

SURVEY OF CURRENT PRACTICES

Health Insurance  
and Shared Services  
Provision for Family  
Child Care Providers



**Survey of Current Practices:**  
**Health Insurance and Shared Services Provision for**  
**Family Child Care Providers**

**Prepared for the Wisconsin Early Childhood Association by**

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## 1.0 Introduction

This report catalogues “best practice” programs that enable family child care providers to access health insurance and/or share services that benefit their businesses. The ICA Group conducted this research on behalf of the Wisconsin Early Childhood Association (WECA) to generate ideas and inform their planning for future services provision to their family child care provider constituents.<sup>1</sup> ICA collected information through Internet searches, literature reviews and interviews with program representatives to determine each program’s sponsorship, scope, eligibility criteria for providers, funding methods and future prospects.

### Health Insurance Models

Mechanisms designed to help family child care providers access health insurance include union organizing, state-sponsored insurance programs and national professional associations. The union and state-sponsored programs are too new or unstable to characterize as “best” practices, but they provide useful examples of efforts to insure low-income providers. Likewise, the only professional association that offers a group insurance plan is fairly new and has experienced some glitches in administering its plan. The models profiled in this report include:

- SEIU Local 925 in Washington and SEIU Local 880 in Illinois, which have contracts with their respective states to establish affordable health insurance plans in 2008.
- Rhode Island’s Child Care Provider Rite Care program, a two-year-old program which extends Medicaid coverage to low-income providers serving children who receive state subsidized care.
- Massachusetts’ Insurance Partnership, a program targeted to *all* self-employed residents within certain family income limits.
- National Association for the Education of Young Children and Association for Childhood Education International, which offer health insurance products to their members through a multi-association trust.
- Child Care Services Association, which helps fund the individual health insurance costs of licensed providers in North Carolina who are working on or have completed child development or early childhood education degrees.
- Freelancer’s Union, a national organization which offers group insurance to individuals who work in New York in one of eight eligible industries (including domestic child care) and individual insurance plans to members in 30 other states including Wisconsin.

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<sup>1</sup> The Wisconsin Early Childhood Association (WECA) is a statewide, nonprofit organization that works to improve the education, professionalism and working conditions of child care givers in center, school and home-based settings.

- National Association for the Self-Employed, which offers individual health insurance plans (and an array of other discounts and business products) to its members.

ICA also looked at strategies that have been pursued to improve access to affordable health insurance for other types of workers. In particular, ICA reviewed the public authority model which has been developed to serve direct care workers in the health care sector, and health insurance purchasing cooperatives. Adapting the public authority model to benefit family child care providers would depend on significant investment by a union, the ability to engage consumers, and a strong economic case to compel the state to act. Purchasing cooperatives have had limited success, however the Wisconsin Federation of Cooperatives has recently created a health insurance purchasing cooperative for farmers and has plans to establish a similar entity for self-employed individuals.

### **Shared Services Models**

In the context of this report, “shared services” relates to cooperative arrangements that enable independent family child care providers to reduce costs, increase efficiencies or otherwise enhance their home-based child care business operations. Among the few models found, administrative functions, including marketing, customer enrollment and billing are the most commonly shared services. Substitutes are also offered by these programs, but with limited success. The model programs that provide management services and shared substitutes are:

- Acre Family Day Care in Lowell, Massachusetts
- Infant Toddler Family Day Care in Fairfax, Virginia
- Monday Morning, Inc. in South Plainfield, New Jersey

A fourth model is the Integrated Care Assistance Network (I-CAN), a relatively new initiative of the Steuben Child Care Project, a Community Action Agency program serving two rural counties in western New York.

### **Bulk Purchasing Programs**

ICA found only one bulk purchasing program benefiting family child care providers. The Steuben Child Care Project in Bath, New York offers providers bulk food items and other products through a local distributor that also supplies its parent Community Action Agency’s senior meal programs. A state-commissioned study in Oregon suggests that family care providers may not need a purchasing cooperative given their ability to access lower cost items through such retailers as Wal-Mart and Costco.

## **Other Services**

### ***Tax Preparation Services***

The annual need for tax preparation is a critical opportunity for outreach to family child care providers to help them improve their business practices and file to receive the Earned Income Tax Credit. Schedule C, a single-page profit and loss statement self-employed individuals are required to file, is an effective tool for helping providers improve their recordkeeping and understand their child care business's finances. Often, low-income providers are eligible for the Earned Income Tax Credit, which can offset their self-employment tax liability and generate cash to their household. Proper documentation of business expenses enables providers to maximize this credit. Several community-based organizations throughout the US have developed tax preparation services and materials specifically to benefit family child care providers, and could be resources to WECA in developing this service.

### ***Public Benefits Screening***

Several organizations have developed web-based applications that enable organizations to screen individuals for eligibility for various federal and state benefits, including Medicaid coverage, food stamps and home heating assistance. Supporting lower income child care providers to ensure access to public sector subsidies to which they are entitled could significantly contribute to their economic security. Bluemark LLC, a New York-based developer of benefits eligibility screening software, has already developed some products for the Wisconsin market and therefore should be able to develop an application for WECA at relatively low cost.

## **2.0 Health Insurance Models**

As self-employed business owners, family child care providers are responsible for their own health insurance. This section of the report includes a description of two union-sponsored health insurance plans, two state plans and five association plans targeting family child care providers or self-employed individuals. The section concludes with a description of public authority and other models developed to serve direct care workers in the health care sector, and health insurance purchasing cooperatives.

Most of the association plans and one state plan (Massachusetts Insurance Partnership) are well-established with long records of service. Rhode Island's plan for low-income child care providers is threatened by budget cuts, although an alternative subsidized health insurance product is available to all low-income, self-employed residents. The two union-sponsored plans are in the process of being implemented. Two characteristics distinguish the union and Rhode Island's insurance plans from the national association plans. First, the union and Rhode Island plans limit eligibility to licensed, home-based providers that serve state-subsidized families, while the association insurance products are available to all members and their families. The association products are individual plans, however, that unlike group plans may exclude people with pre-existing conditions or be priced prohibitively, depending on one's risk profile.

In a survey of Wisconsin family child care providers conducted in 2005, 85% of respondents reported access to health insurance, mainly through their spouse.<sup>2</sup> These results are consistent with data from 10 other states reported by the Center for the Childcare Workforce in 2004, indicating that 60% to 80% of family child care providers have health insurance, usually through a family member. Two states, Kansas and Pennsylvania, reported much lower coverage rates, while data from Nevada showed a disparity between licensed providers (82% covered) and non-licensed providers (64% covered).

