions.

The FMLA applies to all private and public employees who have worked for at least 1,250 hours for an employer preceding the requested leave. A covered employer must have at least 50 employees and must provide up to 12 weeks of leave within a 12-month period for the birth and care of an infant, the placement of an adoptive or foster child, the care for an immediate family member (including elderly parents) with a serious health condition, or the worker's own serious health condition.

More than 35 million employees have taken leave under FMLA since it was enacted in 1993; however, because of employee and employer eligibility requirements, 40% of workers are not covered by the FMLA.[6] Furthermore, those who are eligible may not be able to afford to take unpaid leave. For example, an estimated 78% of those who needed family leave but did not take it report that they did not take the leave because they could not afford to do so.[7]

Hawaii's Family Leave Law

The Hawaii Family Leave Law (HFLL), codified in chapter 398, Hawaii Revised Statutes (HRS), offers four weeks of unpaid family leave during a 12-month period.[8] Unlike the FMLA, there is no requirement that an employee work a minimum number of hours. In order to be eligible, an employee must have been employed for at least six consecutive months. This includes full-time, part-time, temporary, casual, on-call, or intermittent workers.[9] Like the FMLA, the HFLL allows leave in the following situations: for the birth or adoption of a child; to care for a child, spouse, or parent; and due to the employee's own serious health condition. Unlike the FMLA, the HFLL does not restrict use of the family leave to either a husband or wife, nor does it require that they share the four-week period of family leave. Each could take four weeks of leave separately.

Additionally, the HFLL allows employees to use other accrued paid leave to substitute for unpaid family leave. An employee may choose to use paid vacation, sick, or personal leave provided by contract or policy to substitute for unpaid leave. Up to ten days of accrued and available sick leave per year is allowed to be substituted for family leave. Like the FMLA, the HFLL expressly directs an employer to restore an employee to his or her original or an equivalent position, with equivalent terms and conditions of employment upon returning to work.

Elements of Hawaii Leave Laws Compared to Other States

Hawaii's family, medical, maternity, maternity disability, and parental leaves are among the most generous when compared to most states.[10] The National Conference of State Legislatures' state-by-state comparison of state family and medical leave laws is included as Appendix B. Below are several elements of other states' leave laws that are comparable to or more expansive than Hawaii's leave laws.

Expanded definition of family member. Hawaii is among five states that use a more expansive definition than the FMLA's definition of a "parent" for whose illness an employee may take family leave. Hawaii defines a parent as a "biological, foster, or adoptive parent, a parent-in-law, a stepparent, a legal guardian, a grandparent, or a grandparent-in-law."[11] Like Hawaii, the states of Oregon,[12] Rhode Island,[13] and Vermont[14] include a spouse's parent in this definition. The District of Columbia includes all persons related by blood, legal custody, or marriage and a person who has shared a mutual residence within the last year with the employee and who maintains a committed relationship.[15] Hawaii and several states also include what in Hawaii are

referred to as reciprocal beneficiaries, but Hawaii is the only state that includes grandparents and grandparents-in-law in its definition of family member for the purposes of family leave.

Covered employers. While most states' family leave laws apply to employers of between 50 to 100 employees, Hawaii's family and medical leave law applies to private and public employers of 100 or more employees.[16] In its summary of state laws that are more generous than the FMLA, the National Partnership for Women and Families has identified three jurisdictions with "comprehensive" family and medical leave laws that apply to employers of fewer than 50 employees: Oregon, District of Columbia, and Vermont.[17] Oregon requires public employers and private employers of 25 or more employees[18] to offer 12 weeks of family leave within any one year period to care for the birth or adoption of a child or upon the serious illness of the employee, a child, spouse, or parent. The District of Columbia requires public and private employers of 20 or more employees[19] to offer 16 weeks of family leave during any 24 month period for birth or adoption of a child or upon serious illness of the employee, a child, spouse, or parent. Vermont requires public and private sector employers with more than: (1) 10 employees to provide parental leave for birth or adoption; (2) 15 employees to provide leave due to a family member's or the employee's own serious medical condition.[20] Employees are entitled to take up to 12 weeks of leave for such purposes during a 12-month period.

Substituting accrued sick leave or paid leave for unpaid family leave. At least 40 states have laws or regulations allowing public employees to use sick leave to care for certain ill family members such as a child, spouse, parent, parent-in-law, grandparent, or domestic partner, depending on the state. However, significantly fewer states require private sector employees to allow this substitution of sick leave for family leave. At least six states have laws requiring private sector employers to allow workers to use their sick leave to care for certain ill family members (California, Connecticut, Hawaii, Minnesota, Washington, and Wisconsin).

Paid family leave. Like other states, California had allowed disability compensation for an employee's own sickness or the birth, adoption, or foster care placement of a new child. In 2002, however, California became the first state in the nation to provide *paid* family leave by establishing the Paid Family Leave Insurance Program.[21] The new law is unique because it allows an employee to use temporary disability insurance to care for a family member with a serious health condition. No other state in the nation offers this option of paid family leave to provide non maternity-related care for a family member.

The paid family leave program is funded through workers' own mandatory contributions at an estimated average cost of $27 per worker per year.[22] Workers can collect about 55% of their wages up to a maximum weekly benefit amount set yearly by formula. Payments range from a minimum of $50 to a maximum of $840 per week for up to six weeks.[23]

Maternity Disability Leave

Five states (Hawaii,[24] California, New York, New Jersey, and Rhode Island) and Puerto Rico have state-administered temporary disability programs to provide partial wage replacement for employees who are temporarily disabled for medical reasons, including pregnancy and

childbirth.[25] These programs are usually funded by a payroll tax through employee or employer contributions or a combination of both. Benefit periods range from 26 weeks to 52 weeks. The table below summarizes important provisions in existing, state-administered temporary disability insurance programs.

TEMPORARY DISABILITY INSURANCE PROGRAMS IN THE UNITED STATES

	California	**Hawaii**	**New Jersey**	**New York**	**Rhode Island**	**Puerto Rico**
Date enacted	1946	1969	1948	1949	1942	1968
Administering Agency	Employment security agency	TDI division of Labor Department	Employment security agency	Workers compensation board	Employment security agency	Employment security agency
Financing	Employee	Employer	Employer and employee	Employee	Employee	Employer and employee
Qualifying conditions	$300 in earnings	14 weeks of work, min. 20 hrs./wk., earnings of $400	20 weeks of work, with minimum earnings	4 consecutive weeks of employment	Earnings requirement	$150 in base period
Maxium	52 weeks	26 weeks	34 weeks	26 weeks	30 weeks	26 weeks

Source: Vicky Lovell, Institute for Women's Policy Research, citing U.S. Department of Labor, Employment and Training Administration, Unemployment Insurance Service, "A Comparison of State Unemployment Laws," January 2000.

Parental Leave Programs

In 2005, the National Partnership for Women and Families released a state-by-state analysis of parental leave programs, focusing on job protection and benefit programs that help new parents.[26] The analysis focused on leave provided to all new parents (mothers and fathers, both birth and adoptive) to care for an infant or newly placed child. The report reviewed laws governing private sector employees as well as state laws, regulations, and programs governing state employees. It ranked states on a point system after reviewing eight types of benefits they provide to private sector employees and two types of benefits to state employees.

The eight types of benefits the report reviewed for private sector employees were:

(1) Paid family leave benefits;

(2) Paid medical and maternity leave benefits;

(3) Paid flexible sick days;

(4) At-home infant care programs;

(5) Expanded job-protected family leave;

(6) Expanded job-protected medical and maternity leave;

(7) Extended length of family and medical leave; and

(8) State family leave laws.

Hawaii's private sector employers were found to provide four of the eight types of benefits: (1) paid medical leave for new birth mothers placed on maternity disability leave and for recovery after childbirth; (2) flexible sick days allowing accrued paid leave to care for a new child or a spouse or partner with a maternity disability; (3) extended job protection to female employees who become pregnant; and (4) state family and medical leave laws.

The report also reviewed states' benefits for its public sector employees. The two benefits reviewed were:

(1) Paid family and medical leave benefits; and

(2) Extended length of family and medical leave.

California is the only state that offers paid family leave for employees to provide non-maternity related care for a family member. Hawaii was among only five states that provide their own public employees with paid medical leave benefits that cover pregnancy disability and recovery from childbirth. Hawaii was also among 27 states that provide their own public employees with more than 12 weeks of job-protected parental leave.

The report ranked states by giving them a letter grade and gave Hawaii a B+. The only state that ranked higher than Hawaii was California, which received a grade of A- for its paid family leave benefits.

Conclusion

Hawaii is a recognized leader in family leave laws and maternity leave policies. The benefits afforded to working families as a result of Hawaii's progressive legislation are considered generous when compared with most other states.

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12. Section 659A.150, Oregon Revised Statutes.
13. Section 28-48-1, General Laws of Rhode Island.
14. Section 21-472a, Vermont Statutes Annotated.
15. Section 32-501, District of Columbia Statutes.
16. Section 398-1, Hawaii Revised Statutes.
17. *State Family Leave Laws That Are More Expansive Than The Federal Family and Medical Leave Act*, National Partnership for Women and Families, August 2002.
18. Section 659A.153, Oregon Revised Statutes.
19. Sections 32-502 and 32-503, District of Columbia Code.
20. Title 21, Sections 471-472, Vermont Statutes Annotated.
21. Section 984-3300 to Section 984-3306, California Unemployment Insurance Code. The program made paid leave equally available to mothers and fathers. It also provided up to six weeks of *paid* leave (through an employee's family temporary disability insurance) for the care of a seriously ill child, spouse, domestic partner, or parent. Previously, temporary disability insurance was available only for the employee's own serious health condition.
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Chapter 3

ISSUES AND NEEDS OF EMPLOYED CAREGIVERS

Introduction

For the purposes of this study, "caregiver" refers to any person who provides assistance to another person who is, in some degree, incapacitated and needs help. "Formal caregivers" refers to paid care providers or volunteers associated with a service system administered by a public, private or not-for-profit entity. "Informal caregiver" or "family caregiver" refers to unpaid persons who provide health care for adult family members and friends who, because of disabling illnesses or conditions, have limited ability to perform activities of daily living such as bathing, managing their medications, and preparing meals. "Employed caregivers" are persons who work outside the home for pay while simultaneously providing unpaid care for a family member, friend, or neighbor.

This chapter will focus on the issues and needs of employed caregivers. Although caregivers provide care to children, disabled adults, and the elderly, this chapter will primarily highlight employed caregivers caring for older adults, 60 years of age and older.

Background

Informal caregiving or family caregiving--the unpaid services and support system that is provided by family members or friends--continues to a be large part of America's long term care system. The type and degree of care that an unpaid family caregiver provides vary from person to person and may include physical assistance, paramedical services, financial aid, legal guidance, and emotional support. The monetary value of informal caregiving services to the nation's long term care system is estimated at $257 billion a year, exceeding the costs of nursing home care ($92 billion) and home health care ($32 billion).[1]

Much of that value has been contributed by employed caregivers. A 2001 survey conducted by the National Family Caregivers Association found that half of all family caregivers are working, either full or part-time.[2] A 2004 survey[3] estimated that employed caregivers helping an older person comprise 60% of family caregivers, an increase from 40% in 1987. Employed caregivers make personal, economic, and career sacrifices that affect their families, employers, and communities. Prolonged caregiving has produced negative effects on the emotional and physical health of caregivers,[4] even though it is willingly undertaken and often a source of great personal satisfaction.

The financial impact of caregiving also takes a toll on families when caregiving affects a family member's ability to work. Research has shown that some caregivers must quit their jobs to give care, while others experience increased absenteeism, lower productivity, lost career opportunities, loss of future earnings, lost earnings on their own savings for retirement, and decreased contributions to their social security accounts.[5] Employers may deal with an

employee's reduced productivity, missed work time from coming in late or leaving work early, employee turnover, and recruitment and training of replacement workers. A study by MetLife[6] has estimated that American businesses lose between $11 billion and $29 billion each year due to employees' caregiving duties.

The support available to employed caregivers has generally been education and information about available community services provided at workplaces and through a network of area agencies on aging. Some states fund respite services. Many public and private sector employers provide unpaid family leave that protects a caregiver's job while they are providing care. California is the only state in the nation to offer paid leave for family caregiving and sponsors a network of caregiver support resource centers.

