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WEBINAR

WHO WILL CARE FOR AGING BABY BOOMERS?
IMMIGRANTS

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Immigrant Labor and the Institutionalization of the U.S.-born Elderly:

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Does Immigration Improve Quality of Care in Nursing Homes?

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Health of Elderly Parents, Their Children's Labor Supply, and the Role of The Migrant Care Workers

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P R O C E E D I N G S

MS. BUTCHER: Good morning and welcome to our panel discussion of "Who Will Take Care of the Aging Baby Boomers". The leading edge of the baby boomers are turning 77 over the next year. The peak of the baby boom was in the late 1950s and early 1960s. This means that by 2050 about 8.4 percent of the U.S. will be over age 80. That's an age structure that we only see today in some of the very oldest counties in Florida. And that will be the average in the U.S.

I'm Kristin Butcher, the Director of the Center on Children and Families at Brookings. and we wanted to have this pane because this change in age structure is going to have a profound consequence for the elderly themselves and for their families. I emphasized age 80 because we see health problems take an upswing at that point. And surveys of a vast majority of the elderly report that they would prefer to age in community, a number that presumably has increased after the beginning of the Covid-19 pandemic.

People are going to need to help to age-in-place and eventually about a third of those people will spend at least some time in nursing homes. Even under the best of circumstances, providing and/or organizing this care is going to have important consequences for the adult children of the elderly and for their children as well.

It seems very likely that immigrant workers will be a large part of taking part of the baby boomer generation. The question is whether we'll have policy to plan for that in an orderly way or whether this will be a chaotic system where each family tries to find someone to take care of its elderly members with lots of short-term engagements and few workplace protections for workers.

The goal of this panel is first to present some of the emerging research on this topic and then we'll switch to having experts on immigration policy and experts on health and aging policy to discuss the implications of this research. The researchers, who will go

first, include Tara Watson, professor of economics at Williams College and Rubenstein Fellow at Brookings, Delia Furtado, associate professor of economics at the University of Connecticut, and Julia Schmieder, a research affiliate at IZA Institute of Labor Economics and DIW in Berlin.

So, Tara, and then we'll switch over to our panel of experts, Kristie De Peña from the Niskanen Center, Howard Gleckman from Urban Brookings Tax Policy Center, and Anne Tumlinson from ATI Advisory.

Tara Watson is going to first presenting her work on the impact of immigrant labor on the institutionalization of the U.S.-born elderly, co-authored with Kelsey Moran of MIT and myself. Take it away, Tara.

MS. WATSON: Thanks, Kristin. Happy to be here today.

I'm here to tell you about the research that Kristin, Kelsey, and I have been doing about the role of immigrants in caregiving for the elderly. We started with the observation that immigrants are highly overrepresented in health and caregiving occupations. So if we look out in the labor force, we see that about 17 percent of all employed individuals in the working age, 16-64, are foreign born, but 28 percent of home health aides, for example, are foreign born. And that's even higher in some places. So not just in home health aides, but in a variety of health professions immigrants are quite overrepresented. And this suggests that immigration might be an important factor when we consider what's going to happen to the future of our healthcare system and long-term care in particular.

The study with Kristin and Kelsey investigations what happens when immigrants move to a local area to the older population, older U.S.-born population in that area in terms of where they live. So we specifically look at whether older Americans are more likely or less likely to live in institutions as immigration inflows increase. And we

specifically focus on less educated immigrants and their migration to different metropolitan areas across the U.S.

Now, of course we know that immigrants tend to move to places with good job opportunities. And so we have to be really careful to make sure we're really isolating a causal effect of immigration on these outcomes that we're interested in. So we used some sophisticated techniques that have been used previously to make sure that we're really looking at the impact of immigration on living arrangements rather than the other way around. And once we do that we do see that the propensity of older Americans to live in an institution at any given age is affected by immigration. So we do see that institutionalization of our older population has been on the decline. This is due not just to immigration, but things like improvements in health and changes in technology. But we do see that immigration accelerates this trend. So that nursing home use among older Americans falls even more quickly than it would have fallen otherwise when there are increasing numbers of immigrants in the local area.

In the study that we did, we mainly focus on the 1980 to 2000 period, because that is where we saw a really large increase in immigration. And we see there that by 2000 institutionalization rates for older Americans were about 10 percent lower than they would have been if immigration had maintained at its 1980 levels. And if we continue that study into the more recent period, we see the same pattern, that as immigration increases we still see continued declines in institutionalization more than would have happened otherwise.

So the key takeaway here is that the presence of a robust immigrant workforce is really an important component of thinking about the decision of Americans to age-in-place or stay in the community. And I think it's important to consider the backdrop here. We have quite high levels of immigration in terms of the foreign-born population right

now. They're almost as high as they were at the turn of the 20th century, but actually immigration inflows, new immigration, has slowed dramatically in the last few years.

Of course that's partly due to the pandemic and some of that may reverse, but there are also policy changes, backlogs in immigration policies, some of the Trump era decisions have contributed to slowing immigration rates. And so this is a policy area that we need to keep an eye on and think about how it's going to impact caregiving the in the future. And I'm really looking forward to hearing what our experts on the panel have to say about how the long-term care system and the healthcare system in general and immigration policy are linked together in really important ways.

Thanks.

MS. BUTCHER: Thank you so much, Tara, for that nice recitation of our work.

I forgot to mention at the outset that you may submit questions by sending them to #FutureofCaregiving or by email to Events@Brookings.edu.

Next we're going to switch to a related question. So Tara's just told us that where there are immigrants, the elderly are less likely to be in institutions. But we know that spending some time in nursing homes is something that eventually happens to many elderly individuals. And so Delia Furtado is going to present her work with Francesc Ortega examining does immigration improve the quality of care in nursing homes.

Go ahead, Delia.

MS. FURTADO: Thank you. Thank you, Tara, for telling us about the relationship between immigrants and the likelihood that the elderly who need help and care stay in their own homes. This is important because it's preferred. It's also important because it's a lot cheaper to take care of people in their homes than in nursing homes. But like Kristin just told us, some people need round the clock care, perhaps only temporarily

after a hospitalization, perhaps more long-term, at least for people with certain diagnoses.

