



# **TESTIMONY BEFORE THE COMMISSION ON LONG-TERM CARE**

## **“Populations in Need of LTSS and Service Delivery Issues”**

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Chairman Chernof, Vice-Chairman Warshawsky, and members of the Commission, on behalf of AARP's over 37 million members, thank you for the opportunity to testify today on the realities facing family caregivers, and those for whom they care. Chronic illness, disability, and frailty not only affect individuals, but also families. Caregiving for an aging parent, grandparent, spouse, adult child, or other relative or friend is now the "new normal" of family life for millions of people in the U.S. and a growing public issue. It is an intensely personal issue affecting real people in our country every day, in all walks of life.

The term "family caregiver" is broadly defined and refers to any relative, partner, friend, or neighbor who has a significant relationship with, and who provides a broad range of assistance for an older adult or an adult with chronic or disabling conditions.

A recent report by the Congressional Budget Office estimated the economic value of family caregiving to persons aged 65 and older to be \$234 billion in 2011, which far exceeded all paid long-term services and supports for older adults in all settings from all payers combined.<sup>1</sup> At AARP, we made a similar estimate that looked more broadly at the value of family caregiving for all adults aged 18 and older. In 2009, we estimated that about 42.1 million family caregivers in the U.S. provided an estimated 40.3 billion hours of unpaid care to an adult (age 18+) with limitations in daily activities. The estimated economic value of their unpaid contributions was \$450 billion in 2009—more than total Medicaid spending for all populations that year.<sup>2</sup>

The "average" U.S. caregiver is a 49-year-old woman who works outside the home and spends nearly 20 hours per week (about another half-time job) providing unpaid care to her mother for nearly five years. More than eight in ten are caring for a relative or friend age 50 or older.<sup>3</sup>

Most people who need long-term services and supports (LTSS) rely on their families for help. Two out of three (66%) older people with disabilities who receive LTSS at home get *all* of their care exclusively from their family caregivers, mostly wives or adult daughters. Another quarter (26%) receives some combination of family care and paid help; only 9 percent receive paid help alone.<sup>4</sup>

While family members often undertake caregiving willingly and family support is a key driver in remaining in one's home and in the community, it comes at enormous costs to the caregivers, to their families, and to society. The challenge ahead is to better recognize and ease the burden on the largely invisible, isolated, and unpaid workforce of family caregivers in our country—those who are the backbone of the LTSS system and key partners in health care delivery.

In addition to meeting the daily physical, mental, and psychosocial needs of their loved ones, including bathing, dressing, feeding and other tasks, family caregivers often serve as "de-facto" care coordinators, trying to help their loved ones get the care they need, while risking their own health and financial security. We cannot achieve a better system of LTSS without greater recognition of and support for families and other unpaid caregivers, and addressing coordination of care and workforce issues. Families are already doing as much as they can. Adding to their burden will put both the caregiver and the person needing care at risk.

In my testimony today, I would like to make five points:

1. The unpaid contributions of family caregivers fill big gaps in health care and LTSS.
2. The role of family caregivers has dramatically expanded. Family caregivers are the major providers and coordinators of LTSS, and key partners in health care delivery. Increasingly, they are providing complex chronic health care in the home, with little or no training or preparation.
3. Family caregivers are a vulnerable and “at risk” group themselves.
4. The care gap will widen: The aging of the population is growing dramatically while the availability of potential family caregivers (mostly adult children) will decrease dramatically in the coming decades.
5. Family caregivers need better recognition, training, and support in planning for and providing LTSS.

### A Profile of Family Caregivers: Who They Are, What They Do, and How Their Role is Different Now Than in the Past

There is a lack of understanding of the complexity of caregiving today, and the human toll on those receiving and giving care, until it happens to you personally. Family members and friends are often invisible in the care process—yet they provide the bulk of everyday care, are most likely to arrange, navigate and coordinate complex care in an increasingly fragmented and bewildering health care and LTSS delivery system, and face their own health and financial risks.