ICA's Wisconsin survey did not explicitly ask providers if they considered their current insurance plan affordable. However, 82% of the randomly surveyed providers expressed interest in joining a group offering "access to affordable health insurance and other benefits and services." Dental insurance, retirement plans and disability insurance were named as the "other benefits and services" of greatest interest.

### **2.1 Union-sponsored Plans**

Unions have achieved formal recognition for family child care providers in a dozen states including Wisconsin, where home-based providers are represented by AFSCME/Child Care Providers Together. The union was recognized by executive order of Wisconsin's Governor Jim Doyle in October 2006 and represents about 6,000 licensed and certified family child care providers. In April 2008, the union reached an agreement with the state that provides "new rights and a formal role in the regulatory process," according to the union's statement. Union members

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<sup>2</sup> *Preliminary Analysis: Feasibility of Co-Employment Model for Wisconsin Child Care Workforce*, The ICA Group, June 2005.

voted on the agreement in May and the votes will be counted in early June. AFSCME’s plans with regard to health insurance for family-based providers is unknown. In Oregon, AFSCME has won agreement from the state to “work together to explore” ways to help family child care providers “access affordable, comprehensive health insurance coverage.”<sup>3</sup>

AFSCME and SEIU are the two unions most actively working to organize family child care providers, and in 2006 agreed on the states (or regions within states) where each would focus its efforts.<sup>4</sup> The table below provides a summary of their jurisdiction and current status in 25 states. Other unions that represent family child care providers include the American Federation of Teachers, the Communication Workers of America and the United Auto Workers.

<b>Union Jurisdiction</b>	<b>States Where Union Representation Authorized:</b>	<b>States with Signed Contracts:</b>	<b>States Where Legislation Vetoed:</b>
<b>AFSCME</b>			
Hawaii			
Iowa	X	X	
Kansas	X		
Michigan	X	X	
Oklahoma			
New Jersey	X		
New Mexico			
New York	X		
Ohio	X		
Wisconsin	X	pending	
<b>SEIU</b>			
Arizona			
Colorado			
Connecticut			
Illinois	X	X	
Louisiana			
Maine	X		
Massachusetts			X
Maryland	X		
North Carolina			
Rhode Island			X
Washington	X	X	
<b>Shared</b>			
California			X
Minnesota			
Oregon	X	X	
Pennsylvania			

<sup>3</sup> *Getting Organized: Unionizing Home-Based Child Care Providers*, National Women’s Law Center, February 2007

<sup>4</sup> *Ibid.*

Union organizing efforts mainly focus on providers who receive state subsidy payments, but other providers regulated by states may also be included, in the same or a separate bargaining unit. Membership is voluntary. The legislation and executive orders that authorize family child care providers to organize also identify “bargainable” issues, which usually include:

- Subsidy rates
- Health benefits
- Training and professional development
- Grievance procedures
- Health and safety regulations

In developing contracts with the states, members determine priority issues and must approve any contract that is negotiated.

SEIU Locals in Washington state and Illinois have contracted with their respective states to provide affordable health insurance for family child care providers who care for state-subsidized children. Washington has allocated \$5 million to help cover monthly insurance premiums for up to 650 providers in the budget year beginning July 1, 2008. Illinois has pledged \$27 million.

SEIU Local 925 in Washington announced its health plan to providers in early April 2008 and it is still too early to know what the actual level of enrollment will be among an estimated 2,000 providers who are eligible. SEIU Local 880 in Illinois is still finalizing the details of its plan which is targeted to begin later this year. A comparison of each plan, based on currently available information, is presented on the following page.

	<b>SEIU Local 925</b>	<b>SEIU Local 880</b>
<b>Geographic Scope</b>	Washington	Illinois
<b>Annual Union Dues</b>	\$420 private pay providers or 2% of state subsidy payments up to \$50 per month (max. \$600 per year)	2.1% of state subsidy payments with minimum of \$15 per month (minimum \$180 per year)
<b>Eligibility Criteria</b>	Must be licensed, care for at least 4 subsidized children, provide care for 22 full-day units per month, have no other health insurance	Committee still considering how to define eligibility; intent is to provide comprehensive, low-cost benefit to as many individuals as possible
<b>Family Coverage</b>	No; provider only	Unknown
<b>Who Manages</b>	Through SEIU Trust; three insurance companies - Group Health Cooperative, Kaiser Permanente, Regence	The union will manage the fund; the Health Fund Trust will manage the plan
<b>How Marketed</b>	Begins July 1, 2008; info mailed to providers early April	In development
<b>Provider Cost per Month</b>	\$17	To be determined
<b>State Participation</b>	State will contribute up to \$550 per month per provider	To be determined
<b>Total Membership</b>	10,000; includes 4,000 (of 6,000) licensed and 6,000 license-exempt providers	Approximately 35,000 of which 6,500 are licensed providers
<b>Size of Eligible Pool</b>	2,000	Depends on criteria set
<b>Participation</b>	Funding will cover 650 - 680	Unknown
<b>Other Benefits:</b>		Not yet determined; looking into
<b>Life</b>	No	
<b>Disability</b>	No	

## 2.2 State-sponsored Plans

### Rhode Island: Child Care Provider Rite Care

Prior to the SEIU contracts with Illinois and Washington, Rhode Island was the only state that offered subsidized health insurance to home-based child care providers. In 1996, the legislature passed a measure granting health coverage to family child care providers with whom it contracted to care for subsidized children. A key impetus for the program was welfare reform as

the state sought to increase child care slots for welfare recipients who were returning to the workforce. Also driving the process was the Home Daycare Justice Committee, a grass-roots provider group that had been lobbying the state for better pay and benefits since the early 1990s.

By 2005, fiscal pressures led the state to restructure the coverage and restrict eligibility. It increased the amount providers must earn from the state to \$7,700 per 6-month period (the equivalent of two full-time children vs. one-full time child equivalent originally), set the income cap at 350% of federal poverty level, and required eligible providers to join the state’s Medicaid program.

The program is currently threatened by repeal as part of Medicaid cuts proposed by the Governor to balance the state’s budget. An estimated 225 providers and dependents would lose eligibility for coverage under the Governor’s proposed cuts.<sup>5</sup>

**Child Care Provider Rite Care**

<b>Annual Membership Fee</b>	None
<b>Eligibility Criteria</b>	Certified by Department of Children, Youth & Families; annual household income 185% to 350% of Federal Poverty Level; paid at least \$7,800 in state subsidies for child care services in 6 months prior to application.
<b>Family Coverage</b>	Provider and children but not spouse
<b>Who Manages</b>	Department of Human Services
<b>Provider Cost per Month</b>	\$77 to \$130
<b>Size of Eligible Pool</b>	1,017 total licensed day care homes; unknown how many fit eligibility criteria
<b>Participation</b>	Under 2005 plan, 817 providers <i>and dependents</i> were estimated to continue to receive health coverage (through Medicaid <i>and</i> CCPRC)
<b>Other Benefits:</b>	
<b>Life</b>	No
<b>Disability</b>	No

An alternative insurance product – Blue Cross Blue Shield’s Direct Pay plan – is available to *all* self-employed residents of Rhode Island and covers some 14,000 people. Currently, Blue Cross subsidizes premiums of customers whose household income is below 350% of the Federal Poverty Level through its Access Blue program. The state of Rhode Island is also working with

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<sup>5</sup> Rhode Island KIDS COUNT, March 6, 2008

Blue Cross Blue Shield to develop a discount for members who participate in a wellness program.

