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(Original Signature of Member)

119TH CONGRESS
1ST SESSION

H. R. _____

To amend the Public Health Service Act to build a public health infrastructure that promotes the health of family caregivers who support people with disabilities and health conditions across the lifespan, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

Mrs. DINGELL introduced the following bill; which was referred to the Committee on _____

A BILL

To amend the Public Health Service Act to build a public health infrastructure that promotes the health of family caregivers who support people with disabilities and health conditions across the lifespan, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Family Caregiver Awareness, Resources, and Education Partnerships Act'' or the ''Family CARE Partnerships Act''.

SEC. 2. FINDINGS.

Congress finds the following:

(1) It is estimated that more than half (56 percent) of Americans who live to age 65 will develop a disability that requires long-term services and supports (in this section referred to as ''LTSS''), with about 1 in 5 (22 percent) expected to need LTSS for 5 or more years. The vast majority of LTSS is unpaid support provided by family caregivers.

(2) In 2020, a national survey found that an estimated 53,000,000 Americans, about 1 in 5 (21 percent), served as a family caregiver to an adult or a child with a disability or health condition in the past 12 months.

(3) Family caregiving affects Americans of all ages. Although most caregivers (58 percent) are aged 35–64, about 1 in 4 (24 percent) are aged 18–34 and about 1 in 5 (19 percent) are aged 65 and older. Additionally, an estimated 5,400,000 children under age 18 help with providing family care.

(4) In 2021, AARP reported that the unpaid LTSS provided by family caregivers is valued at an estimated $600,000,000,000, which is higher than all out-of-pocket spending on health care in the United States.

(5) Extensive research shows that family caregiving often involves emotional, physical, and financial challenges. Family caregivers also often sacrifice their self-care and delay routine or preventive health care. These challenges place caregivers at risk of costly and potentially debilitating mental and physical health conditions that threaten their own well-being along with the quality of care they provide.

(6) In their 2018 brief, ''Caregiving for Family and Friends — A Public Health Issue'', the Centers for Disease Control and Prevention (in this section referred to as the ''CDC'') and the National Association for Chronic Disease Directors reported that, among Americans aged 45 and older who served as family caregivers, 2 in 5 (41 percent) had multiple chronic conditions such as coronary heart disease, stroke, cancer, arthritis, and diabetes. Further, 1 in 3 (33 percent) had a disability of their own.

(7) When family caregivers are in poor health, they are more likely to relocate their care recipients to an institutional care setting. Institutionalization has profound impacts on people with disabilities, including losing their homes, independence, and community connections. Receiving LTSS in an institu-

tional setting also often exhausts personal and familial resources, requiring significant funding from public and private programs. In 2022, estimates of National Health Expenditure data show that $131,000,000,000 was spent on institutional LTSS in the United States, with over 80 percent of total LTSS spending paid for by Medicaid (61 percent) and other public and private payers (21 percent).

(8) In 2022, a national survey conducted by the National Poll on Healthy Aging found that among Americans aged 50–80 who were family caregivers to adults aged 65 and older, 1 in 3 reported emotional or physical fatigue (34 percent) and 1 in 5 reported a lack of time for self-care (22 percent) because of providing care. Despite these challenges, nearly 2 in 5 (37 percent) said that caregiving made them more motivated to focus on their own health, which suggests a substantial opportunity for public health to address and prevent family caregiver health risks.

(9) The ''National Strategy to Support Family Caregivers'', created pursuant to the Recognize, Assist, Include, Support, and Engage Family Caregivers Act and the Supporting Grandparents Raising Grandchildren Act with public feedback, includes

calls for Federal actions that can be applied to promote family caregiver health. These actions include increasing public awareness, education, and outreach about family caregiving (Goal 1), building community partnerships to support family caregivers (Goal 2), strengthening services and supports for family caregivers (Goal 3), ensuring financial and workplace security for family caregivers (Goal 4), and expanding data, research, and evidence-based practices to support family caregivers (Goal 5).

(10) ''Aging in the United States: A Strategic Framework for a National Plan on Aging'', which was released in 2024 by the Administration for Community Living of the Department of Health and Human Services, highlights the value of promoting the needs of family caregivers.

(11) Existing national public health initiatives, such as the CDC's National Healthy Brain Initiative and the BOLD Public Health Programs to Address Alzheimer's Disease and Related Dementias, include activities to support family caregivers. However, these initiatives are specific to caregivers of people with dementia and do not address the needs of family caregivers who support adults or children with other disabilities and health conditions.

(12) Other national public health initiatives, including the Age-Friendly Public Health Systems developed by the Trust for America's Health and the Healthy People 2030 initiative of the Office of Disease Prevention and Health Promotion within the Department of Health and Human Services, recognize the importance of addressing the needs of family caregivers from a broader, multi-sector public health perspective.