Many individuals who provide assistance and support to a loved one with LTSS needs do not identify themselves as “caregivers.” Rather, they describe what they do in terms of their relationship with the other person: as a husband, wife, partner, daughter, grandson, niece, or close friend, for example.<sup>5</sup>

A recent groundbreaking study<sup>6</sup> conducted by the AARP Public Policy Institute and the United Hospital Fund shows that the role of family caregivers has dramatically expanded in recent years to include performing medical/nursing tasks of the kind and complexity once provided only in hospitals and nursing homes, and by home care professionals. As Susan Reinhard, the lead author of the study, and Senior Vice President and Director of AARP’s Public Policy Institute has said, *“These are tasks that would make nursing students tremble.”*

- In this national study, almost half (46%) of family caregivers reported performing medical/nursing tasks for loved ones with multiple chronic conditions. These tasks include managing multiple medications (such as administering intravenous fluids and giving injections).
- Almost half of the family caregivers were administering five to nine prescription medications a day.
- Family caregivers were also providing wound care, preparing food for special diets, using monitors, and operating specialized medical equipment. All these tasks were in addition to assisting with LTSS needs, such as bathing, dressing, eating, toileting, managing personal finances, providing transportation, or assisting with other household tasks.
- These family caregivers frequently served as care coordinators for their loved ones following hospital discharge.
- Nearly half (45%) of these family members are performing these complex tasks while also carrying out job-related responsibilities during their prime working years.<sup>7</sup>

One of the most important findings from this study is family caregivers report that the help they provided with medical/nursing tasks lessened their family member's pain and symptoms (40 percent), allowed more independence (43 percent), and avoided nursing home placement (51 percent). Family caregivers who provided medical/nursing tasks and had some training were more likely to say they were able to help their family member avoid nursing home placement.<sup>8</sup>

Family caregivers are an essential part of the workforce to maintain the health care and LTSS systems.

Family caregiving has been shown to delay or prevent the use of nursing home care.<sup>9, 10</sup> In health care and in LTSS, settings change, providers change, and systems change. Only the individual and the family remain constant. Individuals with multiple chronic conditions and LTSS needs often experience multiple transitions across settings, seeing many different types of providers. All too frequently, family caregivers find that they are the sole care coordinators.

Family members are now part of the delivery of health care in addition to LTSS—influencing health care decisions, serving as “continuity connectors” and the “eyes and ears” for communication and coordination with a range of health professionals and community service providers.<sup>11</sup>

The absence of a family caregiver has also been linked to hospital readmissions.<sup>12</sup> Studies have shown that caregiver burden or depression is associated with problematic hospital discharges.<sup>13</sup> Problematic care transitions and increased risk of rehospitalization can occur when the family caregiver feels unprepared to bring a loved one home after discharge from a hospital. Often, this is due to an absence of care coordination, poor communication from health care providers, and a lack of follow-up care and supportive services. Family members are increasingly asked to assume a health management role in the home with little preparation and with little to no training in carrying out the requisite health and medical tasks, suggesting that the “medical or health home” is, in reality, the home of the person with chronic care needs.<sup>14</sup>

Consensus exists that both the person with chronic illness or disability and the family caregiver need to be better integrated, along with direct care workers, into the health care and LTSS teams.<sup>15</sup> In a person- and family-centered care system, family caregivers are no longer viewed as just a “resource” for their loved one; rather they are partners on the care team (as appropriate), and also recognized as individuals who may themselves need training and support.

The success of most care or service plans – from hospital discharge to everyday care in the home – often rests on the shoulders of the family caregiver. If the family caregiver becomes sick or can no longer cope with caregiving tasks, the person with chronic care needs suffers. If the strain on the family becomes too great, care in the home may be compromised and can lead to nursing home placement – not what most people want. Therefore, effective outcomes in care settings (home, hospitals, community-based care) depend upon knowing the needs and risks of both the individual and the family caregiver.

Research shows that caregiving often exacts a heavy emotional, physical and financial toll, and family caregivers are themselves at risk.

Family members often undertake caregiving willingly, and many find it a source of deep satisfaction and meaning. Yet, family care can have negative effects on the caregiver's own emotional and physical health, financial situation and retirement security, social networks, careers, and the ability to keep their loved ones at home.

The health effects of caregiving are particularly sobering. In fact, some experts now view family caregivers as a vulnerable group themselves,<sup>16</sup> and family caregiving as an important public health concern.<sup>17</sup>