**Massachusetts: The Insurance Partnership**

As of July 1, 2007 all Massachusetts residents (with some exceptions) are required to obtain health insurance. The Insurance Partnership is a Massachusetts state program begun in 2000 and designed to help self-employed individuals and small businesses (with less than 50 people) pay for health insurance. Essentially, the program provides a subsidy toward the cost of privately-purchased insurance to participants with household income up to 300% of Federal Poverty Level.

**The Insurance Partnership**

<b>Annual Membership Fee</b>	None
<b>Eligibility Criteria</b>	Resident, age 19-64; self-employed or work as independent contractor; maximum income 300% of Federal Poverty Level (currently \$31,212 for individual + \$10,800 for each additional dependent)
<b>Family Coverage</b>	Yes
<b>Who Manages</b>	The Insurance Partnership qualifies participants and determines co-pay amount
<b>How Marketed</b>	Web site; also promoted by chambers of Commerce, private insurance companies, community organizations
<b>Provider Cost per Month</b>	Sliding scale; a 3-person household with \$51,516 income would pay \$528 of a \$1,000 monthly premium
<b>Size of Eligible Pool</b>	Unknown
<b>Participation</b>	18,000 total enrollment includes employees of small businesses
<b>Other Benefits:</b>	
<b>Life</b>	No
<b>Disability</b>	No

Since the new law requiring health insurance, many more people than expected have enrolled in the state’s various subsidized insurance programs. At the same time, revenues from fees paid by businesses that do not provide insurance to employees have fallen far short of budgeted amounts. Thus, the state is considering its options to increase revenues and control costs, including higher premiums and co-pays.

### 2.3 Professional Associations – Child Care Professionals

Two national child care associations, the National Association for the Education of Young Children (NAEYC) and the Association for Childhood Education International (ACEI), offer health insurance to their members.<sup>6</sup> Enrollment through either organization is managed by the same company, which has consolidated some 60 educational associations into a single trust. The plans and rates are the same for all.

Association	NAEYC	ACEI
<b>Geographic Scope</b>	National	National
<b>Annual Membership Fee</b>	\$88 Comprehensive and \$53 Regular (Wisconsin)	\$144 Comprehensive and \$45 Professional
<b>Family Coverage</b>	Yes	
<b>Who Manages</b>	Forrest T Jones & Company. It's Trust for Insuring Educators includes some 60 educational associations including NAEYC and ACEI	
<b>How Marketed</b>	Via web site	
<b>Provider Cost per Month*</b>	\$435 (\$5,700 deductible, 100% after deductible); option to open Health Savings Account to pay deductible with pre-tax dollars	
<b>Total Membership</b>	Nearly 100,000	About 11,000
<b>Size of Eligible Pool</b>	Unknown how many are family child care providers	Unknown how many are family child care providers
<b>Participation</b>	Unknown	Unknown
<b>Other Benefits:</b>	Liability, auto, ID theft	
<b>Life</b>	Yes	
<b>Disability</b>	Yes	

\*The provider cost per month is based on a sample quote for a 40-year-old woman with 2 children in Milwaukee, Wisconsin.

One nonprofit state association, the Child Care Services Association (CCSA), provides a health insurance benefit through a scholarship program it offers to both center-based and family child care providers in North Carolina. Based in Chapel Hill, CCSA provides free referral services to families seeking child care, technical assistance to child care businesses, and educational scholarships and salary supplements to child care professionals through its T.E.A.C.H. Early Childhood and Child Care WAGES\$ projects. CCSA licenses its programs to other states and provides consultation services nationwide to others addressing child care concerns.

<sup>6</sup> WECA is an affiliate of the National Association for the Education of Young Children

As part of CSSA's scholarship program, the T.E.A.C.H. Early Childhood Health Insurance Program funds a portion of the health insurance cost for licensed providers who have a:

- T.E.A.C.H. Early Childhood scholarship to work on a two or four-year degree in child development or early childhood education, or
- two or four-year degree in these fields.

Participating family providers can choose to have their own insurance or insurance through their spouse (usually with the spouse's employer). They must submit documentation monthly to show payment of their health insurance premium or payroll deductions for their spouse's insurance plan. The program reimburses one-third of the cost of providers' individual monthly rate, up to \$80 per month.

At this time the program has 26 actively participating family child care homes. Of these, 22 already have their two or four-year degree in Early Childhood Education. The other four are participating on a T.E.A.C.H. scholarship and working towards their degree. An additional 20 eligible family child care homes are on the program's waiting list, unable to participate due to limited funding. The program is financed by a federal block grant and distributed to CCSA by the Division of Child Development.

According to CCSA, no other states are licensed to implement the T.E.A.C.H. Health Insurance Program at this time. Several states have expressed interest, but have not received funding to start the program.

## **2.4 Professional Associations – Self-Employed Individuals**

Two associations offer health insurance products to self-employed individuals. The first, Freelancers Union, is a nonprofit advocacy organization that receives grant support and charges no membership dues. The second, National Association for the Self-Employed (NASE), is a membership association with close ties to its insurance products provider, MEGA Life and Health Insurance Company. Unfortunately, MEGA Life and Health Insurance has a disturbing pattern of consumer complaints and lawsuits related to misrepresentation of its policy coverage.

### **Freelancers Union**

The Freelancers Union is a national organization with roots in New York City. It began in 2001 as the Portable Benefits Network and sought to deliver benefits to independent workers, including domestic child care workers, in the New York metropolitan area. Broadly, its mission is to provide a "social safety net" for independent workers. Membership is free, and the organization is funded by grant and other support from national and state foundations, and the State and City of New York.

Nationally, the Freelancers Union has grown to 70,000 members, although about three-quarters (53,000) reside in New York. Group health insurance is available to New York State members.

Individual health insurance plans are available in 30 other states, including Wisconsin. Dental, life and disability insurance plans are available throughout the US.