National and Local Caregiving Trends

As record numbers of women enter the work force, many of them will need support services to help juggle the responsibilities of paid employment, home and family, and family caregiving. In 1950 about one in three women, or 34%, participated in the labor force.[7] By 2005, almost 60%, or 117 million women, were working or looking for work.[8] Women are projected to account for 51% of the increase in total labor force growth between 2004 and 2014.[9]

The growth of women in the workforce has major implications because three out of four family caregivers are women. A typical caregiver in the United States is female (60%), approximately 46 years old, has at least some college experience (66%), and spends an average of 20 hours or more per week providing unpaid care to someone 50 or older (80%), most likely to her mother. Six out of 10 caregivers are working or have worked sometime while carrying out their caregiving responsibilities.[10] Similarly, Hawaii's profile of a family caregiver is female (57%), employed (65%), and under the age of 60 (75%).[11]

Nationally, sixty percent of employed caregivers say they had to make some work-related adjustments in order to help the person they care for.[12] In Hawaii, about one-third of caregivers reported going to work late, leaving early, or taking time off during the day.[13] In a follow-up to a national study, MetLife provided an in-depth look at employees who had been providing care for six months or longer and experienced a type of work disruption due to caregiving. The table below provides information on the types of work adjustments the selected employees report having made.

TYPE OF WORK ADJUSTMENT	PERCENT OF CAREGIVERS
Retired Early	13%
Quit Job	16%
Changed from Full to Part-Time	20%
Leave of Absence	22%
Decreased hours	33%
Sick Days/Vacation Time	64%

Source: The MetLife Juggling Act Study (1999)

A second factor affecting the needs of employed caregivers and their employers is the growth of older persons in the general population. Hawaii's older adult population (those 60 years and older) has grown faster than the older adult population nationally. Between 1990 and 2000, there was a 9% increase in older adults nationally. In contrast, the older adult population in Hawaii increased 19% during the same period.[14] Between 2000 and 2020, Hawaii's older adult population is projected to increase by 70%, a rate three times faster than Hawaii's total population.[15] The population of those 85 and older is projected to increase 93%, over four times faster than Hawaii's total population.[16]

In 2002, one in four adults in America was caring for an elderly family member or friend.[17] Because the majority of informal family caregivers also work outside the home while they manage caregiving responsibilities, many experts believe that the largest, single work-family issue is likely to be support for those who care for their elderly relatives. According to projections by the National Alliance for Caregiving, by 2007 the total number of employed caregivers in the United States is expected to reach nearly 15.6 million working Americans. That is roughly one in 10 employed workers who will need to take time off work to care for an elderly family member.[18]

There are also changing social trends that affect families' ability to care for their older relatives. These include the increased rate of divorce and remarriage, which contributes to family fragmentation and reduces spousal caregiving. Increased geographic mobility of family members can also result in long-distance caregiving. Delayed childbearing is also a factor in greater numbers of families who must care for their children and parents at the same time, even as they work to support themselves and their families.[19] If these and other national trends in informal caregiving continue as expected,[20] Hawaii and the nation will continue to face a protracted, long-term care crisis.

Needs of and Policy Strategies to Assist Employed Caregivers

Employed caregivers caring for elder relatives have multi-faceted needs, including needing flexibility and support at work. They report lower work performance, decreased physical well-being, and diminished levels of satisfaction at work and at home.[21] Their self-assessed specific needs[22] include:

(1) Easy and simple process to access resources and services;

(2) Management and coordination of care and services;

(3) Consultation and referral;

(4) Education and support;

(5) Respite from their responsibilities;

(6) Ease of time restraints and stress relief;

(7) Flexible hours or telecommuting; and

(8) Financial assistance.

Large employers have responded to employee needs by developing workplace eldercare programs. It is estimated that 25% of employers with more than 100 employees have some program to assist employees with caregiving responsibilities.[23] Workplace eldercare program models include resource and referral; education, including lunch and after work educational sessions, on-site libraries, and web-based material; and decision support, which includes geriatric care management services, elder law, and assistance with benefits such as insurance.[24]

In addition to private sector initiatives, there are also a number of federal, state, and labor union-sponsored programs that address some of the identified needs of employed caregivers. Four main policy strategies have emerged to support caregiving families[25] and employed caregivers:

(1) Direct services such as respite care;

(2) Financial incentives and compensation, including direct payments and tax incentives;

(3) The "cash-and counseling" model, which is an individualized budget option for Medicaid-funded personal assistance services that allows consumers to directly hire workers and purchase other services or goods; and

(4) Employer-based mechanisms, such as dependent care accounts.

Some of the needs of employed caregivers and examples of the policy strategies used to meet those needs are discussed below in the context of federal programs, state initiatives, labor union-sponsored caregiver support, and private sector best practices.

Federal Caregiver Support Initiatives

Until recently, federal public policy had not recognized or supported the service needs of families in their caregiving role, as long-term care systems and services have traditionally focused on the needs of care recipients. The federal government has recently played an increasingly important role in supporting family caregivers of older persons, primarily through the National Family Caregiver Support Program.

National Family Caregiver Support Program

The Older American Act Amendments of 2000[26] established an important new program, the National Family Caregiver Support Program (NFCSP). Developed by the Administration on Aging and the United States Department of Health and Human Services, the NFCSP was modeled in part after successful caregiver programs in states such as California, New Jersey, Wisconsin, and Pennsylvania.[27] The NFCSP serves family caregivers of older adults, as well as grandparents and relative caregivers of children. For federal fiscal year 2005, Congress appropriated $156 million for the NFCSP to be distributed to the states. Each state receives NFCSP funds under a formula allocation. States may use the funds to support services for: family caregivers of elderly persons; older individuals providing care to persons with developmental disabilities; and grandparents and other relatives who provide care for children 18 years of age and under.

Administered by the Executive Office on Aging (EOA) and locally through federally designated "area agencies on aging" that exist at the county level[28] and contracted service providers, the NFCSP offers various caregiver support services[29] such as:

(1) *Information*. Conduct public education in group settings and outreach services to identify potential caregivers and encourage them to explore service options to caregivers about available services;

(2) *Assistance.* Help caregivers gain access to supportive services through one- on-one contact either through information and referral or case management;

(3) *Counseling*. Provide individual and group counseling services, support groups, caregiver training to assist caregivers in making decisions and developing problem solving skills related to their roles;

(4) *Respite care*. Provide access for caregivers to get temporary relief from the daily responsibilities of caregiving; and

(5) *Supplemental care*. Home modifications and emergency response systems on a limited basis and other services to complement the care provided by caregivers.

Prior to the implementation of the NFCSP in 2000, no statewide caregiver support program existed in Hawaii.[30] Family caregivers, as opposed to just care recipients, now qualify for assistive technology, care management, cash grants, education, counseling, training, legal and financial consultation, home modification, personal and chore assistance, respite care, transportation and other support on a statewide basis through NFCSP-funded programs. For fiscal year 2005, the EOA served a total of 1,651 family caregivers statewide though NFCSP funds. During federal fiscal year 2006, Hawaii received $733,000 from the NFCSP.[31]

Family caregivers as new constituency. A 2002 study[32] of the NFCSP in 10 states found that family caregivers as a consumer or client population is a relatively new concept for many state units on aging, area agencies on aging, and home and community-based programs for

the aged and disabled. The 10 states studied (Alabama, California, Florida, Hawaii, Indiana, Iowa, Maine, Pennsylvania, Texas, and Washington) disagreed about whether family and informal caregivers should be considered clients or consumers in the long-term care system and whether they should have access to their own supportive services. Hawaii, Maine, and Texas viewed family caregivers as a "new constituency" and found the paradigm shift challenging.[33] Five of the states profiled (representing Alabama, California, Florida, Hawaii, and Maine) identified family caregivers as the primary client under the NFCSP.

Although Hawaii has no formal statute generally recognizing family caregivers[34] as a central component of a comprehensive long-term care system, state legislators have recognized the important contributions made by family caregivers and the need to support them to the extent possible in servicing the long-term care needs of the State's residents.[35] The Hawaii legislature also urged the departments of human services and health to develop methods to support family caregivers who provide at-home care to qualified relatives.[36]

Limited funding and workforce shortages affect employed caregivers. The study further found that, like other states who have emerging programs, Hawaii did not receive funds to operate the NFCSP at the state level. All of the funds were passed through to Hawaii's area agencies on aging at the county level.[37] The study noted that the two main challenges to developing and implementing caregiver support services are limited funding and workforce shortages.[38] Hawaii has faced a severe shortage of trained long-term care providers, particularly on the neighbor islands. A lack of trained social workers, nurses, and personal care workers may mean that qualified and trained personnel are not available to provide family caregivers with services to which caregivers are entitled under the NFCSP, including consultation and referral services, management and coordination of care and services, respite care, counseling, and education and support.

Grandparents caring for children. The NFCSP contains provisions for assisting grandparents who serve as caregivers for their grandchildren. Nationally, 2.4 million grandparents report they are responsible for their grandchildren who are living with them.[39] In 2000, there were 49,000 grandparents in Hawaii living with their grandchildren, 29% of whom were responsible for their grandchildren's basic needs (i.e. financially responsible for food, shelter, clothing, day care, etc).[40] Over half of the grandparents in Hawaii who are the primary caregivers of their grandchildren are in the labor force.[41]

Through the NFCSP, the Hawaii EOA, the Hawaii Caregiver Coalition, and a grant from the Brookdale Foundation, grandparents and relatives who are caregivers can receive assistance from the Relatives as Parents Program (RAPP). Operated by the EOA statewide, RAPP initiated two support groups under the sponsorship and support of local organizations that link programs and agencies to local communities.[42] RAPP also established an inter-system task force to address issues surrounding relatives as surrogate parents. It conducted at least one workshop in each county to educate grandparents and relatives about caregiving for children and organized educational opportunities by devoting space in a local, quarterly newsletter, *Family Caregiving*, to address the needs of relatives who are caring for children.[43]

Cash and Counseling Demonstration Program

Funded by the U.S. Department of Health and Human Services and the Robert Wood Johnson Foundation, the Cash and Counseling Demonstration Program began as a research demonstration pilot project for eligible Medicaid recipients in Arkansas, Florida and New Jersey. The program allows program participants to receive some or all of their Medicaid benefits in the form of a cash payment.[44] At a minimum, the programs permit consumers to have a direct employer-employee relationship with their personal care attendants, instead of requiring that attendant care, such as assistance with bathing, dressing, and other activities of daily living, be provided through professional agencies. Many of the programs also allow the care recipient to hire a family member (excluding spouses and legal guardians). Considered a model of "consumer-directed care," the program is currently operating in 15 states.[45]

Consumer-directed care is a philosophical approach that shifts the locus of decision-making from payers and providers to program participants and their families.[46] Consumer-directed care generally includes a variety of models and offers a range of options and control that family caregivers can exercise. The most common option is personal assistance from an aide or attendant who is hired, fired, and supervised directly by program participants or their families (instead of being required to use an employee of a licensed home care agency). This option helps employed caregivers in that it complements the care they are already providing and allows other family members or friends to be paid for providing supplemental care.

A second program model gives users and families an individualized monthly budget to purchase a broad range of services and supports, which include assistive technologies and home modifications, to decrease dependence on human assistance from paid or unpaid caregivers. Participants in cash and counseling programs do not literally receive cash payments, but manage their budgets via a bookkeeping service or fiscal intermediary which assures the third party payer (i.e. public-funded program or insurer)[47] of an independent accounting of how the funds are spent. The cash and counseling demonstration program also helps employed family caregivers by offering respite care as an option for purchase by their care recipients. Respite care provides temporary care for the Medicaid recipient, thus allowing the primary caregiver some short-term relief. All but six of the participating states (Arkansas, Delaware, Mississippi, Nevada, Pennsylvania, and Tennessee) allow payment to families to choose and hire respite care workers in at least one of their state-administered programs.[48]

Although the demonstration program has been controversial in the past, research has shown that paying other family members or friends to provide respite care does not lead to fraud and abuse but to better care. Care recipients reported higher satisfaction, better quality of life, fewer unmet care needs, better access to services and less nursing home use--without compromising health or safety or adding significant costs to Medicaid.[49] Research has also shown that the effects on family caregivers of consumer-directed systems have been positive.[50]

State-Initiated Caregiver Support Programs

Individual states have traditionally led the way in designing and financing strategies to help families in their caregiving role. Some states have continued to fund their own state-funded programs to complement NFCSP. At least six states--Delaware, Iowa, Michigan, New Jersey, Pennsylvania and West Virginia--use alternative funding sources, such as lottery or tobacco settlement funds, to support family caregivers. State revenues have been used to provide convenient and thorough access to information resources, establish public/private partnerships, and provide respite care. Some model programs in these areas are discussed below.