It turns out that immigrants are also overrepresented in nursing homes. They tend to work as registered nurses, they are especially overrepresented at nursing assistants. What happens to the quality of care provided in nursing homes in places with more immigrant labor? This is a question that Francesc Ortega and I seek to answer in our work.

Before telling you about what we find, let me just say that nursing home care is expensive. The U.S. spent $172 billion on this in 2019 before the pandemic. We spent a lot more during the pandemic, and I expect it to increase further after. Despite this cost, there were reasons even before the pandemic to be concerned about the quality of care provided in many of the nation's nursing homes.

As we know, things got much, much worse. During the pandemic despite accounting for only half of 1 percent of residents of the U.S., nursing home residents accounting for approximately 19 percent of all Covid-19 deaths.

A new report put out last week by the National Academy of Sciences, Engineering, and Medicine concludes that the way in which the U.S. finances, delivers, and regulates nursing home care is, and I quote, "ineffective, inefficient, inequitable, fragmented, and unsustainable". The report specifically brings up inadequate staffing as one of the main issues to address. In our paper, we consider whether increasing the availability of immigrant workers might lead to improvements in the quality of nursing home care, even without the use of policy tools, like increasing minimum staffing standards. One of the recommendations in the report.

There are two broad reasons to expect that when there is more abundant immigrant labor nursing homes might be better able to provide quality care. I think the most obvious, at least from the perspective of an economist, is that when there are more people in

the area available to work, nursing homes can staff the nursing homes, fill nursing shortages, even without having to increase wages. With better staffing, nursing homes can better take care of their residents. They can notice when things are going wrong, they can fix things when things are not going well. This can happen regardless of whether the new workers hired by those nursing homes are themselves foreign born.

Another possibility is that foreign born nurses are more effective or more productive because they might not be able to be as picky about where they work.

So what do we do? First, we gather data on the quality of care provided in nursing homes in different areas of the country at different points in time. We look at things like the number of residents who had recently fallen or the number of residents with pressure ulcers. So things specifically that have been shown to be very sensitive to the quality and the availability of staffing in nursing homes. We then match those nursing homes with data on the local availability of immigrant workers and then we can answer the question. Does the quality of care in nursing homes located in areas with increasing numbers of immigrants over time, does that quality improve over time. Just like Tara, we used other statistical techniques to make sure we are isolating the causal impact of immigration. And our best answer is that the typical five-year increase in the number of immigrants in local labor markets between the years 2000 and 2010 led to a 4 percent decrease in the number of residents who had fallen in previous months. These are not small falls, these are serious falls that led to injury. And we know from other research that often a fall can lead to increased mortality. It's a big deal for these residents.

They also, the typical five-year increase in the number of immigrants in local areas has led to a 33 percent decrease in the number of residents who were restrained. This is a technique that is often used by nursing homes when they don't have enough staffing to make sure that residents can stay safe. They have also led to a 20 percent

decrease in the number of pressure ulcers.

There are also decreases in other measures of quality. For example, reports of daily pain among residents, decreases in urinary tract infections, fewer residents who experience declines in their abilities to do things like dressing themselves, bathing themselves after entering the nursing homes.

All of this suggests that a more open immigration policy might lead to improvements of the quality of care provided in nursing homes. Although we do not look specifically of the costs of the improving care quality, it seems reasonable to believe that a more open immigration policy is less costly way to increase staffing compared to other policy tools, like many minimum staffing standards and policies to increase nurse wages.

Regardless of how we do it, improving the quality of care provided in nursing homes is an important thing to do right now that will become more important as baby boomers start approaching the age at which they will likely need very intensive care.

MS. BUTCHER: Thank you so much for that, Delia.

So we've heard from Tara that immigration seems to slow the rate at which people have to be in an institution. They are able to spend more time in community. And we've heard from Delia that immigration seems to improve the quality of care in nursing homes through better staffing once people or if people do have to make that transition into institutions.

Next we're going to switch gears and we are going to try to understand how another country, Austria, has handled some of these same issues and we're going to change the focus not to the elderly themselves, but rather to their adult children and their adult children's labor supply, and understanding how immigration may intersect with some of those pressures.

So I'm happy to introduce Julia Schmieder, who's a research affiliate at IZA

Institute of Labor Economics and DIW Berlin. And she's going to be talking about her work co-authored with Wolfgang Frimmel, Martin Halla, and Jorg Paetzold.

Again, if you'd like to submit questions you can send them to #FutureofCaregiving or by email Events@Brookings.edu.

Julia, why don't you take it away?

MS. SCHMIEDER: Yeah. Well, thank you very much for having me.

So we've heard already about the implications of immigration on formal care that is provided by paid caregivers either in institutions or at home. But, of course, a very important other source for care provision is the family.

so, for example, in the U.S. more than half of all the elderly who rely on long-term care solely receive support from family members in order to help with their everyday activities. And care provision of course may have very important implications for these family members. So, for example, a care giver might reduce the time that is available for other activities, such as for gaining labor income or for pursuing labor market careers. And because most of the family caregivers are women, this of course has very important implications for the gender inequalities that we observe in the labor market.

So in a study together with three co-authors we investigate how a sudden decline in parental health impacts the labor market outcomes elder children and we also investigate how an increase in the availability and affordability of home-based formal care that is provided by migrants impacts this relationship.

And as already mentioned, the study focuses on Austria. And in Austria the elderly who are in need of care, they receive a tax financed care allowance. And this is completely independent of the financial resources of the care dependent person. This care allowance is paid in cash and it can be used in order to pay for formal care services, but it can also be used to reimburse family members for the provision of their care services.

So what we do and what we find in our study is that when the health of parents declines suddenly, elderly children's employment drops. So the likelihood that their paid employment decreases, and we also find that the labor earnings of elder children decreases as well. So, for example, three years after the health decline of parents, children have 6 percent lower earnings compared to what they earned before the health of their parent declined. We find that these negative consequences for the labor market outcomes for children are particularly pronounced for daughters and they are also particularly large for children who live close to their parents.