The group insurance plan offered in New York limits eligibility to individuals in eight professions, including “domestic child care giver.” The eligible employment sector rule does not apply to members outside of New York. The provider cost shown in the following chart is for an individual health plan in Wisconsin.

**Freelancers Union**

<b>Geographic Scope</b>	31 states - Group plan for individuals working in New York only
<b>Annual Membership Fee</b>	None; the only fees are associated with insurance product enrollment
<b>Eligibility Criteria</b>	New York group plan eligibility is based on industry/occupation (8, including Domestic Child Care Giver), hours worked (minimum 20 per week) and/or earnings (\$10,000 in 6-month period). For individual plans, rates and coverage vary depending on medical history, plan and state of residence
<b>Family Coverage</b>	Yes
<b>Who Manages</b>	United Healthcare's Golden Rule Insurance Company and affiliated companies
<b>Provider Cost per Month*</b>	\$178 (\$5,000 deductible, 80% after deductible)
<b>State Participation</b>	Grants received from City and State of New York
<b>Total Membership</b>	70,000 nationally, including 15,000 New Yorkers eligible for group insurance plan
<b>Participation</b>	Unknown
<b>Other Benefits:</b>	Professional discounts, networking opportunities, educational workshops, advocacy initiatives
<b>Life</b>	Yes
<b>Disability</b>	Yes

\*The provider cost per month is based on a sample quote for a 40-year-old woman with 2 children in Milwaukee, Wisconsin.

Freelancers Union staff did not respond to ICA’s attempts to learn how many of its members are family child care providers or their level of participation in the health insurance plans. The extent of the organization’s marketing or outreach to family child care providers is likewise unknown. In New York, information about the Freelancers Union health plan is available from New York

City’s Department of Health (which regulates child care), the Mayor’s Office of Health Insurance Access, and New York State’s Insurance Department.

**National Association for the Self-Employed**

As previously stated, the National Association for the Self-Employed (NASE) has close ties to its insurance products provider, MEGA Life and Health Insurance Company. According to NASE’s public disclosure, “the salesperson that a prospective Member or prospective insured speaks with about NASE membership and about MEGA insurance products serves both as a licensed insurance agent of MEGA and as a field service representative for new Members for the NASE, for which he or she will receive compensation.” Given MEGA’s history of consumer complaints and lawsuits, individuals considering MEGA’s insurance products are advised to check with their state department of insurance for its record of complaints compared with other health insurance companies.

**National Association for the Self-Employed (NASE)**

<b>Geographic Scope</b>	National
<b>Annual Membership Fee</b>	\$120 Basic and \$480 Premier
<b>Family Coverage</b>	Yes
<b>Who Manages</b>	MEGA Life and Health Insurance
<b>How Marketed</b>	Via NASE web site; MEGA agents also market directly to members
<b>Provider Cost per Month*</b>	\$242 (\$5,000 deductible, 70/30 coinsurance)
<b>Total Membership</b>	Over 100,000 members
<b>Size of Eligible Pool</b>	Unknown how many are family child care providers
<b>Participation</b>	Unknown
<b>Other Benefits:</b>	Business, auto, E&O and accidental death insurance plus wide range of product discounts for all; business equipment and liability insurance and additional business services for Premier Level members
<b>Life</b>	Yes
<b>Disability</b>	Yes, for Premier Level

\*The provider cost per month is based on a sample quote for a 40-year-old woman with 2 children in Milwaukee, Wisconsin.

## **2.5 Other Models**

In an attempt to identify models for improving access to affordable health insurance for family based childcare providers, ICA also looked at strategies that have been pursued to accomplish this goal for workers in other industries. In particular, ICA reviewed models that have been developed to serve direct care workers in the health care sector. Several of these models are discussed briefly below.

### **The Public Authority Model**

In several states, organizing efforts have succeeded in establishing public authorities as employers of record for home health workers. The strategy was first successfully pursued in California to benefit workers in the In-Home Supportive Services program (IHSS), California's home care program which employs approximately 300,000 workers. The public authority concept was developed by the labor movement in response to the challenges they had faced in organizing workers in the IHSS program. The Service Employees Industrial Union (SEIU) had tried to organize these workers in the past but had been stymied when the courts ruled that the workers were neither employees of the state that paid them nor the counties to which they submitted their time sheets.

SEIU eventually concluded that they needed to establish an employer of record for these workers if they were to be organized. SEIU formed a coalition with a number of consumer advocacy groups including the California Senior Legislature, the California Foundation for Independent Living Centers and IHSS participants to pursue legislative action to establish a public authority which could serve as an employer of record. In 1992 they succeeded in getting a law passed that made it possible to establish public authorities at the county-level to oversee home health service delivery.

Fifty-eight counties in California now have public authorities for overseeing the IHSS program. Since the introduction of the public authority model, workers have received substantial pay increases and have secured health insurance coverage. The successes in raising wages and benefits is in large part due to a follow-on law passed in 1999 which mandated that the state would pay 65% of wages above a minimum threshold to support total compensation increases to \$11.50 per hour.

Conversations with individuals involved in the development of the public authority model in California indicate that the engagement of consumers (receivers of care and their family members) was absolutely critical to the organizing effort. Consumers had to be persuaded that this was a quality of care issue and not just a labor issue. Once consumers and their advocates had been persuaded, they could be mobilized to advocate for change with the county level decision makers. In addition, proponents of the public authority model were able to make an economic argument to the state centered on the program's potential to increase the amount of community-based care and reduce dependence on more costly institutional care.

Oregon was the next state to adopt a public authority model. In 2000, a constitutional amendment was adopted that created a statewide quality home care commission patterned after

the California model. This new entity became the employer of record for 13,000 formerly independent contractors. In 2001, the caregivers joined SEIU and won a contract that provided paid health insurance, workers compensation coverage, paid vacation, and a \$.70 per hour wage increase.

Washington State followed suit in 2001 with a ballot initiative that approved a public authority to serve as the employer of record for 26,000 home care workers. Its subsequent contract stipulates an hourly rate of \$9.73 and individual health insurance at \$17.00 per month. Since 2001, public authorities have been established in Illinois, Michigan, Ohio and Massachusetts.

### ***Adaptation of Public Authority Model to Family Child Care Providers***

While the public authority model has been very successful in improving wages and benefits for home care workers, it is not clear that it can be successfully adapted to benefit family child care providers. First of all, the model to date has been dependent on a union willing to commit substantial resources to an extended organizing campaign. For a union to justify its investment, the campaign must at least hold out the prospect of a substantial gain in dues paying membership.