California Caregiver Resource Centers

Access to caregiver resources and services has been identified by employed caregivers as a critical need. Established in 1985, the state of California's Caregiver Resource Centers (CRC) is the first statewide state-funded program created for the purpose of providing support for family caregivers.[51] Administered by the California Department of Mental Health through a statewide resources consultant contract, the California CRC system is unique in that income level is not a criterion for eligibility of services.[52] Eleven not-for-profit resource centers provide education, respite care, planning, and support for families and friends who are caring for adults with chronic, disabling health conditions and disorders (e.g., Alzheimer's and Parkinson's diseases, stroke, traumatic brain injury). High priority is given to families caring for cognitively impaired adults who exhibit severe behavioral problems and for whom few respite resources exist.[53]

The California CRCs offer respite options, with care recipients being able to go to adult day care, in-home and institutional settings. Other services offered include weekend caregiver retreats, counseling, education and training, outreach, information and assistance, internet support services, comprehensive assessment of caregiver needs, care management, family consultation and meetings, legal and financial consultations, and transportation to caregivers.[54] There is no minimum age for caregivers to participate; however, the care recipients must be a minimum of 18 years of age and have a diagnosis of adult-onset cognitive disorder. The caregiver must also live with the care recipient to receive respite services.

Outreach to Employers

Many employed caregivers report difficulty getting the information they need for assessing quality services and selecting appropriate resources.[55] This is because most agencies that provide necessary services, such as home health care, adult day services or transportation and escort services, are only open during business hours on "regular" work days. Employed caregivers need to take time away from the job to make calls or visits in order to select providers or service options. However, implementing support programs in the workplace itself would help working caregivers by saving transportation time, providing in-depth information about community resources, and offering professional assistance to help employees make decisions about services, eligibility, and choices.

The majority of companies that offer workplace programs contract with private vendors who specialize in providing services to employees.[56] An exception is the New York City Department of Aging, a public sector organization that has been providing services to employers such as Phillip Morris, American Express, and J.P. Morgan since the mid-1980s.[57] This area agency on aging was one of the early "vendors" to large corporations seeking eldercare solutions for caregiving employees by developing a professional outreach program to area businesses.

Two jurisdictions that have broadened their scope of services to include large private sector employers and to actively seek participation in workplace eldercare programs are Atlanta and New Jersey. The Atlanta Regional Commission by the Aging Services Division not only provides resources and professional assistance to employers to support their caregiving employees, but other corporate services that assist employers to better manage an aging workforce. The commission's services range from: consulting with employees about care planning, caregiving decisions, and the complexities of related insurance and legal matters; providing seminars to employees about the multi-faceted issues of caregiving; and assisting with referrals to caregivers support groups and care management services.[58] New Jersey has implemented a program to increase the capacity of its area agencies on aging to reach out and support working caregivers through partnerships with local employers. They provide information about aging, community services and resources available from state and county offices.

Statewide Lifespan Respite Programs

Respite care is often the most requested family support service and is most typically funded by state government, usually as a specific service within a package of home and community-based services funded by Medicaid or state general revenues.[59] Respite has been shown to improve family functioning, preserve marriages, prevent abuse and neglect, and help avoid or delay more costly out-of-home placements, including nursing home stays and foster care. Yet respite for all age groups remains in critically short supply.[60]

Lifespan respite programs provide respite for the duration of the care recipient's lifespan. This approach utilizes a coordinated system of accessible, community-based respite care services for caregivers and is a venue to integrate federal, state, and local funding to ensure coordination of care for family and informal caregivers. Lifespan respite programs rely on a statewide, coordinated approach to ensure respite services by establishing community-based networks that depend on the development of local partnerships to build and ensure respite capacity. Local partnerships include family caregivers, providers, state- and federally-funded programs, area agencies on aging, non-profit organizations, health services, schools, local business, faith communities, and volunteers. These networks are the central point of contact for families and caregivers seeking respite.[61] Although there are numerous states that offer respite care assistance or have created coalitions to advocate this philosophy,[62] there are five states that currently offer statewide lifespan respite programs: Oregon, Nebraska, Wisconsin, Michigan, and Oklahoma.[63]

The Nebraska Lifespan Respite Program was launched in 1999 to provide assistance to individuals of any age who provide care for persons with any disease or disability who are unable to care for themselves. Six regional networks recruit respite providers, offer training for providers and consumers, provide information and referral, market availability and need for respite, match families with appropriate providers, and conduct program evaluation and quality assurance efforts. The networks identify where specific gaps in respite occur in their communities--such as families caring for someone with behavior disorders, emotional disturbances, or mental illness. Nearly 1,400 new respite providers have been recruited since the program began.

Families choose their own providers, decide how much to pay per hour or per day, and set their own schedules.[64] The subsidy is available to families who do not qualify for any other respite services. A respite subsidy of up to $125 per eligible family client per month can be saved for up to three months prior to use.[65]

Collaborations With the Health Care System

Although the negative effects of caregiving are well documented, physicians and other health care practitioners rarely identify and assist their patients who are caregivers or family members of care recipients.[66] States and their local area agencies on aging have pursued partnerships and collaborations with health care practitioners to identify family caregivers and inform them about caregiver support services. A barrier to promoting partnerships between two distinct but complementary systems--the aging network and health care providers--is the fragmentation of funding sources and the lack of training and information for health care practitioners to recognize and address family caregivers' support needs.

The Maine Primary Partners in Caregiving (MPPC) project was established in 2001 in four rural Maine counties. The MPPC is a partnership among Maine's primary care providers, area agencies on aging, and the University of Maine Center on Aging. It was based on the idea that caregivers will more likely utilize information, support, and training when need is validated by a trusted health care provider and assistance is personally tailored to their needs.[67] The MPPC identified caregivers through patient visits to local physicians, who then expedited referrals to caregiver support services for specialized services, education and training resources, and a statewide hotline. Over 8,000 caregiver status screenings were completed during routine visits to physician's offices over the life of the three-year project period.

The MPPC produced model education curricula for rural caregivers and primary care providers and a best-practice replication guidebook. An outcome evaluation component gauged caregiver well-being, service utilization patterns, quality of community partnerships, and caregiver profiling. Project evaluations have also confirmed that most caregivers needed primarily information, rather than intensive interventions and more expensive supports. Research appears to indicate that early intervention community supports may contribute to a decline in caregiver burnout and delay placement of an elderly family member in a long-term care facility.[68]

Another program that integrates health care providers and the aging network is the Making the Link: Connecting Caregivers With Services Through Physicians project, which is administered by the National Association of Area Agencies on Aging. It has been implemented at the community level by approximately 250 local area agencies on aging and Native American aging programs across the country.[69] Many physicians learn through their office visits that their patients are caregivers and are experiencing caregiver stress, but physicians are often unaware of community resources that are available to support this population.[70] The Making the Link project educates physicians about available community resources and support services, thus facilitating referral of their patients who are caregivers to such resources.

Labor Union-Sponsored Assistance to Caregivers

In the late 1980s, union negotiators put eldercare on the bargaining table and, as a result, dependent care accounts were set up to assist employees in paying for needed services.[71] The most common type of dependent care account allows employees to designate up to $15,000 to be deducted from their pay on a pre-tax basis. The funds would be used to reimburse employees for dependent care expenses such as costs incurred for caregiving. Some dependent care employee deductions are matched by employer contributions.

In 1990, the Communication Workers of America and the International Brotherhood of Electrical Workers created a national eldercare referral program.[72] The program helps employees locate, evaluate, and manage quality care for relatives age 60 and older. It also provides information and training for consumers and caregivers.[73]

The United Auto Workers and General Motors Corporation developed a joint task force of union and management representatives and outside consultants to help caregivers resolve their eldercare concerns.[74] The task force developed a program that offers resource and referral services to employees and their immediate family members though a third-party service provider. Employees can also telephone a toll-free eldercare response line and receive personal consultations, educational materials, and individualized referrals. There is also a home assessment component that allows an employee who is concerned about the health or safety of an elderly family member who lives far away to obtain an in-home assessment by a qualified health care professional who has personally observed the well-being of the elderly person.

In 1994 the Hotel Employees and Restaurant Employees Union Local 2 negotiated with the San Francisco Hotel Multi-Employer Group and won a child and elder care fund for its members.[75] Employers contribute 15 cents for every hour of employee work. Members taking care of an elderly parent or disabled adult receive a monthly cash reimbursement from the fund to help offset the costs of care. Resource and referral services are also available to all members who have work-family challenges.

Private Sector Best Practices

Because most American workers are employed by small companies, few have access to eldercare workplace programs.[76] Smaller employers are less likely to have formal workplace programs or to rely upon informal mechanisms to support the caregiving employee. Moreover, employed caregivers report that they are discouraged from taking advantage of flexible hours, leaves of absences or other options by non-supportive supervisors or coworkers. Research suggests the utilization rate of workplace programs is affected by the culture of the organization itself.[77]

The Families and Work Institute estimates that one in four employers with more than 100 employees has a program in place to assist employees with caregiving responsibilities. Private sector eldercare programs were modeled after programs in already in place for childcare. Corporate eldercare programs were primarily resource and referral programs designed to link workers with services in the community that would be helpful to older persons in need of assistance.

The first workplace eldercare program was started by Hallmark in 1986, when its Family Care Choices resource center was established.[78] IBM followed suit in 1988 with an eldercare program for its 260,000 employees. That same year the New York City Department on Aging began its first public/private partnership to provide workplace eldercare to Phillip Morris, American Express and J.P. Morgan employees.

In 1992, leading American corporations such as Abbott Laboratories, Deloitte and Touche Corporation, ExxonMobil, IBM Corporation, Johnson and Johnson, PricewaterhouseCoopers, and Texas Instruments formed the American Business Collaboration (ABC) for Quality and Dependent Care. The ABC Project members share expertise, information, leadership and financial resources to ensure their employees have access to quality eldercare and child care and support employees' ability to manage work and personal responsibilities.[79] Since its inception, the ABC Project has invested over $136 million for more than 1,500 eldercare and childcare projects.[80] Eldercare initiatives in various cities include bill paying and money management assistance, escorted transportation of elders, meals on wheels expansion, eldercare community and corporate fairs, and recruitment and training of in-home volunteers. Today the ABC project has expanded its services to include technical assistance, research on work-family issues, and recognition of model companies.

Conclusion

The growth of America's elderly population and the significant increase of women in the workforce will continue to have major impacts on caregivers and their employers. Employers must deal with the impact on employees who are caregivers, such as missed work, lower production levels, and financial strain. Support for employed caregivers range from workplace information and referral services, financial assistance through tax provisions, and employer-initiated programs.

Various states have led the way in publicly-funded caregiver support initiatives for caregivers. Federal programs have also tried to create comprehensive, accessible, and affordable caregiver support systems. Labor unions and the private sector have recognized the importance of supporting their employees who have caregiving responsibilities by creating workplace programs and financial incentives. More funding for workplace supports and expanded collaborations with community-based programs are needed to meet the challenges of Hawaii's and the nation's caregivers, particularly the multi-faceted needs of employed caregivers.

ENDNOTES

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voluntary, statewide partnership of public and private agencies called the Oklahoma Respite Resource Network. State agencies, including developmental disabilities, mental health, aging, maternal and child health and others, have come together voluntarily with private agencies and foundations to pool resources for respite and disburse them through a voucher program managed by a single state entity. The Network relies on an already existing statewide resource and referral system to link families to the program, respite services, and training opportunities.

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Chapter 4

CHILD CARE FOR WORKING FAMILIES

Introduction

Child care is an important part of the daily lives of many American families with young children. In 2002, there were 11.6 million children in the United States under the age of five who were typically in some type of regular child care arrangement every week.[1] Additionally, nearly two million children between the ages of 5 and 11 are home alone between the time school lets out and when their parents come home from work.[2] The demand for child care has continued to increase over the past 30 years, as women with children enter the workforce in greater numbers than ever before.[3] In response, policymakers have increasingly recognized that child care is an essential work support for families.

This chapter will consider issues surrounding the cost and quality of child care in the context of working families. It will review subsidized child care programs in Hawaii and compare various states' tax assistance initiatives. Selected states' efforts to improve the quality of child care and employee concerns with on-site and back up child care will also be discussed. Finally, child care best practices in the public and private sectors will be presented.