So, in short, we find that children who are at very crucial points in their working careers, they reduce the labor market involvement in order to provide for their elderly parents.

We then go one step further and we investigation whether liberalizing home-based formal care services provided by migrants impacts the decision of children after parental health declines. So in particular we look at a reform in Austria that introduced a legal basis and an extra cash allowance for privately hiring caregivers at home. In addition, this reform also loosened restrictions for the immigration of healthcare workers.

So in our study we find that this reform led to a very substantial increase in the number of migrant caregivers that are hired in private households. And very importantly, and this is the main result of the paper, we find that children who are subject to this increase in the supply of home-based formal care services, they are able to avoid these negative labor market consequences when the health of their parents declines.

So, to conclude, is this Austrian reform a very good example for a policy that helps to meet the demand for home based care services? Well, I mean we find that children benefit from this from this reform because they can avoid the labor market consequences after parental health declines. Also this reform introduced a legal status and access to

social security coverage for migrant caregivers in private households, but this is very important to mention as well, these privately hired migrant care workers, they work in very precarious working conditions. So they do live and work in the household of the care recipient, which makes them subject to very high risk of exploitation and also particularly taken into account the amount of hours they work, they receive a relatively low remuneration.

So this is all from my side. I am very much looking forward to the discussion.

MS. BUTCHER: Thank you so much for that.

So that tees us up really well I think to turn to our panel of experts. I'll just remind you that we're going to hear first from Kristie De Peña from the Niskanen Center, then Howard Gleckman at Urban Brookings Tax Policy Center, and Anne Tumlinson from ATI Advisory. I was happy to see the panel of experts nodding along as the researchers were presenting their findings. I'm going to ask that each of you spend about five minutes just sort of introducing your thoughts overall and then we'll turn it over to more of a discussion.

And, again, if you have questions you can submit them to #FutureofCaregiving or by emailing Events@Brookings.edu.

Kristie, why don't you start?

MS. DE PEÑA: Happy to do so. It's great to be here with all of you today and hear from all of these incredible experts in your fields.

You know, I think at this point, after hearing from all of you, it's fair to say that, you know, we do have these increasing gaps to fill in a lot of healthcare sectors and that we know are going to only grow in the future. So we sort of have to figure out how to answer the call to fill some of these increased labor needs.

I do think that there are opportunities to explore incentivizing native workers to take some of these jobs and to better enable families to take on some of this responsibility while mitigating some of the negative impacts that Julia just talked about. But ultimately I don't think that it will come anywhere close to filling the need that we're going to see. So discussing how we can utilize foreign workers is really a necessary component of this discussion, in my opinion.

So the kind of questions that follow here are whether we can accommodate those growing needs given our current immigration infrastructure. And if not, what do we really need to do to get there. And unfortunately I think at this point I can pretty resoundingly say that the pathways that exist now for migrant labor to come to the U.S. are pretty woefully inadequate. Even immigrant doctors have to overcome incredible hurdles to come to the U.S., ranging from sort of unfair state licensing requirements to very, very, very rigid visa requirements to practice in the U.S.

And compounding that, you know, many of our global equals, kind of other high-income countries who are experiencing very similar needs in the healthcare space, you know, namely the UK and Canada and Australia, are doing an exponentially better job at recruiting and retaining and protecting their foreign talent, which I think puts the U.S. at an even more distinct disadvantage as we move forward.

So just by way of a little background in the immigration space, you know, foreign born healthcare workers come to the U.S. either on temporary nonimmigrant visas or they come through an immigrant visa, which is a permanent option to come to the U.S. and get, you know, a permanent green card to stay here. But aside from most of the family reunification pathways that do provide a green card, these visas are almost entirely exclusive to physicians, to surgeons, to other kind of healthcare professionals with really advanced degrees or very, very specific skill sets.

Several years ago we were prompted by the nursing shortages that we're still seeing today and we created an H1C Visa for foreign nationals that wanted to come primarily to the U.S. as registered nurses. That unfortunately expired in 2009. We haven't handed out an H1C Visa since about 2012. So generally speaking, because there isn't a lot of political will behind increasing opportunities for migrants and a lot of these kind of "lower skilled healthcare sectors", even though there's this incredible demand, there's really no unique employment-based visa category that is accessible at all to home health aides, personal care aids, nursing assistants, or other kind of individuals in these healthcare support roles. You know, some argue that we can utilize some of the more traditional employment visas, like an H1B Visa. I would suggest that those are still incredibly difficult for most of these workers to get. Most H1B employers employ graduate level migrant workers in specialty occupations. They have really highly specialized knowledge. So that excludes most of these healthcare workers.

Similarly, H2B Visas do allow for some non-agricultural jobs that are temporary, but of course those are temporary, often seasonal in nature. They don't really respond to the ongoing need that most folks have in these space. And there are kind of some additional obstacles. The U.S. has something called per country caps, which are numerical limits on issuance of green cards to individuals from certain countries. So we throw out about 140,000 employment based green cards a year, but only 7 percent of those green cards can go to individuals from any one country.

So I think Delia mentioned these growing backlogs that we're seeing. Employment based green cards have about one million in their backlog currently. Some people will wait a decade, even longer for some of these visas. And if we're seeing most personal health aids and home health aides coming from Mexico and China, these are seeing very long backlogs. So the idea that, you know, we might actually be able to utilize

some of these employment-based pathways is really sort of a pipe dream.

So I'm happy to dive into what some of the changes could be to some of the specific visa categories, options that the Administration might have in the shorter-term, and how we might incentivize workers to come and stay in the U.S., in particular in some rural and underserved medical areas. But I will stop here for now and I'll turn it back over to you, Kristin.

MS. BUTCHER: Great. Thank you so much for that. I look forward to digging into some of those questions.

But for now, let's turn it over to Howard Gleckman. We're transitioning to people whose expertise is in care and elderly policy making and Medicaid and Medicare policies.

So, take it away to Howard.