SEC. 3. FAMILY CAREGIVER AWARENESS, RESOURCES, AND EDUCATION PARTNERSHIPS.

The Public Health Service Act is amended by inserting after section 399V–7 (42 U.S.C. 280g–18) the following:

"SEC. 399V–8. FAMILY CAREGIVER AWARENESS, RESOURCES, AND EDUCATION PARTNERSHIPS.

''(a) CENTERS OF EXCELLENCE IN PUBLIC HEALTH PRACTICE.—

''(1) IN GENERAL.—The Secretary shall seek to enter into contracts or cooperative agreements with eligible entities for the establishment or support of national or regional centers of excellence related to public health practice in family caregiving. Such centers shall—

''(A) promote the education of public health officials of States (including political subdivisions thereof), Indian tribes, and tribal organizations, health care and social services professionals, and the public about family caregiver health risks and resources to support family caregiver health;

''(B) advance the efforts of the public health officials referred to in subparagraph (A) in applying evidence-based systems change, communications, programs, and interventions to improve and maintain the health of family caregivers who support people with disabilities and health conditions across the lifespan;

''(C) establish or expand public-private partnerships engaged in activities to promote awareness, resources, and education pertaining to family caregiver health; and

''(D) coordinate with entities that provide caregiver supports (such as area agencies on aging and the National Family Caregiver Support Program under part E of title III of the Older Americans Act of 1965).

''(2) REQUIREMENTS.—To be eligible for a contract or cooperative agreement under this sub-

section, an entity shall submit to the Secretary an application containing such agreements and information as the Secretary may require, including an agreement that the center to be established or supported under the contract or cooperative agreement will operate in accordance with the following:

''(A) After consultation with relevant State and local public health officials, private sector family caregiving researchers, and family caregiver advocates, the center will develop, implement, evaluate, and promote evidence-based programs and interventions to support family caregiver health for health care and social services professionals, families, and the public.

''(B) The center will prioritize—

''(i) increasing awareness of family caregiving and associated health risks among—

''(I) public health officials of States (including political subdivisions thereof), Indian tribes, and tribal organizations;

''(II) health care and social services professionals; and

''(III) the public;

''(ii) expanding knowledge about, and use of services and supports that can promote, family caregiver health among the individuals and groups referred to in clause (i);

''(iii) educating State, local, and tribal officials and public health professionals in the application of established data and evidence-based best practices to promote family caregiver health;

''(iv) reducing the risk of mental and physical health problems among family caregivers through evidence-based approaches;

''(v) improving the management of mental and physical health conditions, including multiple chronic conditions, among family caregivers through evidence-based chronic disease self-management programs; and

''(vi) supporting public health officials of States (including political subdivisions thereof), Indian tribes, or tribal organizations in implementing strategies related to promoting family caregiver health in the

most recent version of the National Strategy to Support Family Caregivers.

''(3) CONSIDERATIONS.—In entering into contracts and cooperative agreements under this subsection, the Secretary shall prioritize applications from eligible entities that—

''(A) can build on an existing infrastructure of service and public health research;

''(B) have previous experience with supporting family caregivers;

''(C) are integrated into existing State, local, or Tribal government and public health infrastructures; or

''(D) have experience collaborating with—

''(i) area agencies on aging through the National Family Caregiver Support Program under part E of title III of the Older Americans Act of 1965;

''(ii) grantees of the National Lifespan Respite Care Program under title XXIX of this Act; or

''(iii) recipients of other federally funded caregiver support programs.

''(b) CONTRACTS AND COOPERATIVE AGREEMENTS WITH PUBLIC HEALTH DEPARTMENTS.—

''(1) IN GENERAL.—The Secretary shall seek to enter into core capacity contracts or cooperative agreements with public health departments of States (including political subdivisions thereof), Indian tribes, and tribal organizations to promote family caregiver health by facilitating the development and implementation of evidence-based systems change, communications, programs, and interventions related to promoting family caregiver health, including through activities involving—

''(A) increasing public awareness about family caregiving and associated health risks;

''(B) enhancing public knowledge about and use of resources to promote family caregiver health;

''(C) educating the public about family caregiver health risks based on established public health research and data;

''(D) developing and implementing needs assessments related to family caregiver health;

''(E) reducing the risk of mental and physical health problems among family caregivers;

''(F) improving the management of mental and physical health conditions, including mul-

tiple chronic conditions, among family caregivers; and

''(G) supporting actions related to promoting family caregiver health in the most recent version of the National Strategy to Support Family Caregivers.