- Caregivers commonly experience emotional strain and mental health problems, especially depression.
- Findings from the American Psychological Association's *Stress in America* survey, show that those who serve as family caregivers to aging relatives report higher levels of stress and poorer health than the population at large. More than half (55%) of caregivers surveyed said that they felt overwhelmed by the amount of care their family member needs.<sup>18</sup>
- In the recent AARP Public Policy Institute and United Hospital Fund national study, *Home Alone: Family Caregivers Providing Complex Chronic Care*, 40 percent of the caregivers performing medical/nursing tasks reported feeling down, depressed, or hopeless in the last two weeks.
- Research has shown that caregivers have poorer physical health than their noncaregiving peers, with an estimated 17 to 35 percent reporting their own health as fair to poor.
- Various studies have linked family caregiving with serious health consequences including heart disease, hypertension, stroke, poorer immune function, slower wound healing, impaired self-care, sleep problems and fatigue, and increased use of psychotropic drugs, and even death among highly stressed spouse caregivers.<sup>19</sup>
- A recent national study found that individuals reporting high levels of strain from caregiving may have a risk of mortality as strong as someone who has a history of cardiac disease.<sup>20</sup>

Because family caregivers often do not have free time for themselves or to be with others, they frequently experience social isolation from a loss of social contacts or from the difficulties of trying to identify and navigate practical community services to help them and those they care for. According to the National Alliance for Caregiving and AARP study, *Caregiving in the U.S., 2009*, over half (52%) of family caregivers say that their caregiving responsibilities take them away from friends or other family members. Caregivers who experience social isolation also experience high levels of caregiver stress that can lead to burnout. The impact is particularly severe for family members who care for loved ones with complex chronic health conditions and both functional and cognitive impairments, such as Alzheimer's disease.

Family caregivers have also reported financial hardships as a result of caregiving and concerns about the impact of providing care on their personal savings. The financial impact of caregiving takes a particular toll on family members when it affects their ability to work and their future retirement security.

- One survey found that more than four in ten (42%) caregivers spend more than \$5,000 a year on caregiving expenses.<sup>21</sup>
- A Kaiser Women's Health Survey found that about one in five (21%) women report that caregiving strains their household finances.<sup>22</sup>
- Caregivers to persons age 50 and older reported spending an average of 10 percent of their annual income on caregiving expenses, or an average of \$5,531 (in 2007); long-distance caregivers had the highest average annual expenses (\$8,728).<sup>23</sup>
- There is evidence that assuming a caregiving role for aging parents may substantially increase women's risks of living in poverty and receiving public assistance in old age.<sup>24</sup>

Family caregivers report using their own savings and cutting back on spending for their own preventive health to pay for caregiving expenses. They also report reducing or stopping saving for their own future, potentially putting their own retirement security at risk.

Research shows that unrelieved caregiver depression, exhaustion, financial concerns and other care-related strain are major contributing factors to institutionalization of the care recipient, often resulting in higher public expenditures for nursing home costs.

Caregiving is a fragile balancing act for those who combine work in the labor force with unpaid work as family caregivers.

Nearly three in four (74%) family caregivers have worked at a paying job at some point during their caregiving experiences, and over half (58%) are currently employed either full-time or part-time.

- A recent AARP survey<sup>25</sup> found that about seventeen percent of midlife and older workers (aged 45 to 74) have taken a leave from a job in the past five years to care for an adult family member.
- About one in five (20%) of these workers expects to take time off from their job in the next five years because of caregiving responsibilities. For African American workers, 1 in 4 (25%) expects to take a leave from their job due to caregiving concerns.

Caregiving responsibilities can impact both individual workers and employers. When it becomes difficult to juggle caregiving activities with work and other family responsibilities, conflicts can usually be mitigated by relatively minor accommodations.

- Nearly seven in ten (69%) caregivers report making work accommodations because of caregiving, most simply by arriving late/leaving early or taking some time off during the day (64%).
- A smaller number need more substantial accommodations, such as cutting back on work hours or changing jobs (9%), taking a leave of absence (17%), or even stopping work entirely (10%).

The financial impact on working caregivers who leave the labor force due to caregiving demands can be severe.

- Estimates of lifetime income-related losses sustained by family caregivers age 50 and older who leave the workforce to care for a parent range from a total of \$283,716 for men

to \$324,044 for women—or \$303,880 on average, in lost income and benefits over a caregiver’s lifetime.<sup>26</sup>

Many studies document the business case for instituting workplace policies that support and accommodate caregiving employees.<sup>27</sup> The human resources and costs savings to employers from offering supportive arrangements for working caregivers and other employees can amount to far more than the cost of not doing so.

- It has been estimated that U.S. businesses lose up to \$33.6 billion per year in lost productivity from full-time caregiving employees.<sup>28</sup>

### The Future Care Gap: Demographic and Social Trends will Affect Family Care in the Future

The statistics are startling, personal, and no longer abstract. In 2026, only 13 years from now, the U.S. can anticipate a surge in its oldest old population—those most in need of LTSS—as the first members of the baby boomers celebrate their 80<sup>th</sup> birthdays. By 2050, there will be about three times as many older people in the U.S. aged 80 and older than there are today.