Secondly, these campaigns have needed very strong engagement from consumers to be successful in persuading state legislatures of the merits of the argument. Consumers of subsidized child care are, by definition, low income. Their resources and experience in exerting political power may be less developed on average than the average consumer of home health services. Furthermore, consumers of home health services may consume the services for many years or even a lifetime. For consumers of child care, on the other hand, their direct experience with the system may be limited to a relatively short number of years. Accordingly, it may not be possible to achieve the same level of engagement among consumers of child care as among consumers of home health care.

Thirdly, part of the argument for public authorities in health care has been that improving and expanding home-based care reduces reliance on more costly institutional care. As a result, increases in labor costs for community-based care can be justified on an economic basis by asserting that consumption of institutional care will be reduced. With child care, other persuasive economic arguments would need to be made. One such argument might be that if access to quality family child care were expanded, low-income individuals would be able to work more, earn more, and thereby reduce the state's public assistance burden.

There are also logistical questions that would need to be resolved if this model were to be adapted to serve family child care providers. For example, some providers serve a mix of private pay and state-subsidized children. A key question is whether eligibility would be limited to providers exclusively serving subsidized children or a mechanism could be created to pro-rate reimbursements.

## **Other Health Care Sector Initiatives**

In addition to the establishment of public authorities, other models are being tested to improve access to health insurance for direct care workers in the health care sector. Some models focus on directly assisting workers with the cost of health care expenses while others seek to have the costs of providing health insurance included in Medicaid reimbursement rates.

### ***Assisting Workers with Health Care Related Expenses***

In New Mexico, seven disability providers in New Mexico developed a Health Care Arrangement (HRA) for direct care workers, to provide limited assistance with health care expenses. The HRA was funded with a \$1.4 million federal grant to fund a three-year demonstration to test the impact of providing health care coverage on recruitment and retention of direct care workers. The demonstration ended in the fall of 2007.

The HRA had three components: basic health insurance, a prescription discount card, and a monthly cash benefit account. The “health insurance” reimbursed a fixed amount for a select number of health care services. Workers were required to pay the difference between the set amounts and the actual charge for care. The prescription discount card provided discounts of 10% or more on prescription drugs and medical equipment. The monthly cash benefit account was a tax free health reimbursement account established for each enrolled direct care worker. Employees who worked 30 or more hours per week got a \$60 per month contribution to their account, and part-time workers received \$30 per month. These three components together cost \$111 per employee per month.

The HRA program offered low-cost flexible assistance with various health care costs. However, it did not offer true comprehensive coverage but rather very limited health insurance. The program was entirely dependent on demonstration grant funding. It is unknown whether the grantees continued the program beyond the demonstration grant period.

### ***Incorporating Insurance Costs in Medicaid Reimbursement***

In several states, efforts have been launched to link Medicaid reimbursement rates to the provision of health insurance for agency workers. Two such efforts, in New York and Montana, are discussed briefly below.

- *New York*

In 2006 the New York Office of Mental Retardation and Developmental Disabilities (OMRDD) implemented a program to encourage employers to offer health care coverage to direct care workers through additional funding built into the Medicaid reimbursement rate. For agencies that did not previously offer coverage, the program makes available up to \$2,500 per worker per year. For agencies looking to expand coverage, between \$325 and \$425 per eligible worker per year is available. Premium costs, costs to employees and costs to the employer vary by agency. Out of a total of 700 agencies, about half have chosen to participate in the program.

The program seems to primarily be helping agencies that already offered coverage expand coverage and/or reduce out of pocket costs for employees. The funding is insufficient to cover the costs of full coverage and thus very few agencies are electing to offer coverage if they were not already doing so.

- *Montana*

Montana has recently enacted legislation that provides for higher Medicaid reimbursement levels to home health agencies that provide health insurance for their workers. It is anticipated that the program will cover about 1,000 workers. The program will only support individual coverage. However, the program will not be implemented until 2009 and final details of the plan have yet to be established. Because it is embedded within the Medicaid reimbursement it will trigger federal matching funds. In Montana, this means that almost 70% of the cost of the enhanced rate will be paid for by federal matching funds.

It is important to note that the structure of Medicaid is such that it is possible for states to leverage their own increased Medicaid spending with matching funds from the federal government. In addition, many trial efforts to expand health coverage for health care workers have been funded with demonstration grants from the Center for Medicare and Medicaid Services (CMS). A question is whether the Child Care and Development Fund (administered by US Department of Health and Human Services, Administration for Children and Families) or other federal funding sources could provide the same form of leverage or demonstration support for child care workers.

### **Health Insurance Purchasing Cooperatives**

Over the years, the idea of using health insurance purchasing cooperatives as a strategy to expand access to more affordable insurance for smaller employers has been floated, and tried, in several different geographic markets in the U.S. In theory, a purchasing cooperative can consolidate the demand of a number of smaller employers, increase their leverage in the market place, and enable them to negotiate cheaper and/or better health insurance coverage for their employees.

Proponents of health care purchasing cooperatives argue that they could offer other advantages as well. For example, by consolidating demand across employers and achieving scale they should be able to offer a choice of plans to employees whose own employers are too small to offer more than one plan. Another advantage is that if workers leave one job for another position at a firm that buys through the cooperative, they can avoid having to change health plans and therefore avoid changing physicians.

Another advantage often attributed to purchasing cooperatives is the potential to pool risk among employers with various risk profiles. By joining together, employers can spread risk by pooling with firms that differ in respect to the probability that members of their workforce will incur medical expenses for which the insurer will have to pay. In theory, this would reduce the cost of coverage for higher-risk groups. In practice, however, it is difficult to realize this advantage.

In many states, insurers are able to use risk-rating to set premiums for firms that buy coverage outside of the co-op. As a result, lower-risk employers will typically find it cheaper to buy coverage outside of the cooperative since they will be offered a price that reflects their own level of risk rather than the higher average of the cooperative. If that happens, the average level of risk of the employers remaining in the purchasing cooperative would rise, driving up the cost of coverage for the cooperative and encouraging still more lower risk employers to leave. In theory, this would lead to a vicious cycle of exiting firms and increasing costs. As a result, to be viable, a purchasing cooperative must essentially follow the same practices as the outside market when dealing with employers with different risk profiles. If the outside market is permitted to charge higher-risk employers higher premiums, the purchasing cooperative will have to do the same in order to avoid the scenario outlined above.

One of the most successful health insurance purchasing cooperatives is the Cleveland, Ohio based Council of Smaller Enterprises (COSE). COSE currently has over 11,000 member companies with a total of 175,000 employees receiving insurance through the cooperative. COSE is a program of the Greater Cleveland Partnership, one of the nation's largest metropolitan Chambers of Commerce. For many years COSE only offered a single health plan. Thanks to a very close relationship with Blue Cross Blue Shield, and essentially sourcing exclusively from Blue Cross Blue Shield, COSE was able to negotiate lower rates for its members. Recently, COSE has expanded the number of plan options it offers and continues to be the leading insurance provider in the Cleveland area small group market.