Background

For the purposes of this chapter, "child care" includes all types of education and care for young children from birth to age five and programs for school-aged children before and after school and during vacations. Child care also refers to a wide range of programs located in different types of facilities, under a variety of auspices, and with different hours of operation, from part day to full day.[4] Child care can be provided in child care centers, family and relatives' homes, schools, community centers, and on-site at workplaces. PATCH, Hawaii's statewide child care resource and referral agency, indicates that a variety of child care and early education programs[5] exist to meet the various needs of parents:

Family child care. This type of care is provided in the caregiver's home. The caregiver can provide care for up to six unrelated children, depending upon their ages. Hawaii law[6] provides that no more than two of the children can be under the age of 18 months. The child has a single caregiver in a home-like environment.

Child care centers. These centers include daycare nurseries, preschools, parent cooperatives, and drop-in child care centers. They provide more structure and the opportunity for children to interact with a larger number of children and adults.

Infant and toddler centers. Infant and toddler care emphasizes child-directed learning over adult-directed learning. Caregivers serve by learning from the individual infant or toddler what he or she needs, thinks, and feels.

Preschools. Preschools serve larger groups of children, have multiple caregivers, and undergo state inspections for health and safety requirements, and have more organized activities, equipment, and toys.

Head Start and Early Head Start. Head Start is designed to promote the growth and development of children from low-income families. Early Head Start provides learning and development services for families with children up to three years of age. This type of care can be given in a center or private home. The program also offers assistance to children with special needs, as well as career development and training for Head Start parents.

Before and after school programs. Before and after school programs are usually located in schools, child care centers, churches, or other settings that offer child care. They may or may not be licensed by the Sate depending upon their location. Care is usually provided to children from kindergarten through 6th grade before and after school and during school vacations and summer breaks.

Relative care or friend care. Care provided by a relative or friend of the family is not required to meet the State's child care licensing requirements. Providers can care for up to two children who are not related to them in addition to their own children or relatives. This type of care is attractive to parents because sometimes their schedules, budgets, or transportation problems limit their other child care options.

In-home care. This type of care, which is not regulated by the State, is provided in the child's home, and the provider is typically a nanny or au pair. Parents may find in-home care a more convenient arrangement that provides greater flexibility. If several children are involved, the cost of in-home care may not be significantly more expensive than other forms of care.

Cost and Quality of Child Care

Although child care is necessary for millions of families, it is also very expensive. The high cost of child care, especially high quality care, is out of reach for many families. In 2005, the National Association of Child Care Resource and Referral Agencies (NACCRRA) conducted a state-by-state comparison[7] of child care costs in America that underscores the high price of child care. The study revealed that a family with a four-year-old child encounters average prices of $3,016 to $9,628 a year in child care fees. In Hawaii, the annual average cost of child care for a four-year-old child is $5,620, which ranks the 36th highest among the 50 states.[8] The average child care fees for an infant are even more expensive, ranging from $3,803 to $13,480 a year.[9] Hawaii's average annual fee for infant care is $8,105, which ranks 23rd out of 50 states.[10]

To put the cost of child care in perspective, in every region of the United States, average annual child care fees for an infant are higher than the average amount that families spend on food each year.[11] In every state except Nevada, child care fees for two children at any age exceeded the state's median rent cost in 2004.[12] For low- and middle-income families with

children between the ages of three and five, child care is the largest expense after housing and food.[13]

The NACCRRA study further noted that high quality child care can be even more costly. Child care in an accredited facility can add as much as $5,000 more a year than non-accredited care. Research has shown that high quality child care, done in an environment that provides a safe, stable, developmentally appropriate, and stimulating environment, helps children to enter school prepared to learn.[14] Factors contributing to the quality of child care include whether a facility is accredited, what the staff to child ratio is, and the level of staff education and training. Research also shows that a ratio of one caregiver to 10 pre-school age children or less is recommended for quality care and learning.[15]

In 18 states, the ratio of caregivers for four-year-old children is 1 to 10 or less than 10.[16] In contrast, one caregiver can legally care for up to 18 four-year-old children in Georgia and South Carolina. In Hawaii, Alabama, and Mississippi, one caregiver can care for up to 16 four-year old children. However, in New York, the state in which child care is least affordable, one caregiver may not legally care for more than 8 four-year-old children.

The cost and quality of child care is largely determined by the type of facility and child care program offered. In states where the average price for child care is less, there are fewer caregivers per child. The NACCRRA study suggests that states with the least expensive care may also have a lower quality of care.[17]

Subsidized Child Care

For many families, market rate child care costs are out of reach. Child care subsidy programs can help low-income parents to pursue job training, employment opportunities, and economic self-sufficiency. Child care subsidy programs such as the federal Child Care and Development Fund (CCDF), formerly known as the Child Care Development Block Grant, provide resources for states to meet the needs of families receiving welfare, those that are in training or in the workforce, others making the transition from welfare to work, and low-income families who meet eligibility requirements.[18] The CCDF is the funding source for Hawaii's Child Care Connections Hawaii Program.

States also offer subsidies to child care providers or to families who can then access child care in a variety of settings. States fund child care through state matching funds for federal grants and through state general fund appropriations. About half of the states appropriate more money than is required for federal matching funds.[19] Hawaii's Preschool Open Doors program is a state-funded child care program. According to the National Conference of State Legislatures, states are spending more money than ever to provide for the increasing demand for child care assistance.

Subsidized Child Care in Hawaii

The Hawaii State Department of Human Services (DHS) administers the State's child care subsidy programs. The DHS is also responsible for registering and licensing persons and agencies that provide child care. All child care providers are subject to the provisions of section 346-151 through section 346-177, Hawaii Revised Statutes. Group child care homes and group child care centers must be licensed.[20] Persons operating or maintaining a "family child care home," which is defined as "a private home at which care is provided for three to six children" must be registered with DHS.[21] Licensing and registration requirements do not apply to persons caring for children related by blood, marriage, or adoption or where a person who cares for his or her own children also cares for up to two other children who are not related to the person.[22]

There are 422 licensed child care centers and 466 licensed family child care homes in Hawaii.[23] Of 31,162 child care spaces, 65% are located in child care centers and 8% in family child care homes. According to data collected by PATCH, Hawaii's child care programs are operating at capacity.[24] In follow-up calls with families, PATCH noted that 66% of parents reported that the primary reason for not being able to find child care is the lack of available openings.[25] In essence, Hawaii's child care programs are full.

PATCH also identified the average cost of child care as another barrier for working families. PATCH estimates that child care is the second largest expense to Hawaii families, aside from a mortgage or rent payment.[26] There are several local subsidy programs to assist families with the high cost of child care that are offered by the DHS and other private scholarships.

Child Care Connection Hawaii. Through its Child Care Connection Hawaii (CCCH) program located at seven statewide units, the DHS conducts child care licensing activities and provides child care subsidies to help low income families who meet income eligibility requirements to pay for child care. CCCH helps families with child care expenses, guidance in selecting a child care provider, information about quality child care programs, and referrals to community resources for help with other concerns.[27] Eligibility is based on family size and income. The child must also reside with a parent who is working or attending a job training or educational program.

Preschool Open Doors. Also supported by the DHS, the Preschool Open Doors (POD) program provides financial assistance to parents of 3- and 4-year-old children who are living at or below 75% of the state median income. POD's goal is to contribute to the school readiness of children who have special needs, for whom English is a second language or who are homeless. The program allows parents to send their children to a licensed child care facility during the school year prior to attending kindergarten. A higher subsidy is given if the facility is accredited by the National Association for the Education of Young Children for the National Early Childhood Program.

Child Care Assistance for Native Hawaiians. The federal Alu Like Native Hawaiian Child Care Assistance Project and the private Pauahi Keiki Scholars program offer child care services to children of Native Hawaiian ancestry and help to ensure quality care. The Alu Like

program provides subsidies for children of parents who work or go to school. The Pauahi Keiki Scholars program gives preference to Native Hawaiian children who must have been accepted in preschool programs that are qualified by Kamehameha Schools. Families must demonstrate financial need.

Head Start and Early Head Start. Other subsidized child care programs include Head Start and Early Head Start, which are funded by federal grant money and operated locally. Head Start and Early Head Start are comprehensive child development programs that serve children from birth to age five, pregnant women, and their families. These child-focused programs are aimed at increasing the school readiness of young children in low-income families and provide a range of services in the areas of: education and early childhood development; medical, dental, and mental health; nutrition; and parent involvement.[28]

Child Care in the Parks. The City and County of Honolulu's Child Care in the Parks program is an initiative that utilizes private and federal agencies as partners. Conceptualized in 1988 when affordable early education and care services were identified as a need for employees of the City and County of Honolulu,[29] the Child Care in the Parks program was the first employer-sponsored child care center in the State of Hawaii. The Early Education Center, its first site, was constructed on top of the municipal parking lot and is adjacent to the grounds of Honolulu Hale.

Seagull Schools, a private child care provider, currently operates the Early Education Center through a contract with the City and County of Honolulu. In addition to serving families that pay full tuition costs, Seagull Schools has an in-house scholarship program and accepts children whose parents have qualified for financial aid from Child Care Connections Hawaii, Pre-School Open Doors, Child Care Centers of Hawaii, and Pauahi Keiki Scholars. Children of City and County of Honolulu employees receive priority and currently make up 5 to 10 percent of students. The Center currently provides services to 264 children. A licensed and nationally accredited facility, the Center has a waiting list of 9 to 12 months.

The City and County of Honolulu has also partnered with Oahu Head Start - Honolulu Community Action Program to operate Child Care in the Parks at the following sites: Lanakila District Park, Swanzy Beach Park, Kauluwela District Park, Dole Playground, Halawa District Park, Waipahu District Park, Waianae District Park and Beretania Community Park. At these sites, the City and County of Honolulu requires the program operator to provide free or partially subsidized child care services to at least 50% of the children participating at each site.

The City has since worked with private developers to set aside parcels of land in housing developments that are located next to public or private parks. A tenth program site, the Maili Kai Child Care Center, will be located on the Leeward Coast.

University of Hawaii Child Care Programs. Another on-site child care center is the University of Hawaii at Manoa Children's Center (UHMCC) for two- to five-year-old children.[30] Funded by state general funds and program fees, the Center is available to the children of university students, staff, and faculty. Tuition fees are based on family size and monthly income. Financial assistance is only available to children of students. The UHMCC accepts financial aid

vouchers from Child Care Connections Hawaii, Pre-School Open Doors, Alu Like, and Pauahi Keiki Scholars. Established in 1987, UHMCC is an accredited facility that also serves as an observation and practicum site for University of Hawaii students and visitors. The center, which has already met its capacity of 100 children, currently has a waiting list. About 75% of the available slots are devoted to children of students and 25% for faculty and staff. [31] There are also child care centers at Honolulu, Kapiolani, Leeward, Kauai, and Hawaii Community Colleges.

Hawaii Pre-Plus Program. Child care for children of pre-kindergarten age is offered through the Hawaii Pre-Plus Program, which is a private-public partnership where state funds are used to construct facilities located at public elementary schools. Private preschool providers are then contracted by the Department of Education to operate these facilities. Launched in 2001, the Pre-Plus program is currently located at 16 public elementary schools.[32] It was established in recognition of the need for additional pre-kindergarten facilities. Pre-plus targets children ages three and four who are not currently attending preschool and has a preference for children whose family income falls at or below 200% of the federal poverty level.[33] The Department of Education and the Department of Human Services have contracted with Oahu Head Start - Honolulu Community Action Program to operate ten of the sites. The other three sites are operated by Seagull Schools, Kama`aina Care, and Parents and Children Together.

Hawaii After School Plus (A+) Program. The most expansive state-subsidized program for school-age child care is the Hawaii After School Plus (A+) Program.[34] Established in 1990 within the Department of Education, the A+ Program provides after-school care, including homework assistance, enrichment activities, and supervised recreational activities until 5:30 p.m. each school day during the regular school year. Over 190 elementary schools participate in the program. It is available statewide to all public elementary school children whose parents work, attend school, or are in job-training programs. Fees are determined on a sliding scale based upon the number of children enrolled, and participation fees are waived for eligible families receiving state aid.

Honolulu Summer Fun Program. About 11,000 children participate each summer in the City and County of Honolulu's Parks and Recreation-sponsored summer fun program.[35] The program runs approximately seven weeks at over 60 sites. While there is a registration fee, it is waived for eligible families receiving state aid.