MR. GLECKMAN: Kristin, thanks very much. And this has been very interesting to hear about this. As you said, my knowledge is long-term care and not immigration, so it's interesting to hear this from the immigration perspective.

What I thought I'd do is just spend a couple of minutes talking about the effects on the labor market in the U.S. and then a little bit about the effects on family caregivers of these labor shortages.

Let me start by saying that every conversation I have with operators of senior care facilities and home health agencies, no matter what I ask them about, comes around to the same subject, which is their inability to hire workers. And now increasingly I'm hearing the same thing from family members. They cannot hire aids at any price. This labor shortage was happening before Covid and Covid has simply accelerated this and it is now truly a crisis.

The reasons I think are fairly obvious. Nearly half of direct care workers live

in or near poverty and it's a critical reason why so many workers leave long-term care for other industries, like retail and fast food. The research and advocacy group, PHI, has found that direct care worker median wage is lower than the median wage for other low-wage occupations, such as janitors or retail salespersons or customer service reps.

Another thing to keep in mind, is while a lot of these data that we're all talking about show that somewhere in the 27-28 percent of long-term care aids are immigrants, most of those data are people who are here and working in the — sort of the above ground market, those are people who work for agencies or similar groups. There's a very large and largely unknown group of people working in the gray market. Many of them we suspect are immigrants. We know very little about them, but I suspect if you look at those you're going to find that a significantly higher percentage of aids in this country, particularly home care aids, are actually nonnative born.

Think about a little bit about Covid. According to BLS data, 400,000 care workers left their jobs during Covid. And some recent research suggests that while other low-wage workers have returned to work in recent months, it's not true for direct care workers. Again, PHI and the University of California at San Francisco did a study about people who left their jobs in 2020. And I'll just quote from that study. "An immeasurably small number of displaced workers from direct care or other occupation were reemployed into direct care in the first quarter of 2021." And that may have changed a little bit, but probably not much.

And again we can speculate on the reasons. Noncompetitive wages and benefits, few opportunities for advancement, dangerous work — even before Covid. And of course because many of these aids are women, they were staying home to care for their own children or their own parents. Whatever the reasons, people are returning to these jobs very slowly, if at all. And the effect on providers is actually quite striking. The occupancy of

nursing homes and assisted living facilities has rebounded from the lows of early 2021, but it remains well below pre-pandemic levels and well below profitable levels, especially for nursing homes. And one constraint I hear over and over again is labor force shortages. There's just not enough workers to care for residents in fully occupied facilities.

So one query is in the current labor market, would an influx of immigrants drive down wages and benefits? Now, what would the impact be? Would these immigrants even be willing to take direct care jobs with so many other jobs available to them?

Let me switch gears for just a minute now and talk about the effects of the shortages of direct care workers on families. As others have noted, much of the caregiving in the United States is done by family members, not by paid aids. And the consequences of that are quite striking. You can point to physical, emotional, and financial costs. The physical costs are actually — home care is one of the most dangerous occupations in the United States. It's more dangerous to be a home care aid in the U.S. than it is to be a coal miner. And those are trained aids. Now think about the effects on an 80-year-old who is caring for her spouse who has no training, who's frail, and who's terrified of doing something wrong.

The emotional stress is also significant and it's so common it's now been given a name, something called caregiver's stress syndrome. And this is especially true for long duration caregivers, especially those caring for family members with dementia. As Anne has written in a wonderful essay for Health Affairs, family caregivers are being asked to provide an incredibly broad range of supports for their loved ones. They're being asked to act as care managers, registered nurses, and personal care aids, all roles for which they're rarely trained and often unsuited.

Let me just wrap up by talking about the financial cost. Now, there was a recent survey by the Rosalind Carter Institute that found that 20 percent of U.S. workers

identify as family caregivers. On average these caregivers report about 20 hours a week of caregiving, so another half-time job. Almost a third of workers report having left a job at some point during their career because of caregiving responsibilities. The reasons for leaving include an inability to find affordable or high-quality aids. And, again, most of these surveys were done before Covid, so you can imagine it's worse now.

AARP did a study in 2020 with National Alliance for Caregiving. It found that half of aids said they had days where they either start work late or — half of workers who were caring for family workers find that they either had days where they started work late or left work early, 15 percent said they reduced their work hours, 14 percent took a leave of absence. Again, all these data are pre Covid. I suspect it's worse now.

The long-term effects are even more striking, loss of lifetime income in terms of wages, Social Security benefits, and retirement savings. There's a wide range of research that looks at the amount of this loss. Some studies show up to $300,000. And most agree that most family caregivers are more likely to age in poverty themselves.

So the bottom line is without the support of paid aid these burdens on family caregivers is only going to rise. So it's a strikingly important issue and if we don't deal with it, we're going to have really a growing crisis among family members who just cannot manage this care by themselves.

MS. BUTCHER: Thank you for painting that very bleak pictures.

I'll turn it over to Anne Tumlinson from ATI Advisory.

MS. TUMLINSON: Thank you. Wow, this has just been terrific and I'm just delighted to be part of the conversation.

I mean I think what I want to first say is that when we talk about the care delivery system and how we're paying for it and how we're organizing it, I will just say in sort of the — in the aging and healthcare world, we sort of skirt around these issues of

immigration and don't — I don't know that we are very integrated in bringing the immigration as a policy issue into these conversations. And maybe as a first step and just congratulate the Brookings Institution so much for making this connection and bringing us all together for a conversation. And I hope that it is just the beginning because — we've talked a lot about the baby boomers growing and I would say I think many of you have made many of the points that I had prepared, so I want to just try to fill in a few gaps. I guess that's the benefit and the curse of going last.

But just kind of want to underline that not only are the baby boomers getting older, so it's an over age 65 population, but they are also aging within that 65 to death age band, if you will. But the working age population, so adults 18 to 64, is basically remaining constant. So even within my own family, I look at basically the children available to provide care to all of us who are heading into our 50s and 60s. And I worry for them because, as everybody — as so many people have already pointed out in this conversation, we are highly reliant on individual family members to provide — not just provide the hands-on daily care, but also to organize it and to essentially what I call kind of create that infrastructure and systems on an individual family and household basis over and over and over again. So like the least efficient possible way we could be delivering care is in this kind of like — it's like a frontier mentality, homesteading long-term care, as I call it, in our society.