The aging of the population and changing patterns of family life will greatly increase the demands on family who provide and coordinate LTSS for their relatives or close friends. These profound changes will affect nearly every American family in the future.

Forthcoming research from AARP’s Public Policy Institute looks at the potential supply of family caregivers between 1990 and 2050.<sup>29</sup> We constructed a “caregiver support ratio” by comparing the number of potential caregivers to the number of people in the high risk years of age 80 and older. We used ages 45-64 as the range of potential caregivers, since these ages roughly correspond to the ages of the adult children of the very old and they are confirmed by data regarding the most common ages of family caregivers.

Our research indicates that from 1990 to 2010, the population age 80+ increased by 62 percent, but the number of potential caregivers age 45-64 increased more rapidly—by 77 percent—as Boomers aged into the peak caregiving years. As a result, the number of potential caregivers for every person age 80+ increased from 6.6 in 1990 to 7.2 in 2010.

In combination with declining rates of widowhood and disability, the increasing number of family caregivers has been a major factor in a 37 percent decline in institutional use among the older population between 1984 and 2004—and a 26 percent decline in the “aged” Medicaid population in nursing homes between 1995 and 2010.<sup>30</sup>

The positive trends of the past couple decades may continue for another decade, but the aging of the Baby Boomers will send the caregiver support ratio plummeting. It will also likely place enormous strains on family caregivers and paid LTSS services after that time. The widening of the care gap will grow dramatically as Baby Boomers age into their 80’s, beginning in 2026. By 2030, the number of potential caregivers to every person 80+ will decline sharply from 7.2 to 4.1, and it will continue declining to 2.6 by 2050. These national trends will be reflected in major declines in the caregiver support ratio in all 50 states and the District of Columbia.<sup>31</sup>

Several factors may influence the future supply of family support for the frail older population, such as: delayed marriage and childbirth, high rates of divorce, fewer adult children (means smaller family size), increasing numbers of childless women, and more women in the labor force. A few facts illustrate these social trends:

- The divorce rates of persons aged 50 and older has doubled between 1990 and 2010, and research suggests this trend will continue until 2030.<sup>32</sup>
- Nearly twenty percent of women in their early 40s are childless today; double the percentage in 1970 (10 percent).<sup>33</sup>
- The percentage of frail elders without any surviving children is projected to increase from 16 percent in 2000 to about 21 percent in 2040.<sup>34</sup>
- In 2010, nearly half (47%) of women worked outside the home, up from only 33 percent in 1960.<sup>35</sup> Women in their 40s and 50s are most likely to have eldercare responsibilities, and the great majority (76% for women aged 40-49; 71% for women aged 50-59) are employed.<sup>36</sup>

Sharp declines in the availability of family caregivers will add to the burdens of already stressed families. But they also raise concerns about the future needs for paid services and the pressures on Medicaid and other programs supporting older persons and adults with disabilities. *The future looks unlike the past.*

### Suggested Recommendations for the Commission on Long-Term Care

The following are some steps the Commission could recommend toward greater recognition of and support for family caregivers:

- Develop and implement a national strategy to recognize and bolster families in their caregiving roles. The strategy should identify the specific actions that government, communities, providers, employers, and others can take. The strategy should address areas including:
  - Promoting greater adoption of person- and family-centered care in all health and LTSS settings, with the person and the family caregiver (as appropriate) at the center of care teams;
  - Assessment and service planning (including care transitions and coordination), involving care recipients and family caregivers;
  - Training (including on medical/nursing tasks) and other supports;
  - Information, education, referral;
  - Respite options;
  - Financial security;
  - Workplace policies and supports.
- Preserve and increase funding for existing caregiver support programs, including the National Family Caregiver Support Program and the Lifespan Respite Care Program.
- If a care plan or discharge plan is dependent on family caregivers, ensure that family caregivers' needs are assessed and they have the information, training (including on medical/nursing tasks), equipment, and support needed to carry out their roles.



- Consider reforms in the broader context of Social Security solvency that would protect, and, if possible, improve Social Security benefits for people who provide caregiving to older people, other adults, and children.
- Examine existing programs/mechanisms or create new mechanisms, such as tax credits, to improve the financial security of family caregivers and fund them in a fiscally responsible way. Family caregiver financial security should consider lost wages and benefits, job security and mobility, lost opportunities to plan for the future, and caregiving costs incurred (including for LTSS and medical expenses).
- In Medicare and Medicaid payment, reward provider identification of, assessment of, and communication with family caregivers.