Child Care Assistance Policies in Other States

The National Women's Law Center's 50-state analysis, *State Child Care Assistance Policies 2006: Gaps Remain, With New Challenges*, compares child care assistance policies from 2001 to 2006 in four policy areas:

(1) Income eligibility limits;

(2) Waiting lists for assistance;

(3) Co-payment requirements; and

(4) Reimbursement rates for providers or families.

Families must qualify for child care subsidies based on their income. Annual increases in income eligibility requirements for child care subsidies help low-income families from losing eligibility if their incomes increase to keep pace with inflation. Between 2005 and 2006, Hawaii was among states that raised their income eligibility limits enough to keep pace with or exceed increases in the federal poverty level.[36] However, between 2001 and 2006, less than one-third of the states increased their income eligibility levels enough to keep pace with or exceed increases in the federal poverty level.

In 2006, 18 states had waiting lists or had frozen intake for child care assistance, a slight improvement over 2005 and 2001. In 2005, there were twenty states that had waiting lists, compared to twenty-two states in 2001. Hawaii was not among these states. Hawaii did not have a waiting list of eligible families who applied for subsidized child care assistance in 2006, 2005, or 2001.[37] See Appendix C.

States usually require families receiving child care assistance to cover at least a portion of their child care costs in the form of a co-payment. Like most states, Hawaii has a sliding fee scale that requires families with higher income levels to contribute more than families at lower income levels. Co-payment polices are important because high co-payments can leave low-income families with significant out-of-pocket costs for care despite receiving child care assistance, or it can dissuade families from applying for assistance in the first place.[38]

Hawaii was one of 22 states whose co-payments remained the same as a percentage of income between 2005 and 2006. Between 2001 and 2006, Hawaii's co-payment remained the same, at 2% of an eligible family's income. Only one state, New Hampshire, had co-payments at less than 1% of an eligible family's income.[39] Hawaii's co-payment was $50, while New Hampshire's was $2. See Appendix D.

Individual states set the reimbursement rates they will pay to child care providers or families. These rates may vary by geographic region, age of the child, type of care, and other factors. For example, in Hawaii, only families, not providers, are reimbursed for child care fees. When reimbursement rates are set too low, it is difficult for families to find child care providers whose rates are comparable to their reimbursement limits. This situation contributes to the difficulty of working families to access child care and quality child care.

States are required, as a condition of federal funding for child care,[40] to conduct surveys every two years to determine providers' current market rates. This is so that children from low income families can have a better chance of accessing child care that is available to children of families with higher incomes. However, states are not required to regularly update their rates based on the survey they conduct or set their rates at any particular level.[41] The reimbursement level recommended in federal regulations[42] is set at the 75th percentile of the individual state's current child care market rates. This level is a benchmark that allows families to access 75 percent of the providers in their communities.[43]

In reviewing reimbursement rates, the National Women's Law Center report found that "states are particularly remiss in compensating providers that serve low-income children." The number of states that adequately reimburse child care providers dropped from 22 in 2001, to 13 in 2005, and to only nine in 2006.[44] The decrease in the number of states that reimburse providers at the 75th percentile of current child market rates has negative consequences for children, parents, and providers.[45] Although Hawaii did not meet the recommended reimbursement rates in 2006, 2005, or 2001, it was not far off compared to other states that also failed to meet this benchmark.

For example in 2005, Missouri's reimbursement rate in Saint Louis for center care for four-year-olds was only $331 per month, although the federally recommended rate was $660 per month. By way of comparison, Hawaii's reimbursement rate in 2005 was $500 a month.[46] With regard to infant care in 2005 for one-year-olds, center-based providers in Texas were reimbursed only $520 per month, which is far below the federally recommended rate of $851 per month. In contrast, Hawaii's reimbursement rate in 2005 for one-year olds in center-based care was $700 a month.[47] See Appendix E.

Other Financial Assistance For Child Care

There are limited options for families who do not qualify for subsidized child care because their income exceeds eligibility limits. PATCH, the State's child care resource and referral agency is not aware of any publicly-funded financial assistance program for families whose income exceeds child care subsidy income requirements.[48] PATCH notes, however, that some private providers may offer scholarships for child care, while other providers may accept payment plans. Federal and state tax provisions for child and dependent care can offer some financial assistance for families with their child care expenses.

Federal Tax Assistance

The federal child and dependent care tax credit (DCTC) is one of the largest sources of federal child care assistance.[49] The DCTC is available to parents who, in order to work or to look for work, pay for child care services for a dependent child under age 13 who lives with the tax filer.[50] Families may be able to reduce their federal income tax by claiming this credit on their tax returns. The credit is a percentage, based upon adjusted gross income, of the amount of work-related child and dependent care expenses paid to a care provider. The credit can range from 20 to 35% of a family's qualifying expenses, depending on their income. The federal credit is not refundable.[51] As of 2006, the DCTC provides a maximum of $2,100 for families with incomes under $15,000 and two or more dependents, and $1,200 for families with incomes under $43,000 with two or more dependents.[52]

State Tax Assistance

In 2006, the National Women's Law Center published *Making Care Less Taxing, Improving State Child and Dependent Care Tax Provisions*, a report that analyzed state child and dependent care tax provisions for tax year 2005. The report found that many states provide little or no tax assistance to families struggling to pay for child care.

Hawaii is among the twenty-seven states that offer child and dependent care tax relief. Most of these states provide a tax credit that is calculated as a percentage of the federal child and dependent care tax credit.[53] Like the federal DCTC, these credits are amounts that offset a taxpayer's state tax liability by reducing the amount of tax owed. Tax relief may also take the form of a deduction, which reduces the amount of income subject to the state tax and ultimately reduces the amount of state tax owed.

In a companion piece to its report on child and dependent care tax provisions, the National Women's Law Center (NWLC) issued a state-by-state report card ranking states on their tax assistance efforts for families struggling to pay for child and dependent care.[54] NWLC researchers analyzed state tax provisions to obtain the rankings, which were based on the following criteria: total dollar value of the tax break; refundability; targeted to or provides expanded assistance to low-income families; extent to which it covers the cost of care; indexing for inflation; coverage of both child and adult dependents; existence of provisions that promote high-quality care; and ease of use of the tax forms.

The NWLC report card gave the highest marks to New York's child and dependent care credit and Oregon's working family child care credit with grades of A-. New York offers a tax credit of up to $2,310, which is more than the federal DCTC. NWLC noted that Oregon's efforts improved from a grade B four years ago to an A- because the credit is now refundable. Like Hawaii's and Oregon's tax credit, New York's is also fully refundable, enabling low-income families with limited state tax liability to take full advantage of its benefits. The report card ranked Hawaii third, with a grade B+, along with California, Iowa, Minnesota, and Nebraska who also received a B+.

Hawaii and Oregon are among those who offer the most generous state tax assistance credits. Hawaii and Oregon are the only states that provide a tax credit for a portion of child and dependent care expenses whose amount is not determined by the federal DCTC.[55] Hawaii's credit is 15 to 25% of eligible child and dependent care expenses, up to $2,400 for one child or dependent and $4,800 for two or more children or dependents, for a maximum credit of $1,200, but that amount is further reduced by the amount excluded under the federal law.[56] Oregon’s tax credit is 8 to 40% of child care expenses, with no maximum credit amount. Both states have structured the credit so that lower-income tax filers receive the higher percentages.[57]

Best Practices in Child Care

Public Sector Model: The Department of Defense Child Care Program

While programs that are accessible only to specific populations, such as university students and staff, low- to moderate-income parents, or department of defense employees, are not available to a majority of families, they provide models for best practice approaches. One such program that has been acclaimed by numerous observers and child care practitioners as a model for the nation is the Department of Defense Child Care Program. A 2000 report from the National Women's Law Center (NWLC)[58] documents the dramatic turnaround in the military child care system and offers lessons on how improvements could be made in civilian child care systems. A follow up report in 2004[59] concluded that the military had continued to improve its model system, but that events in Afghanistan and Iraq have presented special challenges.

The initial challenge began in 1989, when Congress passed the Military Child Care Act[60] to improve the quality of care for the children of military families. The military child care system had been plagued by many deficiencies, including: lack of capacity to meet the needs of a changing workforce; unsafe and unsuitable facilities; reports of child abuse; lack of adequate standards or inspections; untrained, under-compensated staff; high staff turnover; and inability of parents to pay for care.[61] The Act prompted the military to develop a systemic approach to providing child care that simultaneously addressed quality, affordability, and availability.

In 1996 the military identified inspection and certification as the "single most important" aspect of the program and mandated accreditation for programs in military child care centers. This resulted in 95% of all military child development centers meeting rigorous national accreditation standards of the National Association for the Education of Young Children, in contrast to only eight percent of the civilian child care centers meeting accreditation standards.[62] Unlike the military child care systems, states do not generally require any of their child care programs to be accredited. Perhaps in response to the military's lead, the number of states that pay higher subsidies for child care providers who were accredited or met higher standards have increased from only 22 states in 2000, to 35 states in 2004.[63]

Child care fees were also kept affordable through a sliding scale at a rate below that of center-based civilian care. For example, a family whose annual income is below $28,000 pays between $43-59 per child per week. Assistance is also available to higher income families. A family whose annual income is $70,000 or more pays $107 to $126 per week. [64] Fee increases are also less than the rate of inflation.

To develop a stable, well-trained staff to produce high-quality child care, the military increased staff compensation and expanded comprehensive training. They offered rates of pay that were equivalent to other Department of Defense employees with comparable training, seniority, and experience. This compensation system was also extended to caregivers in student activity centers in a school or other off-site facility, thereby bringing in a range of school-age care providers. This resulted in turnover caregiver rates dropping to below 30% annually.[65]

Researchers also reported an increase in staff morale, professionalism, and commitment to early learning and care as a career.

The NWLC 2004 follow-up report found that, since the initial 2000 examination and report, the Department of Defense child care compensation system has kept pace with inflation. The NWLC report also found the child care program has continued to make progress despite new challenges. It noted that states in the civilian sector have made some progress in emulating several of the military's core strategies, but have suffered setbacks due to federal and state funding constraints. Additionally, advances in the civilian sector have tended to address individual child care issues rather than build on a comprehensive child care system, the way the military has done.[66]

Private Sector Models

In its October 2006 issue, Working Woman magazine ranked private employers' family-friendly offerings, including child care-related practices. In its list of 100 best companies that meet the needs of working mothers, Working Woman magazine used four criteria: access to company-sponsored full-time centers on-site or near the work site; access to before- and after-school care; access to back up care; and access to sick-child care. Several companies were lauded for the innovative ways in which they encourage access to child care information and referral services, provide financing assistance with child care, and assist with back up care, which is needed when a crisis or emergency occurs that unexpectedly leaves the parent without child care.

Employees of the American Express Company can take advantage of eight, free backup-care facilities throughout the country. The company allows employees to bring along their children when traveling on business to cities with available emergency child-care centers. Ernst & Young, a tax, accounting and financial services company in 140 countries worldwide, established a backup-care policy in 2005. More than 1,700 employees' children can use any of 4,600 centers and 1,000 in-home care agencies approved for use by Ernst & Young. At Accenture, a New York-based management consulting, technology, and outsourcing services company, 25% of its employees have children under the age of 12. Accenture employees can call a toll-free backup-care hotline for backup-care that costs $2 to $4 per hour. Staff who prefer to have a neighbor or friend look after their child are eligible for a $50 reimbursement per use.

Having options for child care when a child is sick is another concern of employed parents. At Grant Thornton, the company makes use of technology (i.e. laptops, videoconferencing, and BlackBerry personal digital assistants), along with flexible work arrangements for parents to work at home if their child is sick and they are unable to find back-up care.

Many of the company's on Working Woman's Top 100 companies offer on-site care and assistance with child care fees. At Harvard University, where more than 50% of its employees are women, on-site care and subsidies are provided. Employees may use any of the six university-affiliated on-site child care centers, five of which are accredited by the National Association for the Education of Young Children. In 2005, Harvard University distributed $1.2

million in child-care subsidies to employees. The IBM Corporation, with a history of family-friendly policies, sponsors 71 on-site or near-site full-day child-care centers. Fannie Mae, a financial services firm based in Washington, D.C., offers on-site day-care center for its employees' children ages six months to 12 years of age. The firm subsidizes 70% of that child care cost, with employees paying only $63 per week. The company also covers 75% of the cost for after-school care at 800 sites nationwide. Extra back up care can be paid for with up to $1,200 in vouchers annually per child.