So Howard did a great job of explaining what's been happening in the labor force, and of course that even before Covid family members were picking up a lot of the slack, both in terms of the availability of workers, but also the availability of financing to pay those workers. And so as I listened to this conversation, I think the thing that strikes me is that a change in immigration policy and including immigration policy as part of our — if we were to have one — a national strategy about how we're going to take care of our older adult population going forward, is that that's just table stakes. It's not even really a question

of "if", it's more to be, as I'm listening to this, a question of "how". And I'm really struck by the fact that we need to be competing for this labor force with a lot of other countries that not only are ahead of us, as Kristie so smartly pointed out — or maybe it was Julia — I can't remember — that we are — they're ahead of us in terms of their immigration policy, but they're also ahead of us in terms of their care delivery systems and financing for these services and supports. And so we — if I am a foreign-born worker and I am looking at a variety of options in terms of where I am going to go and participate in this labor force, perhaps I might look at the U.S. and think that's doesn't look like a great job, but it looks like a great job somewhere else.

And I'll just — just to kind of put a fine point on it, because Howard certainly talked about the working conditions, the challenges, and the compensation, but I think that, you know, there's also this problem of a lack of infrastructure in systems. We don't have a care system in this country. So we create an even more kind of vulnerable situation for these workers and we risk kind of wasting any immigration — anything that we do to improve the flow of the workforce into this country because we still make it so hard to connect families and individuals who have need to workers. So aging in place requires an infrastructure and a system that we lack and, of course, it requires that we have a way to pay for these services and supports so that we can — so that everybody can have access to these workers, not just people who are either very, very wealthy, or people who are on Medicaid.

So I look forward to the discussion that we're about to have and the questions that people may have sent it.

MS. BUTCHER: All right. Thank you so much, all of you, for that.

Let's start with just a little bit of defining terms. Because we're getting a few questions about what is a nursing home, what is a long-term care facility, what's available to

pay for those things? And I think it might help if one of you talked a little bit about the aging process and the needs as they arise.

So, you know, sometimes people — we have these activities of daily living and instrumental activities of daily living and different types of workers might provide different sets of those services. And there might be things that individual family members are more suited to do, like organizing a family dinner with grandchildren and reminiscing, right. That is not something you can contract out.

So, I don't know, Anne, could you sort of table set for us a little bit about what kinds of care are involved and if you know the ages at which those things happen and the institutions in which they get provided? I think that could help.

MS. TUMLINSON: I will, but I will lean heavily on Howard to do this with me.

So, I'm trying to think of the succinct way to explain this, but what we — we tend to look at — so maybe what I would just try to do is conjure in everybody's mind for a moment, you know, sort of the trajectory of aging. You know, we tend to think about this in terms of lifetime — like, you know, you turn 65 and if you turn 65 then you have about, in the Urban Institute Work, you know, a 50 percent chance at some point over the rest of your life of having and needing somebody else to help you with two or more of these very basic life activities. And so very, very generally, what we do is we tend to say — we call that a need for these long-term services and support. So that's really very, very basic.

But, obviously, that sort of — you don't just wake up one morning and need — I mean sometimes you do, but often times you do not wake up in the morning and suddenly need help with two or more activities of daily living. You come into your older adult years often with many chronic conditions, you're using the healthcare system, all of those services are paid for by Medicare, the health insurance program for older adults. Then at

some point you're beginning to need help with things that are more like long-term services and supports in nature. Maybe you're beginning to become forgetful, maybe cognitive impairment is just starting to set in. you need a light supervision in your home. These are all things that can be done by family members, are often done by family members. You know, at some point you may need somebody to help you drive. So start to think about — you know, this — maybe put this in the context of your own family — you begin to kind of picture how these things over time build up to a point where somebody needs long-term services and supports. And at that point we have a pretty bifurcated system. So if you have a lot of resources you might choose to pay privately for services in what we call an assisted living facility, which employs many, many, many of these direct care workers and immigrants that we've been discussing. If you don't have resources, you may sort of try to get by with a family member's help and at some point it gets to be too much and you go into a nursing home, which is most often funded by the Medicaid program.

And then if you're lucky, you may actually be able to access home and community-based services, either on a private pay basis or through the Medicaid program. If the Medicaid program happens to have those services in your area and makes them available to you.

But, Howard, what have I missed? It was a good quick course on long-term services and support system.

MR. GLECKMAN: So let me just quickly make a couple of other points. It was a really good summary.

A couple of things for people to keep in mind. So think about nursing homes. Nursing homes are highly regulated, they actually provide two different kinds of care. One of them is what's known as post-acute care. This is care people get after they've been discharged from the hospital. Maybe they've had a knee surgery or they've had a

stroke or something like that. And then there's long stay, the long-term care that they do. They require a significant number of staff, aids, housekeepers, nurses, management of course.

Then there are assisted living facilities. There is no agreed upon definition of assisted living facilities. Every state regulates them in different ways. They provide a range of services from relatively modest amount of services, maybe communal dinners, somebody to clean your apartment, that sort of thing, to fairly heavy levels of need. There's a lot of overlap. For example, many people with memory loss may be in an assisted living facility or they may be in a nursing home. Many people are in nursing homes, as Anne noted, only because that's where Medicaid pays. Medicaid generally does not pay for care in an assisted living facility and rarely even pays for any of it.

So if you're on Medicaid, if you're very low income and have very few assets and you are quite sick, you are generally — you're entitled to care in a nursing home. You are allowed to get care, depending on what your state is offering, at home. Assisted living again is provided mostly entirely private pay, not by Medicaid at all.

So there are really I think significant differences, but also a lot of overlap between the kinds of institutions that we think about.

In terms of the aids, generally the training is more or less the same, but one of the issues that we all confront is somebody who's a health aid has to be licensed differently for working in a hospital or working in a nursing home or working at home. And it would probably be much more efficient if we could create some sort of a universal license so somebody could work across those settings, especially, again, at a time of huge labor shortage.