## Conclusion

Family caregivers are the cement holding America's long-term services and supports infrastructure together. They provide LTSS, perform medical/nursing tasks, coordinate care, help individuals live in their homes and communities, and without them, the economic cost to the U.S. health care and LTSS systems would increase astronomically.

Providing meaningful support for family caregivers is one of the least appreciated but important issues that our country must grapple with in the coming years as our population ages. Caregiving families need public acknowledgement, family-friendly workplaces, and real choices for affordable and coordinated services and supports to assist them and those for whom they care, and to help maintain their own health and well-being.

As a country, we need to raise the visibility of and support for caregiving families to prevent burnout. We must also guard against building an LTSS system that relies too heavily on family caregivers. Family members and friends who voluntarily take on the caregiving role should be offered support, not expected to assume greater responsibilities without help.

The current strains on already overburdened families will only be greater in the future.

We urge you to focus on the individuals and their families behind the policy discussion about LTSS—the faces of families struggling to help a parent with Alzheimer's disease, or a grandparent with Parkinson's disease, or a loved one at any age with a disability, or a spouse caring for his wife with multiple chronic conditions and functional limitations.

The magnitude and urgency of the crisis we face in today's LTSS system demands that we act.

AARP thanks the Commission for acknowledging the needs of family caregivers. We look forward to working with the Commission to address the emerging LTSS crisis facing us all. A comprehensive, person- and family-centered LTSS system would both serve the needs of individuals, provide support to family and friends to continue in their caregiving roles, and allow efficiencies in public spending. Thank you for the opportunity to testify today, and I would be happy to answer any questions you may have.