Conclusion

The demand for child care has continued to increase over the past 30 years, as women with children enter the workforce in record numbers. Policymakers, employers, and communities have increasingly recognized that child care is an essential work support for families. The cost and quality of child care is largely determined by the type of facility and child care program offered by child care providers. Child care options include family child care, child care centers, infant and toddler centers, preschools, Head Start and Early Head Start, before and after school programs, relative care or friend care, and in-home care.

Although child care is necessary for millions of families throughout the country, it can also be very expensive. Federal child care subsidy programs can help low-income parents pursue job training, employment opportunities, and economic self-sufficiency. State funded child care programs also help families access child care in a variety of settings. Because of limited federal funds, individual states are spending more money than ever to provide for the increasing demand of child care assistance.

Hawaii's child care assistance policies for subsidized child care programs have kept pace with other states. Hawaii does not have a waiting list of eligible families who applied for subsidized child care. Hawaii was among states that raised their income eligibility limits between 2005 and 2006 to keep pace with increases in the federal poverty level. Hawaii was also among states whose co-payments required from families remained the same as a percentage of an eligible family's income, at 2%, from 2001 to 2006. Although Hawaii did not meet the federally recommended reimbursement rates to families for child care fees, it was not far off compared to other states that also failed to meet this benchmark. Hawaii is generally doing well in helping low income families with accessing child care.

However, families who do not qualify for subsidized child care have limited options. They can receive child care assistance through federal and state tax provisions for child and dependent care. A family may be able to reduce its federal income tax by claiming the federal child and dependent care tax credit, which is not refundable. Hawaii's child and dependent care tax credit is viewed as quite generous, compared to other states, because it is refundable.

Best practice models in child care can be found in the public and private sectors. The Department of Defense child care program has been acclaimed by numerous observers and child care practitioners as a model for the nation. The military used a systemic approach to providing child care by simultaneously addressing quality, affordability, and availability. Some states in

the civilian sector have made gains in emulating the Department of Defense's core strategies, but have suffered setbacks due to federal and state funding constraints. Employer-sponsored child care initiatives range from on-site care, extended care, back up care, financial assistance with child care, and flexible work arrangements to before- and after- school care.

ENDNOTES

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25. Ibid.
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27. Hawaii Department of Human Services website: www.hawaii.gov/dhs/dhs/self-sufficiency/childcare.
28. Ibid.
29. Email correspondence from Ernest Y. Martin, Chief Executive, Office of Special Projects, Department of Community Services, City and County of Honolulu, October 11, 2006.
30. Information from the University of Hawaii at Manoa Children's Center website: http://www.hawaii.edu/childrenscenter/.
31. Phone interview with Wayne Watkins, Director, University of Hawaii at Manoa Children's Center, October 12, 2006.
32. The Pre-Plus program sites at elementary schools on Oahu are: Aiea, Ewa, Fern, Jefferson, Kaala, Kailua, Kapolei, Kuhio, Salt Lake, Wahiawa, Waiau, Waimanalo, Waipahu; Lihikai on Maui; and Keonepoko and Mountain View on the island of Hawaii. Construction is scheduled to begin on Kilauea Elementary School on Kauai.
33. Hawaii State Department of Human Services, Pre-Plus Information Sheet, August 8, 2006.
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35. Ibid.
36. Ibid., p 3.
37. Ibid., Table 2: Waiting Lists for Child Care Assistance, p. 13.
38. National Women's Law Center, *State Child Care Assistance Policies 2006: Gaps Remain, With New Challenges Ahead*, Issue Brief, September 2006, p. 5.
39. Ibid., Table 3A: Parent Copayments for a Family of Three With an Income at 150 Percent of Poverty and One Child in Care, p. 15,

40 45 Code of Federal Regulations, Parts 98 and 99.

41 National Women's Law Center, *State Child Care Assistance Policies 2006: Gaps Remain, With New Challenges Ahead*, Issue Brief, September 2006, p. 6.

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44 Ibid.

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61. Ibid., pp. 5-8.

62. Nancy Duff Campbell, et al, *Be All That We Can Be, Lessons From The Military For Improving Our Nation's Child Care System*, National Women's Law Center, April 2000, p. 2.

63. Kate Pomper, et al, *2004 Follow-Up, Be All That We Can Be, Lessons From The Military For Improving Our Nation's Child Care System*, National Women's Law Center, 2005, p. 7.

64. Ibid.

65. Jennifer Moon and John Burbank, *The Early Childhood Education Career And Wage Ladder: A Model for Improving Quality in Early Learning and Care Programs*, Economic Opportunity Institute, July 2004, p. 22.

66. National Women's Law Center, "Military Child Care Continues to Serve as Model for the Country, Budget Constraints Slow Improvements in Civilian Sector," News Release, August 10, 2005.

Chapter 5

CONCLUSION

Policymakers have long recognized the importance of work supports that help employees meet the demands of work, personal, and family responsibilities. With record numbers of women in the workforce and the significant growth of the elderly population, communities have advocated for laws and policies to help families deal with issues relating to family leave, caregiver support, and child care.

Family leave legislation in the United States has its roots at the state level. Hawaii's family, medical, maternity, maternity disability, and parental leave policies appear to be among the most generous when compared to most states. Hawaii is one of five states whose definition of "parent" is more expansive than the federal Family and Medical Leave Act's definition of a parent for whose illness an employee may take family leave. Hawaii also requires public and private sector employers to allow their employees to substitute their sick leave to care for certain ill family members.

Hawaii also is among five states that have state-administered temporary disability insurance programs to provide partial wage replacement for employees who are temporarily disabled for medical reasons, including pregnancy and childbirth. In a state-by-state analysis of parental leave programs, the National Partnership for Women and Families ranked Hawaii second only to California, which is the only state in the nation that offers paid family leave benefits. If the legislature would like to expand Hawaii's leave laws, paid family leave would be an option--although to date, only California has taken this step.

Caregiving is another area of growing concern for working families. In 2002, one in four adults in America was caring for an elderly family member or friend. Because the majority of caregivers work outside the home while they manage caregiving responsibilities, many experts believe that the largest, single work-family issue is likely to be support for those who care for their elderly relatives. Employed caregivers report lower work performance, decreased physical well-being, and diminished levels of satisfaction at work and at home.

The federally-funded National Family Caregiver Support Program, modeled after successful caregiver support programs in individual states, helps family caregivers of elderly persons, older individuals providing care to person with developmental disabilities, and grandparents and other relatives who provide care for children 18 years of age and under. For some states, family caregivers as a consumer or client population is a relatively new concept. Hawaii, like other states who have emerging caregiver support programs, faces major challenges with limited funding and workforce shortages.

Policy strategies that support caregiving families and employed caregivers include respite care, financial incentives and compensation, and consumer-directed budget options that allow caregivers to directly hire workers and purchase others services or goods. California's caregiver resource centers, Nebraska's lifespan respite programs, and Maine's collaboration with the health

care system through its Primary Partners in Caregiving project are considered models of caregiver support programs. There are also a number of labor union-sponsored assistance programs for employees who are caregivers and corporate initiatives developed by private employers. As the population continues to age, solutions to the multi-faceted needs of employed caregivers will likely become a critical component of any state's comprehensive long-term care system.

Child care is an essential element in the daily lives of many American families with young children. The cost of quality child care is out of reach for many families. Federally-funded child care subsidy programs provide resources for states to meet the needs of families receiving welfare, those that are in training or in the workforce, others making the transition from welfare to work, and low-income families who meet eligibility requirements. States also use their general funds to offer subsidies to child care providers or to families who can then access child care in a variety of settings. There are limited options for families who do not qualify for child care because their income exceeds eligibility limits. Federal and state tax provisions for child and dependent care can offer some financial assistance with child care expenses.

A national model is the Department of Defense child care program, which was the result of a systemic approach to providing child care that simultaneously addressed quality, affordability, and availability. The military mandated accredited child care programs, increased staff compensation, expanded comprehensive training, and kept fees affordable. Large corporations in the private sector also offer a range of child care initiatives to their respective employees. States may want to consider ways to incorporate elements of the military's and the private sector's successes in expanding access to quality child care.

THE SENATE
TWENTY-THIRD LEGISLATURE, 2006
STATE OF HAWAII

JAN 27 2006

S.C.R. NO. 13

SENATE CONCURRENT RESOLUTION

REQUESTING THE GOVERNOR TO CONVENE A WORK-FAMILY TASK FORCE TO REVIEW HAWAII'S WORK-FAMILY LAWS AND POLICIES, AND REQUESTING THE LEGISLATIVE REFERENCE BUREAU TO STUDY OTHER STATES' LAWS AND PRACTICES THAT PROMOTE GOOD WORK-FAMILY POLICY.

WHEREAS, working families bear two important responsibilities, often referred to as work-family issues, which are caring for family members and earning the income needed to support their families; and

WHEREAS, working families are headed by individuals of all ages, requiring many different types of caregiving responsibilities and preferences for employment; and

WHEREAS, working families with young children have patent work-family challenges as they must provide for the care of their children; and

WHEREAS, many working families have responsibilities for family members with extraordinary needs, including children with special needs, adults with disabilities, and dependent elders; and

WHEREAS, presently, a growing number of working families include single parent families, parents who share custody of their children, and single individuals who help to care for relatives and older adults; and

WHEREAS, conflicts over work-family issues will often enter the workplace, becoming issues of concern to employers; and

WHEREAS, examples of work-family issues that manifest themselves out of the workplace are employees who may miss work when unable to make arrangements for unexpected or unusual family needs or become preoccupied with work-family issues and consequently are unable to focus on work; and

WHEREAS, additionally, some employees who want or need to work full-time may decide to cut back on work hours or completely leave the workforce because they cannot meet the demands of both caring for a family and working full-time; and

WHEREAS, many states, including Hawaii, have enacted a multitude of laws which support state policies that seek to assist families with work-family issues in order to develop a sustainable and successful economy through workforce development; and

WHEREAS, some of the issues addressed in these state policies include the provision of child care and afterschool programs, employer strategies for easing work-family tensions, family and medical leave, flextime, and family care for older relatives; and

WHEREAS, although programs and policies are in place within the State to address work-family issues, the extent of the success or failure of the implementation of these programs and policies is unclear; now, therefore,

BE IT RESOLVED by the Senate of the Twenty-third Legislature of the State of Hawaii, Regular Session of 2006, the House of Representatives concurring, that the Governor is requested to convene a Work-Family Task Force consisting of representatives from the executive and judicial agencies, community coalitions, and private entities that deal directly with working families, to review Hawaii's work-family laws and policies; and

BE IT FURTHER RESOLVED that the Legislative Reference Bureau is requested to study other states' laws and practices identified as promoting good work-family policy; and

BE IT FURTHER RESOLVED that the Legislative Reference Bureau and the Work-Family Task Force are each requested to submit a separate report of findings and recommendations, including any proposed legislation, to the Legislature no later than twenty days prior to the convening of the Regular Session of 2007; and

S.C.R. NO. 13

BE IT FURTHER RESOLVED that certified copies of this Concurrent Resolution be transmitted to the Governor and Acting Director of the Legislative Reference Bureau.

OFFERED BY: Suzanne Chun Oakland

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APPENDIX B

Source: National Conference of State Legislatures, January 2006

State Family and Medical Leave Laws

The following table identifies state family and medical leave laws, qualifying employers and amount of leave offered. Some states have enacted rules and regulations regarding family and medical leave laws that are not included in this table.