MS. BUTCHER: Okay. Thanks.

We're going to turn in just a second to the direct links with immigration and

immigration policy. But, Howard, could you just remind us. I think most people think, oh, once you turn 65 Medicare is going to pay for your healthcare and that's going to include all of these things. And I know that's not true, but I don't know that most people know how this works. And among some people you get into nitty gritty discussions about how can I protect my assets so that I qualify for Medicaid. So you could you just give us a few brushstrokes about that really complicated system?

MR. GLECKMAN: Sure. So it is really complicated. It would take about an hour to go through it, but I'll try to do it in just a couple of minutes.

So Medicare, the health insurance program that almost all older adults participate in, traditional Medicare, fee for service Medicare, does not pay for long-term care pretty much period end of story. There are models of managed care that will pay for some version of long-term care. There are special needs plans for example that will pay for — provide a whole range of services, including long-term supports and services, personal assistants, that sort of thing. There are pace programs, which are a combination of Medicare and Medicaid, that will pay for a range of services, including personal care. But traditional Medicare, the Medicare Part A, Part B that awe know, does not pay for this — full stop.

Medicaid does, but as I said, only if you are very poor — and very poor generally means financial assets of less than $2,000 — and have very little income. Again, depending on the setting, maybe income of less than $1,000 a month, and you have to be very sick. And if you're on Medicaid you have, as I said, an entitlement to a nursing home. Under state waiver programs you can get some home care. In most of those states, the amount of home care you get in the state Medicaid program in insufficient if you're living at home alone. You pretty much need a family member with you to supplement whatever care Medicaid provides. Or a better way to think about its Medicaid is providing care that

supplements the care you're getting from your family.

As far as eligibility is concerned, you know, the government has made it increasingly difficult to hide your assets so you can become eligible for Medicaid. And I have to say given the kind of care that people get through Medicaid, I'm not sure why anybody would want to. If you have the financial assets, you don't want to be on Medicaid, you want a private care. Your care is going to be much better. For example, at a nursing home, if you can private pay you'll be in a single room. If you're a Medicaid resident you're very likely to be sharing a room with a stranger. I don't really know who would want to do that.

MS. BUTCHER: So we have this very complicated system. It also varies by state, right. And even though Medicare and Medicaid are Federal programs, different states have different rules. So we have this system that's very difficult for families to manage. So I'm going to think about a typical, you know, person — we could make her my age, she could have a parent — just to pull something out of a hat — have parents who are 77 to 81 and just facing some decisions. So it seems like a typical thing is to try to make things work either by family care, right. And then things sort of go downhill and that's not going to work anymore. And so more care is needed. And so then people start to try to find some help. Like just a housekeeper maybe to come in or somebody to do some cooking or gardening or driving, or something like that. So those jobs are disproportionately staffed by immigrants in this country.

Kristie, can you tell us a little bit about like if there are — like — I think you said it before, but I think it's worth emphasizing — there's no like visa for home healthcare aids or something, right? So how are people who are immigrants who are here doing those jobs, how are they typically getting here? And under what conditions are they living and working? And how might that affect the quality of those jobs?

MS. DE PEÑA: I mean it's a great question. And a lot of the folks that we know that are in this space are primarily women, women migrants. Many of them come over on family-based visas, they get green cards because they have a child or a spouse that is a U.S. citizen. They're able to come and live in the United States.

To Howard's point, there are a fair number of them who are undocumented and who are working in some of these spaces because, you know, often households are willing to sort of pay them under the table. And they have some relative stability in some of those working conditions. So by and large, that's where a lot of the workforce is coming from. And of course there's an incredible demand for these jobs, which I think all of the speakers have talked about today. And one of the things that really strikes me that Anne was talking about that I think is worth mentioning, is that this lack of a care system and infrastructure is a problem that we've already seen. We have already seen the failure of the U.S. to help us care for our children. And especially during this pandemic, we have seen I mean an enormous breakdown in people's ability to find childcare. We've seen women leaving the workforce in extraordinary numbers. And we're starting to see, I think as Julia was pointing out, we're starting to see that happen now as we see households trying to not only care for young children, especially since many people are having children later in life, but on top of that, they're in charge of caring for their parents.

And so if we think that this is somehow going to magically get better, we're really deluding ourselves. And now I think that the kind of one upside is that while kids can't vote, our elderly population can and they often do in big numbers. And so they might actually be the drivers here that say I want to stay at home, I want to have those options, I don't want to put the onus on my children to try and do this. So there may actually be the political will to create some of these additional immigration pathways that I would argue absolutely need to be created if we are going to even scratch the surface of the need that

exists now, but is going to grow.

And I think that's the only impetus that's really going to get Congress to move on anything on immigration. Is that they're really going to start hearing about it from constituents. And certainly we're starting to hear the rumblings already in rural America, where not only have they not been able to get any care as they age, but they haven't even been able to get access to the physicians that they need in this moment to handle the pandemic and sort of all the situations related.

MS. TUMLINSON: Could I just — Kristin, would you mind if I just jumped in really quickly?

I just want to say yes to the rural — I mean we — you know, I was talking to some nursing home operators in a rural area and I said are you — this was a little bit sort of early Covid, right before Covid —– I said are you — do you feel threatened by aging-in-place movement? Do you feel threatened by it. And they laughed. They are like, what do you mean? What home care? There's no home care here.

So even in my own family, many members live in rural areas and are — I have an aunt with very serious dementia. She served at a nursing home. That's it. That's it. That's all there is.

And the other thing I want to just mention is that I got contacted by a Wall Street Journal reporter who was doing a story about family caregivers going back to work. What are the challenges of family caregivers heading back into the workforce. And I said I can't help you with your article because I don't know any. So I actually –– and then it turns out the Federal Reserve Board, you know, and using some of the American Community Survey data that I'm not totally convinced is the right measure, but it's indicative anyway that the non-parental caregiver category is a much bigger drag now on the labor force participation rate than the parental caregiver category. So just kind of confirming for me, at

least just my — you know, just my sense that, as Kristie was saying, you know, it's — there's no adult daycare centers on every corner where we can like — like we don't — there's no place to take your family member if you want to go back to work right now. And there's obviously no one to staff them.