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- <sup>1</sup> Congressional Budget Office, *Rising Demand for Long-Term Services and Supports for Elderly People*, (Washington, DC: CBO, June 2013).
- <sup>2</sup> L. Feinberg, S.C. Reinhard, A. Houser, and R. Choula, *Valuing the Invaluable: 2011 Update, The Growing Contributions and Costs of Family Caregiving*. AARP Public Policy Institute Insight on the Issues 51 (Washington, DC: AARP, June 2011).
- <sup>3</sup> National Alliance for Caregiving (NAC) and AARP: *Caregiving in the U.S. 2009* (Bethesda, MD: NAC, and Washington, DC: AARP, November 2009). Funded by the MetLife Foundation.
- <sup>4</sup> P. Doty, "The evolving balance of formal and informal, institutional and non-institutional long-term care for older Americans. A thirty-year perspective." *Public Policy & Aging Report* 20, no. 1 (2010): 3-9.
- <sup>5</sup> AARP and the Ad Council are in the midst of a three-year caregiving campaign that seeks to bring awareness to the issue of family caregiving. The campaign aims to help boomer women: 1) recognize that the help they provide to a parent, family member or friend is what can be called "caregiving"; 2) identify, impact, and connect with them through a series of public service announcements across the United States; and 3) provide them with caregiving information and resources through our Caregiving Resource Center, [www.aarp.org/caregiving](http://www.aarp.org/caregiving).
- <sup>6</sup> S.C. Reinhard, C. Levine, and S. Samis, *Home Alone: Family Caregivers Providing Complex Chronic Care* (Washington, DC: AARP; New York, NY: United Hospital Fund, June 2013). Funded by The John A. Hartford Foundation.
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- <sup>8</sup> S.C. Reinhard, C. Levine, and S. Samis, *Home Alone: Family Caregivers Providing Complex Chronic Care*.
- <sup>9</sup> E. Miller and W. Weissert, "Predicting elderly people's risk for nursing home placement, hospitalization, functional impairment, and mortality: A synthesis," *Medical Care Research Review* 57, no. 3 (September 2000): 259-97.
- <sup>10</sup> B.C. Spillman and S. K. Long, "Does high caregiver stress predict nursing home entry?" *Inquiry* 46 (2009): 140-61.
- <sup>11</sup> C.L. Levine, D. Halper, A. Peist and D. Gould, "Bridging troubled waters: Family caregivers, transitions, and long-term care," *Health Affairs*, 29, no.1 (January 2010):116-124.
- <sup>12</sup> K. Schwartz and C. Elman, "Identification of factors predictive of hospital readmissions for patients with heart failure," *Heart Lung* 32, no. 2 (March-April 2003): 88-99.
- <sup>13</sup> L. Shugarman, A. Buttar, B. Fries, T. Moore, and B. Blaum, "Caregiver attitudes and hospitalization risk in Michigan residents receiving home and community-based care," *Journal of the American Geriatrics Society* 50, no. 6 (June 2002): 1079-85.
- <sup>14</sup> L. Feinberg, S.C. Reinhard, A. Houser, and R. Choula, *Valuing the Invaluable: 2011 Update, The Growing Contributions and Costs of Family Caregiving*. .
- <sup>15</sup> Institute of Medicine, *Retooling for an Aging America* (Washington, DC: The National Academies Press, 2008).
- <sup>16</sup> Family Caregiver Alliance, *Caregiver Assessment: Principles, Guidelines and Strategies for Change. Report from a National Consensus Development Conference*, Vol. I (San Francisco, CA: Family Caregiver Alliance, 2006).
- <sup>17</sup> R.C. Talley and J. E. Crews, "Framing the public health of caregiving." *American Journal of Public Health*, 97 (2007):224-2009.
- <sup>18</sup> American Psychological Association, *Stress in America* (Washington, DC: American Psychological Association, January 2012).
- <sup>19</sup> See *Valuing the Invaluable: 2011 Update, The Growing Contributions and Costs of Family Caregiving* for citations of research on caregiving and physical health.
- <sup>20</sup> M. Perkins et al., "Caregiving strain and all-cause mortality: Evidence from the REGARDS study," *Journal of Gerontology Series B: Psychological and Social Sciences*, 68 (4): 504-512.
- <sup>21</sup> Caring.com, Usage and Attitude Survey (Caring.com, February 2011).
- <sup>22</sup> U. Ranji and A. Salganicoff, *Women's Health Care Chartbook: Key Findings from the Kaiser Women's Health Survey* (Menlo Park, CA: The Henry J. Kaiser Foundation, May 2011).
- <sup>23</sup> Evercare and National Alliance for Caregiving (NAC), *Family Caregivers—What They Spend, What They Sacrifice; The Personal Financial Toll of Caring for a Loved One* (Minnetonka, MN: Evercare, and Bethesda, MD: NAC, 2007).
- <sup>24</sup> C. Wakabayashi and K. M. Donato, "Does caregiving increase poverty among women in later life? Evidence from the Health and Retirement Survey," *Journal of Health and Social Behavior*, 47, no. 3(2006): 258-74.
- <sup>25</sup> AARP, *Staying Ahead of the Curve 2013: AARP Multicultural Work and Career Study*, (Washington, DC: AARP, June 2013).

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- <sup>26</sup> MetLife Mature Market Institute, *The MetLife Study of Caregiving Costs to Working Caregivers: Double Jeopardy for Baby Boomers Caring for their Parents* (Westport, CT: MetLife Mature Market Institute, 2011).
- <sup>27</sup> L. Feinberg, *Keeping Up with the Times: Supporting Family Caregivers with Workplace Leave Policies*, AARP Public Policy Institute Insight on the Issues 82 (Washington, DC: AARP, June 2013).
- <sup>28</sup> MetLife Mature Market Institute and National Alliance for Caregiving (NAC), *MetLife Caregiving Study: Productivity Loses to U.S. Business* (Westport, CT: MetLife Mature Market Institute, and Bethesda, MD: NAC, 2006).
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- <sup>30</sup> D.L. Redfoot, "The Good News about Medicaid Costs and an Aging Population," AARP Public Policy Institute blog: <http://blog.aarp.org/2013/06/28/the-good-news-about-medicaid-costs-and-an-aging-population/>
- <sup>31</sup> D.L. Redfoot, L. Feinberg, and A. Houser. *The Aging of the Baby Boom and the Growing Care Gap: A National and State-by-State Look at Future Declines in the Availability of Family Caregivers*.
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- <sup>33</sup> G. Livingston and D.V. Cohn, *Childlessness Up Among All Women: Down Among Women with Advanced Degrees* (Washington, DC: Pew Research Center, June 2010).
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- <sup>35</sup> U.S. Bureau of Labor Statistics. *Women in the Labor Force: A Databook*, Report 1034 (Washington, DC: U.S. Bureau of Labor Statistics, December 2011).
- <sup>36</sup> AARP Public Policy calculation of annual averages for 2012 from the Bureau of Labor Statistics, Labor Force Statistics from the Current Population Survey.