State/Citation	Public Sector	Private Sector	Type of Leave
Alabama § 36-27-58	X		**Maternity:** an active and contributing member of the public Employees' Retirement System may purchase service credit in the system not to exceed one year for any period of time while he or she is on maternity leave from service without pay
Alaska §39-20-305	X		**Family and medical:** a public employer is required to offer 18 workweeks during any 24 month period for pregnancy, childbirth or adoption and to care for an ill spouse, child, parent or because of the employees own serious health condition
Arizona §41-783	X		**Family and medical:** public employees may share leave to care for a family member suffering from incapacitating or severe illness
Arkansas §21-4-209	X		**Maternity:** a public employee may use accumulated sick and annual leave for a pregnancy after which leave without pay may be used.
California Government Code §12945.2	X	X	**Family and medical:** public employers and private employers of 50 or more employees are required to offer 12 weeks in any 12 month period for leave to care for the birth or adoption of a child or upon the serious illness of the employee, a child, spouse or parent; employees who are temporarily disabled for medical reasons, including pregnancy and childbirth, can receive partial wage replacement through the state's Temporary Disability Insurance (TDI) program
Colorado §19-5-211	X	X	**Maternity:** all employers that offer benefits for the birth of a child must offer equivalent benefits for the adoption of a child
Connecticut §5-248a	X	X	**Family and medical:** public employers must offer 24 weeks of unpaid leave within any two year period to care for the birth or adoption of a child or upon the serious illness of the employee, a child, spouse or parent

State/Citation	Public Sector	Private Sector	Type of Leave
§31-51kk		X	**Family and medical:** private employers of 75 or more employees are required to offer 16 weeks in any 24 month period to care for the birth or adoption of a child or upon the serious illness of the employee, a child, spouse or parent
Delaware 29 Del. C 5120	X	X	**Maternity:** public employers are required to offer six weeks of leave for the adoption of a child
District of Columbia §32-502 §32-503	X	X	**Family and medical:** all employers are required to offer 16 weeks of family leave during any 24 month period for birth or adoption of a child or upon serious illness of the employee, a child, spouse or parent
§32-1201	X	X	**Family:** all employers are required to offer parental leave to participate in a child's school activities
§1-612.31	X		**Family:** public employees may transfer annual or universal leave through a leave bank, which may then be drawn upon and used for parental leave, sick leave, or to care for a seriously ill family member
Florida §2001-Ch0110-Section%20221"110.221	X		**Family and medical:** public employers are required to offer no more then six months for birth or a adoption of a child or upon serious illness of the employee, a child, spouse or parent
Hawaii §398-1	X	X	**Family and medical:** public employers and private employers of 100 or more are required to offer four weeks of family leave during any calendar year for the birth or adoption of a child or upon serious illness of the employee, a child, spouse or parent; employees who are temporarily disabled for medical reasons, including pregnancy and childbirth, receive partial wage replacement in the form of Temporary Disability Insurance (TDI) benefits
Illinois 5 ILCS 400/10 820 ILSC 147/1 et seq	X		**Family and medical:** public employees may sick leave to a leave bank, to be used for future sick leave; employees must use up all other types of leave prior to using leave from the leave bank. All employers with 50 or more employees must allow 8 hours of unpaid leave annually to employees to attend school activities of their children; however, all acrued leave other than sick and disability leave must be exhausted before school-related leave is granted; employers are required to make a good-faith effort to allow the employee to make up the time taken for school-related leave.
Indiana §5-10-6-1	X		**Family and medical:** public employees with sick leave may use this leave to care for certain sick family members
Iowa §70A-23	X		**Family and medical:** public employees with sick leave may use this leave to care for certain sick family members

State/Citation	Public Sector	Private Sector	Type of Leave
Kansas §75-5549	X		**Family and medical:** public employees may share leave to care for a family member suffering from extraordinary or severe illness
Kentucky §18A-197	X		**Family and medical:** public employees may use donated leave to care for a family member for at least ten consecutive working days
Maine 26 M.R.S.A. §843	X	X	**Family and medical:** public employers and private employers of 15 or more employees are required to offer 10 consecutive work weeks of leave in any two years for the birth or adoption of a child or upon serious illness of the employee, a child, spouse or parent
26 M.R.S.A. §636	X	X	**Family and medical:** public employers and private employers of 25 or more employees are required to offer 40 hours in a 12 month period to care for immediate family member
Maryland §9-1001	X		**Family and medical:** requires the implementation of the federal family and medical leave act
§3-802		X	**Maternity:** an employer who provides paid leave to an employee after the birth of a child must provide equivalent leave if an employee adopts a child
Massachusetts 149 §52D	X	X	**Family:** public employers and private employers of 50 or more employees are required to offer 24 hours of leave during any 12 month period to participate in the school activities of the employees children, to accompany children to routine medical appointments and to accompany an elderly relative to routine medical appointments
149 §105d	X	X	**Maternity:** public employers and private employers of six or more employees are required to offer eight weeks of leave for the purpose of giving birth or adopting a child
Michigan §38.1376	X		**Maternity:** employees of the public school system may purchase service credits for maternity or paternity leave
Minnesota §181.941	X	X	**Family:** private employers and public employers of 21 or more employees are required to offer six weeks of leave for birth or adoption of a child
§119B.035	X	X	**Family:** provides low-income families with some wage replacement when one parent chooses to stay at home to care for an infant child; families can receive up to ninety percent of the maximum subsidy payable for an infant in family child care

State/Citation	Public Sector	Private Sector	Type of Leave
§181.9412	X	X	**Family:** public employers and private employers of 21 or more employees are required to grant an employee leave of up to a total of 16 hours during any 12-month period to attend school conferences or school-related activities of the employee's child
Mississippi §25-3-95	X		**Family and medical:** public employees may accrue leave for the illness or injury of an employee or member of the employee's immediate family; agencies of more than 500 employees are allowed to use up to 90 days of donated leave
Missouri §105.271	X		**Family:** public employers are required to allow an employee to use sick or accrued leave to attend to the adoption of a child
Montana §2-18-606	X		**Family:** public employers are required to offer no more then 15 days of sick leave for the birth or adoption of a child
§49-2-310		X	**Maternity:** private employers are required to permit a reasonable leave of absence and permit the use of sick leave immediately following the birth or placement of a child
§52-2-710	X	X	**Family:** provides low-income families with some wage replacement when one parent chooses to stay at home to care for an infant child; families can receive up to ninety percent of the maximum subsidy payable for an infant in family child care
Nebraska §48-234	X		**Maternity:** a public employer who provides paid leave to an employee after the birth of a child must provide equivalent leave if an employee adopts a child
New Hampshire §100-A:9-a	X		**Family and medical:** any person on leave under the federal family and medical leave act is considered eligible for death or disability benefits
New Jersey §34:11 B-2	X		**Family and medical:** public employers of 50 or more employees are required to offer no more than 12 weeks of paid, unpaid (or some combination of unpaid and paid) leave in any 24-month period.
§43:21-25	X	X	**Family and medical:** employees who are temporarily disabled for medical reasons, including pregnancy and childbirth, receive partial wage replacement in the form of temporary disability insurance (TDI) benefits
New Mexico §10-7-10			**Family and medical:** public employees may use an unlimited amount of accrued sick leave to care for certain sick family members

State/Citation	Public Sector	Private Sector	Type of Leave
New York Labor Law §201-c	X		**Family:** prohibits discrimination of child-care leave in cases of adoption
North Carolina §95-28.3	X	X	**Family:** all employers are required to offer leave up to four hours per year for parent involvement in schools
North Dakota §54-52.4-02	X		**Family:** public employers are required to offer 16 weeks to care for the birth or adoption of a child and to care for a sick spouse or child
Ohio §124.136	X		**Maternity:** public employers are required to offer employees six weeks of leave for birth or adoption of a child
Oklahoma §74-840-2.22	X	X	**Family and medical:** implements federal family and medical leave act
Oregon §659A.153	X	X	**Family and medical:** public employers and private employers of 25 or more employees are required to offer 12 weeks of family leave within any one year period to care for the birth or adoption of a child or upon the serious illness of the employee, a child, spouse or parent
Rhode Island §28-48-1	X	X	**Parental and family medical:** all public employers of 30 or more employees and private employers of 50 or more employees are required to offer 13 weeks of leave in any two calendar years to care for the birth or adoption of a child or upon the serious illness of a child, spouse or parent
§28-48-8	X	X	**Family:** covered employees are entitled to partial wage replacement for up to 30 weeks if they are unable to work for medical reasons, including pregnancy or childbirth.
South Carolina §8-11-40	X		Family and medical: public employees may use up to 10 days of sick leave to care for immediate family.
Tennessee §4-21-408	X	X	**Maternity:** public employers and private employers of 8 or more must offer female employees 16 weeks for childbirth
§8-50-806	X		**Family:** public employers must offer employees six weeks for the adoption of a child
Texas Govt. Code §661.912	X	X	**Family and medical:** implements federal family and medical leave act
Vermont 21 V.S.A §470	X	X	**Family and medical:** public employers and private employers of 30 or more employees are required to offer 12 weeks in a 12 month period to care for the birth or adoption of a child or upon the serious illness of the employee, a child, spouse or parent

State/Citation	Public Sector	Private Sector	Type of Leave
21 V.S.A. §472a	X	X	**Family:** public employers and private employers of 30 or more employees are required to offer leave to participate in the school activities of the employees children, to accompany children to routine medical appointments and to accompany an elderly relative to routine medical appointments
Virginia §51.1-1108	X		**Family and medical:** public employers are required to allow employees the use of sick leave for incident, illness, or death of a family member or other personal need
Washington §49.78.005	X	X	**Family and medical:** public employers and private employers of 100 or more employees are required to offer 12 weeks in any 24 month period for the birth or adoption of a child or to care for a child under 18 years old with a terminal health condition
West Virginia §21-5D-1	X		**Family:** public employers are required to offer 12 weeks during a 12 month period following the exhaustion of annual and paid leave to care for birth or adoption of a child or upon the serious illness of the employee, a child, spouse or parent
Wisconsin §103.10	X	X	**Family and medical:** public employers and private employers of 50 or more employees are required to offer six weeks in a 12 month period for birth or adoption of a child and two weeks in a 12 month period for a severe illness of an employee; employees covered by and eligible for the state's family and medical leave law may elect to substitute any type of accrued paid leave they may have for the job-protected leave specified under that law

TABLE 2: WAITING LISTS FOR CHILD CARE ASSISTANCE

State	Number of children or families on waiting lists as of early 2006	Number of children or families on waiting lists as of early 2005	Number of children or families on waiting lists as of December 2001
Alabama*	9,408 children	13,260 children	6,089 children
Alaska	No waiting list	No waiting list	588 children
Arizona	No waiting list	No waiting list	No waiting list
Arkansas*	1,761 children	517 families	8,000 children
California*	280,000 children (estimated)	280,000 children (estimated)	280,000 children (estimated)
Colorado*	Waiting lists at county level	602 families	Waiting lists at county level
Connecticut	No waiting list	No waiting list	Frozen intake
Delaware	No waiting list	No waiting list	No waiting list
District of Columbia*	No waiting list	1,483 children	9,124 children
Florida*	53,965 children	39,677 children	46,800 children
Georgia*	10,250 families (and frozen intake)	17,600 families	16,099 children
Hawaii	No waiting list	No waiting list	No waiting list
Idaho	No waiting list	No waiting list	No waiting list
Illinois	No waiting list	No waiting list	No waiting list
Indiana*	4,125 children	7,975 children	11,958 children
Iowa	No waiting list	No waiting list	No waiting list
Kansas	No waiting list	No waiting list	No waiting list
Kentucky	No waiting list	No waiting list	No waiting list
Louisiana	No waiting list	No waiting list	No waiting list
Maine	2,010 children	2,025 children	2,000 children
Maryland*	No waiting list	19,674 children	No waiting list
Massachusetts*	16,479 children	13,563 children	18,000 children
Michigan	No waiting list	No waiting list	No waiting list
Minnesota*	4,876 families	859 families	4,735 children
Mississippi*	107 children	478 children	10,422 children
Missouri	No waiting list	No waiting list	No waiting list
Montana	No waiting list	No waiting list	Varies by resource and referral district
Nebraska	No waiting list	No waiting list	No waiting list
Nevada	No waiting list	No waiting list	No waiting list
New Hampshire	No waiting list	No waiting list	No waiting list
New Jersey*	4,803 children	6,994 children	9,800 children
New Mexico	No waiting list	No waiting list	No waiting list
New York*	Waiting lists at county level	Waiting lists at county level	Waiting lists at county level
North Carolina	37,195 children	15,871 children	25,363 children
North Dakota	No waiting list	No waiting list	No waiting list
Ohio	No waiting list	No waiting list	No waiting list
Oklahoma	No waiting list	No waiting list	No waiting list
Oregon	No waiting list	No waiting list	No waiting list
Pennsylvania*	7,353 children	2,929 children	540 children
Rhode Island	No waiting list	No waiting list	No waiting list
South Carolina	No waiting list	No waiting list	No waiting list
South Dakota	No waiting list	No waiting list	No waiting list
Tennessee*	14,273 children (and frozen intake)	Frozen intake	9,388 children (and frozen intake)
Texas*	33,506 children	22,045 children	36,799 children
Utah	No waiting list	No waiting list	No waiting list
Vermont	No waiting list	No waiting list	No waiting list
Virginia*	9,462 children	4,819 children	4,255 children
Washington	No waiting list	No waiting list	No waiting list
West Virginia	No waiting list	No waiting list	No waiting list
Wisconsin	No waiting list	No waiting list	No waiting list
Wyoming	No waiting list	No waiting list	No waiting list

* indicates notes found on page 14.