So, you know, I think — I don't know how we're going to actually operate a labor force five, six, seven years from now if we not only have this immigrant workforce as part of this strategy, but we have to have a larger strategy. There are a piece of it, they can't be the strategy, but they can certainly be a piece of it.

MS. BUTCHER: Thank you so much for that.

I'm getting a lot of questions that I'm going to characterize as — well, if there are no immigrants won't the wages for home healthcare workers just rise and there will be better jobs and then U.S. citizens will take them? And I think that this often comes up in the caregiving space because for childcare workers as well, we on the one hand are very concerned that these are not very high paying jobs, they tend to be unstable, not great schedules, et cetera. And on the other hand, they tend to be too expensive for people who need them.

And so those two things go hand in hand. And I think what can provide the wedge that's needed between every one of those wages is somebody else's price, is government subsidy for this.

So what would we need to change now to make it so that those jobs could be better jobs and people could afford it?

MR. GLECKMAN: So I can jump in. You're exactly right, Kristin. The paradox here is we have these aids who are not paid enough. I guess we've never actually said, but the average wage of an aid is about $11 an hour. Many of them live in poverty. One of the issues maybe we can talk about a little bit in this conversation is a public charge

rule, which the Trump Administration posed. Because so many aids get paid so little, they're on Medicaid or they would be on Medicaid. And because they would be on Medicaid they can't get into the country.

So there is the problem that these aids are insufficiently paid. As Kristie mentioned, one of the problems of course is a lot of them that — they're taxes are not paid by the people who hire them, they're not on Social Security because they're not paying payroll tax. They are really being taken advantage of by the system.

On the other hand, even when they were being paid $11/hour, families couldn't afford it. So how do you fix this? How do you deal with this wedge as you say? It's actually a fairly simple analytical answer complicated political. And the simply analytical answer I there has to be more money in the system. We have to take some of the money from somewhere else and we need to put it in the long-term care system, otherwise it simply doesn't work.

MS. TUMLINSON: Can I just say, I don't think there's enough money in the national treasury if we zero out every single other budget item, to come up with enough — yes, yes, it would be great if we could pay the workers we have now so much more that we just attract a whole bunch of U.S.-born or people who are already in this country to these jobs. I don't think there's enough money. I don't know how we would do it.

I mean I'm talking about like no people — this is a very challenging workforce to provide for in the first place. And I think it to be a really interesting — I think somebody should do an economic analysis. Seriously, like if we don't adjust immigration policy at all and we're reliant on the current workforce in this country to do these jobs in the future, how much will we need to pay them and how much would it cost the Federal Government, under the program that we do now, not to mention subsidizing further? And I mean we'd have to have a pretty robust financing system. And even then I don't know that it

would work.

MS. DE PEÑA: Yeah, I mean I think those are all really good questions to ask, but the other sort of reality that we have to grapple with is there just aren't enough sheer people currently in the United States to fill not only the labor shortages that we're seeing in all of these occupations, but the ones that we're seeing across the board in lots of other spaces that I would argue don't require some of the more innate skills that people that are short of drawn to these careers really need to have. It's not a career for everyone. And I think it's worth acknowledging that. And I think it's also worth acknowledging that we have seen wages rise in many industries across the United States in the last year as we're trying to fill these labor shortages, and there are just jobs that for whatever reason American workers won't take. And while I think that there are opportunities to think about more incentives and different structures to get them to do that, ultimately we don't have enough people. Even if we filled it with every available American worker across the U.S., we would still have these shortages.

So to try and pretend that somehow we're going to create a new labor force, especially when we're not giving anybody childcare, you know, it's kind of a pipe dream. So that's kind of like the next necessary step.

And if I may, very quickly, I saw that Tara was sort of talking about highest priority needs. One of the things that I think is really critical now to start to set the table for some of these changes is to look at the Department of Labor's schedule A jobs, which is where they sort of list their kind of shortage occupation list. For whatever reason, they haven't updated that in many years. I think the last update was in the early 2000s, maybe 2005. right now only registered nurses and physical therapists are on that list. They're the only healthcare occupations on that list. I would strongly, strongly urge the Department of Labor to revisit those numbers and to expand that list of shortage occupations, which allows

us to bring in more workers under all of those occupations moving forward.

MS. BUTCHER: So that —

MR. GLECKMAN: One other point about this that I think is worth just noting is that there is, as several people have said, a huge drive to increase home care for older adults. One of the challenges of that is that providing care, aids providing care for people living at home, it's a much less efficient way for them to provide that care than if people are living in a nursing home. Think about the amount of time you have to spend in a car, in traffic, going from client to client. There are a lot of disadvantages to nursing homes, but one great advantage is you have a lot of people in one confined space and you can provide a lot of care to them with fewer people.

So as we continue to demand more home care, we're going to have to find even more workers than we've had in the past.

MS. BUTCHER: So Delia Furtado had something she wanted to add to this conversation, what economists should do.

MS. FURTADO: Yes. And I won't do the study because something similar has already been done. There was a study just published this year actually that calculated that it would cost $7.25 billion each year just in salary costs to meet the proposed minimum staffing levels in nursing homes in bills introduced but not passed by the U.S. Senate and House of Representatives in 2019, before the pandemic.

The largest shortfalls were in RN and nursing assistant staffing, coincidentally the very occupations in which immigrants are overrepresented. I think minimum staffing levels are important for providing higher quality care. And maybe we just can't pass those bills if it's going to be this expensive. And maybe with a more open immigration policy, we're able to meet those minimum staffing levels in a more — more realistic costs. And, again, this was just salary, this was not any of the other benefits or

anything like that.

MS. BUTCHER: Thank you. Thanks for that, Delia.