Unfortunately, COSE's success has proven to be exceptional among health insurance purchasing cooperatives. Other models, even ones that are frequently cited as successful, have failed in recent years. For example, PacAdvantage, which was founded in 1989 in California, had been providing insurance to approximately 150,000 workers. However, in 2006 they were forced to suspend operations when they were unable to renegotiate acceptable terms with their insurers. Similarly, the Florida Community Health Purchasing Alliances also failed, even after attracting significant numbers of participants. Originally a state-created consortium of 11 separate alliances, the cooperatives enrolled 92,000 people at their peak in 1998. Over time, though, the Florida alliances found that they were able to attract only very small employers. As a result, they became less attractive to insurers and found, as did PacAdvantage, that insurers lost interest in participating in the program. Enrollment began to fall as the number of plans offered declined. The Florida Community Health Purchasing Alliances finally ceased operations in 2000.

It is clear from the experience of purchasing cooperatives that to succeed they must be able to attract large numbers of employers, or more precisely, a large number of employees seeking coverage. Furthermore, it is important that they attract not just very small employers but also small and medium size enterprises. Without large numbers of participants, purchasing cooperatives are unable to achieve economies of scale, exert purchasing power to negotiate lower rates, or attract and retain health plans.<sup>7</sup>

Purchasing cooperatives are, by their nature, often unappealing to health plans, for many of the same reasons they are potentially attractive to consumers. They are designed to give consumers

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<sup>7</sup> Health Insurance Purchasing Cooperatives, Elliot K. Wicks. Task Force on The Future of Health Insurance, Issue Brief November, 2002

increased bargaining leverage with insurers and provide expanded choice of plans. From the health plan's perspective, this means lower margins and higher turnover among enrollees. It also may mean that their chances of attracting and retaining all of the employees of an employer group may be better if they market directly to the employer rather than through the coop.

To be attractive to health plans, the cooperative must be able to offer significant scale. To be attractive to consumers, the cooperative must be able to offer competitive rates and a choice of plans. The cooperative is thus faced with a chicken or egg problem: without large numbers of enrollees it is difficult to attract health plans and negotiate lower rates. Without a choice of plans and lower rates it is difficult to attract consumers.

Finally, research has shown that, in general, purchasing cooperatives have failed to significantly reduce the cost of health insurance for their members. For the most part, premiums for cooperative members have not been lower than those available to other small employers in the market outside of the cooperative.<sup>8</sup> The failure to achieve significant cost reductions is apparently attributable to the difficulty these cooperatives have had in achieving market share sufficient to negotiate discounts with health plans. Since most purchasing cooperatives have tended to attract large numbers of expensive-to-serve small employers, they have also had difficulty achieving operating efficiencies to reduce member costs.

Despite the mixed track record of purchasing cooperatives new initiatives continue to develop. In Wisconsin, recently enacted Coop Care legislation permits cooperatives of farmers, small businesses, and self-employed individuals to be treated as large groups for insurance purposes. The Wisconsin Federation of Cooperatives was the driving force behind the legislation which enables the Federation to create five health care purchasing cooperatives. The first of these, The Farmers' Health Cooperative, is just completing its first year of operations. To date, they have 2,000 enrolled farmers/families.

To be eligible to enroll in the Farmers' Health Cooperative you must live or work in Wisconsin and be actively at work in production agriculture whereby at least 66 percent of your income is derived from farming. "Actively at work" is defined as working a minimum of 30 hours per week on a regular basis and not on a temporary (less than six months) or substitute basis.

The cooperative offers six plans with deductibles ranging from \$300 to \$5,000. Monthly premium costs range from \$978 per month for a \$300 deductible 80%-20% plan to \$796 for a \$2,500 deductible 80%-20% plan. In addition to monthly premium costs, members pay a \$12 per month administrative fee and a one time "capitalization" charge equal to 110% of a month's premium. This capitalization charge is refundable upon leaving the cooperative provided you have been enrolled for at least three years.

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<sup>8</sup> U.S. General Accounting Office, *Private Health Insurance: Cooperatives Offer Small Employers Plan Choice and Market Prices*, GAO-HEHS-00-49, March 2000, p. 20.

The cooperative's provider network includes approximately 17,000 practitioner locations, 500 ancillary care facilities and 125 participating hospitals with access to service throughout Wisconsin. Benefits of membership include:

- Guaranteed issue – no denial for pre-existing health conditions
- Coverage for work related injuries
- Tax deductible health savings account (HSA)-compatible plans
- First dollar preventive care coverage
- Prescription drug coverage
- Maternity coverage
- Freedom to choose one's own provider
- 24-hour nurse line

The cooperative's goal is to improve the quality of coverage offered to farmers and workers in farm-related occupations while maintaining rate stability. Rate increases for the second year of operations were about 7.9%, less than the average increase in the broader market according to the cooperative.

Ultimately, the Wisconsin Federation of Cooperatives hopes to expand health insurance purchasing cooperatives beyond workers in the agricultural sector to serve a broad range of individuals. While the Farmers' Health Cooperative is an interesting model for providing insurance coverage to family child care providers and their families it is still in the early stages of development. Whether it will be able to achieve scale sufficient to retain the interest of plan providers and enrollees remains to be seen. Additionally, it is too early to tell whether the cooperative will be able to reduce rate increases in the future (relative to the market) and maintain economic viability.

A health care purchasing cooperative focused exclusively on serving family based child care providers is likely to struggle with the same issues that have challenged most other health care purchasing cooperatives. The very small size of family child care businesses, with most having only one worker seeking coverage, would make it difficult to achieve scale in terms of enrolled individuals. Furthermore, the large number of members required to achieve significant scale would mean that operating efficiencies would be very difficult, if not impossible, to achieve.

### 3.0 Family Child Care Shared Services Models

“Shared services” relates to cooperative arrangements that enable independent family child care providers to reduce costs, increase efficiencies or otherwise enhance their home-based child care business operations. Among the models identified in this report, administrative functions, including marketing, customer enrollment and billing, are the most commonly shared services. Substitutes are also offered by these programs, but with limited success. Only one program offers bulk purchasing discounts to providers.

Community development agencies in at least seven states have developed tax preparation services and materials specifically to benefit family child care providers. Other organizations have developed public benefits screening services to help low-income families take advantage of Medicaid coverage, food stamps, home heating assistance and other federal and state benefits that can enhance their economic well being. In addition to benefiting individual providers, the availability of such support services can help retain family care providers and recruit new providers, thus increasing the number of quality child care slots in a community.