NATIONAL WOMEN'S LAW CENTER

TABLE 3B: PARENT COPAYMENTS FOR A FAMILY OF THREE WITH AN INCOME AT 100 PERCENT OF POVERTY AND ONE CHILD IN CARE

State	Monthly fee in 2006		Monthly fee in 2005		Monthly fee in 2001		Change 2005 to 2006		Change 2001 to 2006	
	As a dollar amount	As a percent of income	As a dollar amount	As a percent of income	As a dollar amount	As a percent of income	In dollar amount	In percent of income	In dollar amount	In percent of income
Alabama	$67	6%	$65	5%	$65	5%	$22	1%	$22	1%
Alaska	$14	1%	$13	1%	$14	1%	$1	0%	$0	0%
Arizona	$65	5%	$99	7%	$68	5%	-$34	-3%	$0	-1%
Arkansas*	$84	6%	$0	0%	$0	0%	$84	6%	$84	6%
California	$0	0%	$0	0%	$0	0%	$0	0%	$0	0%
Colorado	$140	10%	$122	9%	$113	9%	$18	1%	$27	1%
Connecticut	$65	4%	$59	4%	$49	4%	$1	0%	$6	0%
Delaware	$104	8%	$60	4%	$55	5%	$44	3%	$49	3%
District of Columbia	$35	3%	$53	4%	$32	3%	-$18	-1%	$3	0%
Florida*	$87	6%	$134	10%	$69	6%	-$47	-4%	$18	1%
Georgia	$120	9%	$78	6%	$21	2%	$43	3%	$99	7%
Hawaii	$0	0%	$0	0%	$0	0%	$0	0%	$0	0%
Idaho	$103	7%	$103	8%	$65	5%	$0	0%	$38	2%
Illinois	$65	5%	$65	5%	$134	11%	$0	0%	-$69	-6%
Indiana*	$71	5%	$0	0%	$0	0%	$71	5%	$71	5%
Iowa*	$20	1%	$22	2%	$22	2%	-$2	0%	-$2	0%
Kansas	$22	2%	$22	2%	$22	2%	$0	0%	$0	0%
Kentucky	$100	7%	$100	7%	$97	8%	$0	0%	$3	-1%
Louisiana*	$91	7%	$163	12%	$68	4%	-$72	-6%	$46	3%
Maine	$110	8%	$80	6%	$97	8%	$30	2%	$13	0%
Maryland*	$161	11%	$119	9%	$80	7%	$39	2%	$81	4%
Massachusetts	$90	7%	$60	4%	$40	3%	$30	2%	$50	3%
Michigan	$36	2%	$29	2%	$36	2%	$8	0%	$0	0%
Minnesota	$45	3%	$53	4%	$5	<1%	-$9	-1%	$40	3%
Mississippi*	$65	5%	$65	5%	$47	4%	$0	0%	$18	1%
Missouri	$88	6%	$66	5%	$43	4%	$22	1%	$45	3%
Montana	$35	4%	$32	4%	$40	4%	$3	0%	$0	0%
Nebraska*	$53	4%	$52	4%	$30	2%	$1	0%	$23	1%
Nevada	$65	4%	$29	2%	$0	0%	$36	2%	$65	4%
New Hampshire	$1	<1%	$1	<1%	$0	0%	$1	0%	$1	0%
New Jersey	$99	7%	$95	7%	$71	6%	$3	0%	$18	1%
New Mexico	$57	4%	$54	4%	$47	4%	$3	0%	$10	0%
New York*	$17	1%	$0	0%	$4	<1%	$16	1%	$13	1%
North Carolina	$138	10%	$134	10%	$106	9%	$4	0%	$32	1%
North Dakota	$169	13%	$169	13%	$135	13%	$0	0%	$22	0%
Ohio	$99	7%	$137	10%	$43	4%	-$38	-3%	$56	4%
Oklahoma*	$82	7%	$107	8%	$54	4%	-$17	-1%	$28	2%
Oregon	$141	10%	$129	10%	$90	7%	$12	1%	$51	3%
Pennsylvania	$87	6%	$83	6%	$65	5%	$7	0%	$22	1%
Rhode Island	$14	1%	$13	1%	$0	0%	$1	0%	$14	1%
South Carolina	$39	3%	$36	3%	$48	4%	$3	0%	-$9	-1%
South Dakota	$0	0%	$0	0%	$0	0%	$0	0%	$0	0%
Tennessee	$82	6%	$79	6%	$39	3%	$3	1%	$43	3%
Texas*	$125–$180	9%–13%	$121–$174	9%–13%	$109–$170	9%–14%	$4–$6	0%	$10–$16	-1%–0%
Utah	$16	1%	$39	2%	$36	3%	-$23	-2%	-$20	-2%
Vermont	$0	0%	$18	1%	$0	0%	-$18	-1%	$0	0%
Virginia	$136	10%	$134	10%	$122	10%	$4	0%	$16	0%
Washington	$50	4%	$50	4%	$20	2%	$0	0%	$30	2%
West Virginia	$43	3%	$60	4%	$27	2%	-$16	-1%	$16	1%
Wisconsin	$74	5%	$73	5%	$61	5%	$1	0%	$13	0%
Wyoming	$10	1%	$11	1%	$10	1%	-$1	0%	$0	0%

* indicates notes found on page 17.

TABLE 4C: STATE REIMBURSEMENT RATE AMOUNT IN 2006 COMPARED TO MARKET RATE AMOUNT FOR CHILD CARE CENTERS

		Center Care for a Four-Year-Old					Center Care for a One-Year-Old				
State	City/county/region*	Monthly state reimbursement rate	75th percentile of market rate	Year of market rate	Difference between state rate and 75th percentile	Percentage difference between state rate and 75th percentile	Monthly state reimbursement rate	75th percentile of market rate	Year of market rate	Difference between state rate and 75th percentile	Percentage difference between state rate and 75th percentile
Alabama*	Birmingham Region	$429	$433	2005	-$4	-1%	[illegible]	[illegible]	2005	-$22	[illegible]
Alaska*	Anchorage	$550	$685	2005	-$135	-20%	$647	$700	2005	-$53	-8%
Arizona*	Maricopa County (Phoenix)	$502	$650	2005	[illegible]	-23%	[illegible]	$736	2004	[illegible]	[illegible]
Arkansas*	Central Arkansas, Pulaski County	$434	$434	2006	$0	0%	$509	$509	2006	$0	0%
California	Los Angeles	$872	$860	2005	$12	[illegible]	[illegible]	[illegible]	2005	-$75	[illegible]
Colorado*	Denver	$520	$693	2005	-$173	-25%	$650	$823	2005	-$173	-21%
Connecticut	North Central Region	$650	$862	2005	-$212	-25%	[illegible]	$1,031	2005	-$212	-21%
Delaware	New Castle County	$453	$539	2005	-$86	-16%	$528	$598	2005	-$70	-12%
District of Columbia*	Citywide	$632	$909	2004	-$277	-30%	[illegible]	$1,178	2004	-$297	-25%
Florida	Miami-Dade County	$390	$468	2005	-$78	-17%	$420	$511	2005	-$91	-18%
Georgia	Fulton County (Area 3)	$420	$530	2005	-$110	-21%	[illegible]	$520	2005	-$40	[illegible]
Hawaii	Oahu	$500	$520	2005	-$20	-4%	$700	$923	2005	-$223	-24%
Idaho	Boise Metro Area (Region IV)	$492	$518	2004	[illegible]	[illegible]	[illegible]	[illegible]	2004	-$44	-7%
Illinois*	Metropolitan Region	$527	$788	2004	-$261	-33%	$731	$979	2004	-$247	-25%
Indiana	Marion	$619	$619	2005	$0	0%	$714	$714	2005	$0	0%
Iowa	Statewide	$480	$500	2004	-$20	-4%	$580	$620	2004	-$40	-6%
Kansas	Douglas & Johnson Counties	[illegible]	$703	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Kentucky	Central Region	$380	$387	2003	-$7	-2%	$460	$480	2003	-$20	-4%
Louisiana	Statewide	$363	[illegible]	2005	[illegible]	[illegible]	[illegible]	[illegible]	2005	-$33	[illegible]
Maine	Cumberland County	$701	$701	2004	$0	0%	$801	$801	2004	$0	0%
Maryland*	Region W	[illegible]	$612	2005	[illegible]	[illegible]	[illegible]	[illegible]	2005	[illegible]	-20%
Massachusetts	Boston Region	$752	$875	2003	-$123	-14%	$1,117	$1,370	2003	-$253	-18%
Michigan	Wayne County	[illegible]	$758	2005	[illegible]	[illegible]	[illegible]	[illegible]	2005	[illegible]	[illegible]
Minnesota	Hennepin	$811	$901	2005	-$90	-10%	$1,088	$1,234	2005	-$146	-12%
Mississippi	Statewide	[illegible]	N/A	N/A	N/A	N/A	[illegible]	N/A	N/A	N/A	N/A
Missouri	St. Louis (Metro Region)	$331	$660	2004-05	-$329	-50%	$557	$823	2004-05	-$266	-32%
Montana	Billings Region	[illegible]	$433	2004	[illegible]	[illegible]	[illegible]	$541	2004	[illegible]	[illegible]
Nebraska	Urban Counties	$541	$602	2005	-$61	-10%	$693	$745	2005	-$52	-7%
Nevada*	Clark County	[illegible]	[illegible]	2004	[illegible]	[illegible]	[illegible]	[illegible]	2004	[illegible]	[illegible]
New Hampshire	Manchester	$554	$650	2003	-$96	-15%	$657	$779	2003	-$122	-16%
New Jersey	Statewide	$552	$723	2006	-$171	[illegible]	[illegible]	[illegible]	2006	[illegible]	[illegible]
New Mexico	Metro Areas Statewide	$386	$520	2005	-$134	-26%	$468	$585	2005	-$117	-20%
New York*	New York City	$779	$779	2005	[illegible]	0%	[illegible]	$1,247	2005	[illegible]	[illegible]
North Carolina*	Mecklenburg County	$594	$702	2005	-$108	-15%	$632	$803	2005	-$171	-21%
North Dakota	Statewide	$460	$470	2005	[illegible]	[illegible]	[illegible]	[illegible]	2005	[illegible]	[illegible]
Ohio	Metro Counties	$580	$609	2004	-$30	-5%	$736	$772	2004	-$36	-5%
Oklahoma*	Metro Area	$411	$454	2006	[illegible]	[illegible]	[illegible]	[illegible]	2005	[illegible]	-12%
Oregon*	Portland Metro Area	$398	$666	2004	-$268	-40%	$545	$850	2004	-$305	-36%
Pennsylvania	Philadelphia	$617	$652	2005	[illegible]	[illegible]	[illegible]	[illegible]	2005	[illegible]	[illegible]
Rhode Island	Statewide	$649	$714	2004	-$65	-9%	$780	$844	2004	-$64	-8%
South Carolina*	Statewide Urban and Rural	$359	$359	2006	$0	0%	[illegible]	[illegible]	2006	[illegible]	0%
South Dakota	Minnehaha County	$497	$497	2005	$0	0%	$605	$605	2005	$0	0%
Tennessee*	Top Counties in Population/Income	[illegible]	$480	2004	[illegible]	[illegible]	[illegible]	[illegible]	2004	[illegible]	-21%
Texas	Gulf Coast Local Board	$411	$688	2005	-$277	-40%	$520	$851	2005	-$332	-39%
Utah	Statewide	$412	$433	2004	-$21	-5%	[illegible]	[illegible]	2004	-$52	[illegible]
Vermont	Statewide	$470	$600	2005	-$130	-22%	$533	$640	2005	-$107	-17%
Virginia	Fairfax County	$827	N/A	N/A	N/A	N/A	$1,005	N/A	N/A	N/A	N/A
Washington	Seattle/King County (Region 4)	$574	$770	2004	-$196	-25%	$684	$937	2004	-$253	-27%
West Virginia	Statewide	$390	$433	2005	-$43	-10%	$520	$520	2005	$0	0%
Wisconsin	Milwaukee County	$780	$780	2005	$0	0%	$1,005	$1,005	2005	$0	0%
Wyoming*	Statewide	$500	$500	2004	$0	0%	$500	$500	2004	$0	0%

* indicates notes found on pages 21 and 22.