I think it's also important to say that one of the things that older people often need to age-in-place is some light construction on their home — handrails, bathrooms that you don't have to leap over a high jump to get into the shower, and those sorts of things. And immigrants are also overrepresented in the construction industry as well. And so if we're thinking about changing things so that people can age-in-place as long that is possible and the move to some other type of institution, which itself might need to be built, that's another place that things would need to happen.

So I am getting some questions from our audience about just overall immigration. Like we're looking at one piece of the puzzle, and it certainly seems like having more immigrants is going to be necessary to solve this. But people do have questions about, well, are there costs elsewhere, right. And so I don't know, Kristie, if you'd like to take that on. Or, Tara, you have a book on immigration, so maybe you can jump in and talk about immigration just sort of more generally, to leave people with a sense of what immigrants do overall.

Kristie, do you have some thoughts?

MS. DE PEÑA: Well, I will make a plug for Tara's book first, which is phenomenal and gives you an extraordinary overview of a lot of things on immigration.

But, yeah, I mean these are questions that we get all the time. You know, across the board in many different sectors of immigration, what are sort of the cost-benefit analysis. There are people with legitimate concerns about culture and language barriers and how they might potentially communicate with a worker. And I think that these are all sort of natural questions that require us to sit back and talk about some very real issues.

But the takeaway continues to be for many, many years we have had sort of

a suppressed level of immigration. We haven't changed our immigration laws in the better part of 40 years now. And we are starting to see some of the deleterious effects of that across the board on not just like numbers of people that exist in the U.S., but on innovation, on business, on labor needs, on all of these things sort of across the board. And we can look at the countries that have done a better job at it and we can see now some of the incredible differences that places like Canada —– the edge that they're getting in technology, in enabling foreign students to come to their countries. Canada is doing better, the UK is doing better, Australia is doing better. You can look at the happiness index, the economic indices. All of these things suggest that these countries are sort of moving ahead because they have better and more thoughtful immigration policies that we do.

There is a lot of opportunity to also think about, you know, how to prioritize certain immigrants coming to the United States. And I think that while we've gotten close at certain periods in time in the last 20-ish years, I think that we have taken a couple of giant steps back in the last 10. and so we have to start again that sort of incremental march towards thinking about the kind of immigrants that we need, how to balance that out with the humanitarian needs of the rest of the world, and how we can participate in a lot of that. But ultimately, if we want to keep up and we want to fill these needs, the answer is in refreshed immigration policy that reflects what people are clamoring for, even if they don't recognize that those are immigration needs per se.

So I'll stop there. And I'm sure Tara has some thoughts.

MS. BUTCHER: Tara, please join us.

MS. WATSON: I'll just add, in thinking about the very broad picture of immigration, there's a lot of economic literature looking at the overall impacts of immigration and it overwhelmingly suggests that immigrants are good for the economy and good for growth. There's less robust evidence on the issue of what happens to the lowest wage U.S.-

born workers when more immigrants arrive. But even there, most of the evidence suggests that those negative impacts are small or nonexistent. And so if we're thinking about immigration policy, my view is there is certainly room to grow substantially before we have to worry about seeing really strong adverse impacts on low wage U.S.-born workers.

And so when we look at other areas that people are often concerned about, like the safety net. Howard mentioned that some immigrant workers might be on Medicaid, which is health insurance for low-income individuals, and that's certainly true that some immigrants are on safety net programs, but if you look at the numbers, the prevalence of immigrants using those services is lower than you might expect. If you look at low-income immigrants, they actually use them at much lower rates than low-income U.S.-born populations.

And also another concern is crime. There is a long literature basically debunking the link between an increase in crime stemming from immigration.

So taken as a big picture, there are certainly some things to think about and to be aware of, like potential adverse impacts on the lowest wage workers in the U.S., but overall economists are in fairly strong agreement that immigration is good for the economy.

MS. DE PEÑA: That's exactly right. And I'll just add too very quickly that most of the newer more immigration policy ideas out there not only think about sort of new immigration pathways, but they couple that with workforce training for Americans in the sectors where we need them to be experts, we need them to be skilled, we need them to be educated. And I think that that is sort of the right way to think about not just growing the number of immigrants that come into the U.S., but better enabling our own workforce to fill the needs that exist now.

MS. BUTCHER: That's great.

So our time is running short, so I had a question for you. Kristie, I think you

mentioned that the elderly do in fact vote, right. So if you wanted to leave people with a thought about what should you be looking to your elected representatives to do, what should you vote for? I was hoping that each of you could leave us with a thought about what people should —– if they care about this issue, what should they be thinking about when they go to vote?

MS. DE PEÑA: Yeah. I think the very first step sort of —– especially as we have seen a lot of the conversation around immigration reduced to some very simple talking points, is to demand of your congressperson, your senators, to start talking about some of these policies with a little bit more nuance. You know, really making the need very tangible for them, make them understand how this impacts your daily life and let them know that this is a real priority for you and hopefully that starts to set the stage to talk about some immigration reform opportunities or thinking about new visa categories in a more nuanced way so that these conversations really have the space to happen and grow in a bipartisan way.

MS. BUTCHER: Great.

Anne, do you have any thoughts about that?

MS. TUMLINSON: No, I think Kristie covered it.

MS. BUTCHER: Okay.

Howard?

MR. GLECKMAN: So from the long-term care perspective, I guess what I would say is the message to send your politicians is there are 14 million people in this country who require long-term care. There are, depending on who's counting, somewhere between 30 and 50 million people caring —– family members who are caring for them and they need help. They need help from paid aids, they need their own training, they need their own support. This isn't just going to happen magically. They need money, they need help.

MS. BUTCHER: All right. Thank you so much.

I will just wrap up by saying thank you to our researchers. This was really fabulous. I know it is years and years of work to produce those papers that you summarized beautifully in just a couple of minutes.

I want to thank our panelists. When I first wrote the invitation to this, it was a little bit awkwardly written and the answers I got were like I am not an expert on immigration and elder care. And I thought, well, that's the point, no one is, but we need some people who are experts on immigration and elder care. So I hope that this is the beginning of many, many more conversations as we try to come together to make sure that we all have a dignified, safe, and happy old age.

So thank you all so much.

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