''(2) ELIGIBILITY.—To be eligible to receive a contract or cooperative agreement under paragraph (1), a public health department referred to in such paragraph shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a plan that details—

''(A) how the public health department will develop or expand programs to educate the public about family caregiver health and resources to support family caregiver health through strategic communication, partnership engagement, interventions, and evaluation;

''(B) how the public health department will implement actions in the most recent version of the National Strategy to Support Family Caregivers;

''(C) how the public health department will partner and coordinate efforts with appropriate

State and local authorities, along with any relevant agencies and public and private organizations; and

''(D) how the public health department will evaluate the effectiveness of any program or initiative carried out under the contract or cooperative agreement.

''(3) MATCHING REQUIREMENT.—

''(A) IN GENERAL.—Each public health department that enters into a contract or cooperative agreement under paragraph (1) shall provide, from non-Federal sources, an amount equal to 15 percent of the amount provided under the contract or cooperative agreement (which may be in cash or in-kind) to carry out the activities supported by the contract or cooperative agreement.

''(B) WAIVER AUTHORITY.—The Secretary may waive all or part of the matching requirement described in subparagraph (A) for any fiscal year for a public health department, if the Secretary determines that applying such matching requirement would result in serious hardship or an inability to carry out the contract or cooperative agreement.

''(4) COORDINATION.—A public health department entering into a contract or cooperative agreement under this subsection may, in executing such contract or cooperative agreement, coordinate with the centers of excellence referred to in subsection (a)(1).

''(c) CONTRACTS AND COOPERATIVE AGREEMENTS FOR THE COLLECTION, ANALYSIS, REPORTING, AND DISSEMINATION OF DATA RELATED TO FAMILY CAREGIVER HEALTH.—

''(1) IN GENERAL.—The Secretary shall seek to enter into contracts or cooperative agreements with eligible entities for the following activities:

''(A) The collection, analysis, timely public reporting, and public dissemination of data at the State and national levels related to family caregiver health.

''(B) The monitoring of objectives related to family caregiver health in the 'Healthy People 2030 Report' regarding health status goals for 2030, as well as the development and monitoring of such objectives in subsequent Healthy People reports.

''(2) ELIGIBILITY.—To be eligible to enter into a contract or cooperative agreement under this subsection, an entity shall—

''(A) be a public entity or nonprofit private entity (including an institution of higher education); and

''(B) submit to the Secretary an application at such time, in such manner, and with such information as the Secretary may require.

''(3) SURVEILLANCE.—The collection, analysis, timely public reporting, and public dissemination of data related to family caregiver health at the State and national levels under a contract or cooperative agreement under this subsection may be carried out by eligible entities using the following data sources:

''(A) The Behavioral Risk Factor Surveillance System.

''(B) The National Health and Nutrition Examination Survey.

''(C) The National Health Interview Survey.

''(D) Data sources of other Federal, State, or private entities.

''(4) REPORTING.—Not later than 2 years after the date of enactment of this section, and every 2

years thereafter, the Secretary shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate a report that includes—

''(A) a summary of key findings of eligible entities in carrying out contracts and cooperative agreements under this subsection; and

''(B) a description of how the data collected pursuant to such contracts and cooperative agreements have been, or will be, shared with relevant stakeholders and the public.

''(d) NONDUPLICATION OF EFFORT.—The Secretary shall ensure that activities under any contract or cooperative agreement under this section do not unnecessarily duplicate efforts of other agencies and offices within the Department of Health and Human Services related to—

''(1) the activities of centers of excellence in public health practice related to family caregiver health described in subsection (a);

''(2) the activities of public health departments related to family caregiver health under a contract or cooperative agreement entered into under subsection (b); or

''(3) the collection, analysis, timely public reporting, and public dissemination of data related to family caregiver health under subsection (c).

''(e) DEFINITIONS.—In this section:

''(1) FAMILY CAREGIVER.—The term 'family caregiver' means a family member or other individual who has a significant relationship with, and who provides a broad range of assistance to, an individual with a chronic or other health condition, disability, or functional limitation.

''(2) INDIAN TRIBE; TRIBAL ORGANIZATION.—The terms 'Indian tribe' and 'tribal organization' have the meanings given such terms in section 4 of the Indian Self-Determination and Education Assistance Act.

''(3) INSTITUTION OF HIGHER EDUCATION.—The term 'institution of higher education' has the meaning given such term in section 101 of the Higher Education Act of 1965.

''(4) NATIONAL STRATEGY TO SUPPORT FAMILY CAREGIVERS.—The term 'National Strategy to Support Family Caregivers' means the Family Caregiving Strategy developed under section 3(a) of the RAISE Family Caregivers Act (Public Law 115–119).

''(f) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—For the purpose of carrying out this section, there is authorized to be appropriated for each of fiscal years 2026 through 2030—

''(A) $16,000,000 for the activities described in subsection (a);

''(B) $27,000,000 for the activities described in subsection (b); and

''(C) $7,000,000 for the activities described in subsection (c).

''(2) AVAILABILITY.—Funds appropriated pursuant to paragraph (1) shall remain available until expended.''.