#### 3.1 Administrative Services

ICA identified four organizations that provide shared administrative services to their respective networks of family child care providers. As summarized below, Monday Morning, Inc., Infant Toddler Family Day Care and Acre Family Day Care have operated for at least two decades and are well-established.<sup>9</sup> The fourth model, Integrated Care Assistance Network (I-CAN), is a relatively new initiative sponsored by the Steuben Child Care Project, a Community Action Agency program in western New York.

Organization	Year Began	Type of Agency	Number of Providers	Customer Base	Fees to Providers
Monday Morning Inc. South Plainfield, New Jersey	1981	for-profit	90	Private pay	None; parents pay all fees
Infant Toddler Family Day Care Fairfax, Virginia	1983	non-profit	125	Private pay	16.5% admin fee on parent billings
Acre Family Day Care Lowell, Massachusetts	1988	non-profit	55	Public subsidy	None
Integrated Care Assistance Network (I-CAN) Steuben Child Care Project Bath, New York	2004	non-profit	23 (of 140 total)	Public subsidy	\$35 annual membership

<sup>9</sup> *Collective Management of Early Childhood Programs: Approaches That Aim to Maximize Efficiency, Help Improve Quality and Stabilize the Industry*, 2004, Louise Stoney, Cornell University and the National Smart Start Technical Assistance Center

## **Marketing/Recruitment**

All four agencies market child care services on behalf of their members and help facilitate matches between parents and providers.

## **Billing and Fee Collection**

Monday Morning, Inc. and Infant Toddler Family Day Care, which mainly serve private pay customers, require advance payment from parents. Monday Morning, Inc. bills every two weeks and Infant Toddler Family Day Care monthly. This service is free to Monday Morning, Inc. providers; Infant Toddler Family Day Care charges participating providers a 16.5% administrative fee. Many of Infant Toddler's customers set up accounts for automatic payments via electronic transfer.

Acre Family Day Care administers the subsidy program for its state-contracted slots, including payments to providers. This accounts for most of the providers' business revenue. At providers' request, Acre will also process billings to private pay customers at no charge.

In New York, Steuben Child Care Project likewise administers the subsidy program, qualifying eligible parents and paying providers in the counties it serves. Implementing its offering of billing and fee collection services to I-CAN members will therefore involve enhancing its existing resource capacity to add private pay customers. Steuben intends to purchase a group subscription to Skyhill Software's CK Kids, a web-based child care management software. I-CAN provider members will have the option to manage billings on their own, utilizing this software, or Steuben can perform this service on their behalf.

## **Other Business Services**

Monday Morning, Inc. offers equipment and curriculum ideas for daily activities and projects.

Acre Family Day Care manages a loan program that enables providers to borrow up to \$5,000 for business purposes. Loan terms are one year at 4% interest, with occasional extensions. Larger loans are often for home furnace repair or replacement.

Business services currently available to I-CAN's members include a:

- Business center equipped with a laminator, book binder, computer, printer and Internet connection which member providers can access as needed.
- Lending library of curriculum kits and project supplies
- "Business Essentials" class, to address family providers' lack of good business records, formal policies and contracts.

In addition, I-CAN has piloted tax preparation services this year, to assist low-income providers eligible for the Earned Income Tax Credit.

### 3.2 Substitute Staffing Services

Monday Morning, Inc., Infant Toddler Family Day Care and Acre Family Day Care each offer substitute care for network providers as described below:

- Monday Morning, Inc. guarantees providers “back up care” to take a sick day or vacation leave (short or long-term). Providers are seldom at maximum capacity and can therefore cover each other.
- Infant Toddler Family Day Care’s providers are each licensed to care for up to 5 children. Typically they enroll only 4, leaving 1 space available for substitute care, when needed.
- Acre Family Day Care can arrange back-up care for vacation and planned absences up to a month, likewise because its homes are not always full. At least two weeks’ advance notice is requested. Children may receive care at another home, subject to the parent’s approval. Alternatively, a certified assistant (usually a relative) may provide substitute care in the absentee provider’s home. Acre also tries to arrange back-up care for unplanned or emergency situations that arise, such as illness.

Steuben Child Care Project notes that “substitute issues are huge” and is considering the concept of a “floating” substitute pool. The pool will consist of 3 to 4 trained, credentialed individuals available to substitute for I-CAN members. The substitutes will be paid through the agency and might also assist in delivering other member services.

For additional perspective on shared substitutes, ICA spoke with the former director of the defunct Satellite Child Care Program in New York City.<sup>10</sup> This network of 155 employee family care providers initially tried using “floating” substitutes who were trained, registered and worked as assistants when not providing substitute care. All were paid full-time, but were only utilized on a part-time basis. Ultimately, this became too expensive. Subsequently the program tried organizing providers in “pairs” or “trios” to help cover each other. This method only worked about half the time, mainly due to difficulties with geographic “match.” It also proved very difficult to manage because it often required last minute, early morning coordination which the program’s own staff was unwilling to do.

Finally, a state-commissioned study in Oregon describes the experience of a collaborative which sought to create a substitute pool serving providers in Clackamas, Washington and Multnomah counties (which includes the Portland metropolitan area).<sup>11</sup> The report states that “the substitute pool, while valued by those who did participate, was not used by a large number of providers, and recruiting and maintaining substitutes proved difficult.” The report suggests that “teaching providers how to build in time for personal days and vacation as a strategy for self-care may be a more effective way to provide this type of support, especially for family child care providers.”

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<sup>10</sup> The Satellite Day Care Program was operated by the Consortium for Worker Education from 1998 until 2005. Home-based providers were CWE employees and received full-time wages and benefits (about \$9.00 per hour for 40 hours per week, plus a family health insurance benefit through AFSCME).

<sup>11</sup> *Child Care Quality Improvement Project Evaluation*, July 2005, NPC Research for the Oregon Commission on Children and Families

### **3.3 Bulk Purchasing**

Steuben Child Care Project offers bulk food items and other products to family child care providers that participate in the USDA Child and Adult Care Food Program.<sup>12</sup> The Child Care Provider Bulk Food Purchasing Program was initially envisioned as a food “co-op,” and state grant money was used to buy refrigerators and freezers. The co-op did not materialize and instead, the director arranged for the Community Action Agency’s existing food distributor to extend its discount pricing to family child care providers.

A monthly order sheet goes out to providers with other subsidy forms. The sheet featured 62 items in March, for example. Of 140 providers, eight consistently participate; others participate seasonally, mainly during the holidays and in the summer to buy fresh produce. Providers especially like individual portions that meet USDA requirements such as juice cups, individual cereal portions and individual cans with lids. They also buy bulk paper towels, toilet paper, disposable gloves and individual Kleenex packets. Providers value the program’s convenience, time savings and transportation cost savings, and more providers would participate if there were drop-off sites in the east and west ends of Steuben’s rural service area (Corning and Hormel respectively).

In the course of ICA’s research, no other bulk buying programs were found, and the Oregon study suggests that family care providers may not need a purchasing cooperative given their ability to access lower cost items through such retailers as Wal-Mart and Costco.<sup>13</sup> Beginning in 2001, a tri-county collaborative including Clackamas, Washington and Multnomah counties (which includes the Portland metropolitan area) sought to create a purchasing cooperative (in addition to a benefits and substitute pool). Few providers there were interested in attending informational meetings about a purchasing cooperative, despite considerable efforts to recruit participants. The report concluded that purchasing cooperatives are “difficult to implement, and may not be feasible and/or needed.”

### **3.4 Other Services**

#### **Tax Preparation Services**

The annual need for tax preparation is a critical opportunity for outreach to family child care providers to help them improve their business practices and file to receive the Earned Income Tax Credit. As self-employed business owners, family child care operators are required to file a “Schedule C” (or C-EZ) as part of their individual return. Schedule C is essentially a one-page profit and loss statement and thus an effective tool for helping operators improve their recordkeeping and understand their child care business’s finances. Often, low-income operators are eligible for the Earned Income Tax Credit, which can offset their self-employment tax liability and generate cash to their household.

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<sup>12</sup> Family child care homes may participate in the USDA program if 25% of children (enrolled or licensed capacity) are eligible for free or reduced price meals.

<sup>13</sup> *Child Care Quality Improvement Project Evaluation*, July 2005, NPC Research for the Oregon Commission on Children and Families

The Corporation for Enterprise Development (CFED), through its Self-Employment Tax Initiative, is working with community-based organizations throughout the US that use free tax preparation programs to help self-employed individuals improve their business financial literacy and build assets. Several of its partner organizations have developed tax preparation services and materials specifically to benefit family child care providers, including:

- AccountAbility, Minnesota
- Accounting Aid Society, Michigan
- Action for Boston Community Development, Massachusetts
- Center for Economic Progress, Illinois
- Just Harvest Education Fund, Pennsylvania
- Nehemiah Gateway Community Development Corporation, Delaware
- United Way of Tucson and Southern Arizona

Nehemiah Gateway CDC, for example, has developed and delivered advanced training on Schedule C and C-EZ to volunteer tax preparers, held trainings on taxes and record-keeping for childcare providers, and is developing a full-service financial planning service for these businesses. The Center for Economic Progress in Chicago also has a Family Child Care Tax Project that provides free, year-round income tax information and tax planning classes to help family child care providers throughout Illinois operate their businesses and maximize their incomes. The Center partners with Child Care Resource and Referral agencies and other community-based organizations to provide classes.

CFED's current partner in Wisconsin is the Western Dairyland Economic Opportunity Council, Inc. The National Community Tax Coalition does not list any Wisconsin member programs.

### **Public Benefits Screening**

Several organizations have developed web-based applications that enable organizations to screen individuals for eligibility for various federal and state benefits, including Medicaid coverage, food stamps and home heating assistance. Providing support to ensure that lower income child care providers are applying for public sector subsidies to which they are entitled could significantly contribute to their economic security. Bluemark LLC, a New York-based developer of benefits eligibility screening software, has already developed some products for the Wisconsin market and therefore should be able to develop an application for WECA at relatively low cost. The most significant cost associated with providing benefits eligibility screening would be staff costs.

## 4.0 Closing Observations

In considering the programs and ideas described in this report, some key points and generalizations emerge:

### Health Insurance

- The existing union plans serve a select subset of the family child care provider population in their respective states. Eligibility is limited to providers who are licensed and serve state-subsidized families.
- Dependency on state funding makes the union plans' long-term prospects (and Rhode Island's immediate-term prospects) highly uncertain as elected officials weigh multiple policy priorities, and various interests compete for scarce public dollars.
- Individual states are trying a variety of approaches to help their uninsured residents access insurance and/or health care. In this dynamic and fluid policy environment, foundations, insurance companies and government agencies may be very open to funding proposals that test innovative ideas or replicate promising demonstration projects.
- Association plans, while available to all, are individual plans that, unlike group plans, assess risk on a case-by-case basis. Accordingly, they favor healthy individuals and may exclude people with pre-existing conditions or be priced prohibitively high, depending on one's risk profile.
- Adapting the public authority model to benefit family child care providers will require union backing and leadership, strong consumer engagement, and a compelling economic argument to the state.
- In general, health insurance purchasing cooperatives have achieved little cost advantage and few have been successful. Cooperatives need to attract large numbers of participants in order to appeal to health plans, ensure choice and exert purchasing power. The very small size of family child care businesses would make it difficult to achieve scale. That said, the Wisconsin Federation of Cooperatives has plans to create a health insurance purchasing cooperative for self-employed individuals that could benefit family child care providers.

### Shared Services

- Delivering shared services involves administrative costs that programs offset in a variety of ways. Two networks (Monday Morning, Inc. and Infant Toddler Family Day Care) finance their operations by passing on costs to private pay customers. At Acre Family Day Care, the state of Massachusetts covers the program's incremental administrative costs. Integrated Care Assistance Network is a pilot receiving grant support.

Thus, to promote more shared services networks for providers serving subsidized children, states must be persuaded to pay the incremental management costs or increase their reimbursements to providers for payment of fees for network services. Alternatively, grants would need to be secured.

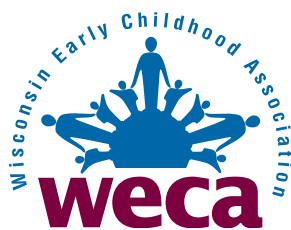
- Since the pioneering of several shared services programs for family care providers in the 1980s, there has been little apparent progress. The reason is unknown, but lack of sufficient funds may be a factor. Satellite Child Care Program initially operated with grant support but ultimately failed to win the state reimbursement rate needed to achieve sustainability.<sup>14</sup>
- Technological advances are making it easier and less costly to coordinate customer billing and provide public benefits screening. In particular, web-based software facilitates communications and access to data among providers, parents, third-party payers and network managers.
- Substitute care is logistically difficult. Shared substitutes appear to work when participating homes are at less than full capacity and are geographically clustered for parents' convenience.
- The wide availability of discount retailers such as Wal-Mart and Costco may obviate the need for bulk purchasing cooperatives.
- Tax preparation services provide an opportunity to leverage existing community services and establish a basis for delivering technical assistance and business counseling to family child care providers.

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<sup>14</sup> Consortium for Worker Education sought reimbursement at 95% of the prevailing rate for center-based care but failed to obtain this.

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