Providing for Providers: Health Care Benefits as a Retention Solution in Louisiana’s Child Care Crisis

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Prepared for the United Way for the Greater New Orleans Area Success by Six Initiative

In Collaboration with Tufts University and the Departments of Child Development and Urban and Environmental Policy and Planning
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Abstract

The problem of retaining quality child care providers has reached crisis level. Lack of health care benefits is one reason that turnover within the child care industry is especially high. The purpose of this report is to better inform the reader of the controversial issue of providing child care providers in Louisiana with health insurance through a state funded plan as one solution to the retention crisis.

The political climate currently appears favorable to this issue, both nationally and in the state of Louisiana, thus those pursuing a state funded health care plan for child care workers in Louisiana should take advantage of this window of opportunity. It is recommended that a coalition be built and the child care providers be organized. Administration of a state wide survey will aid in designing and lobbying for a health care plan. Linking further education with wages and benefits increases the likelihood of retaining qualified child care providers in the industry. Particular attention must be paid to the affordability of the plan. Learning from other states’ efforts exemplifies the importance of being creative in designing and implementing health care plans. If setbacks are encountered, consider alternative plans rather than completely abandoning efforts.
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The problem of retaining quality child care providers has reached crisis level, becoming a hot topic at both the state and national levels. Turnover within the child care industry is especially high due to common characteristics such as low wages, no benefits and increasing educational requirements. As a result, workers are leaving the industry, thereby compromising the quality of child care centers. The United Way for the Greater New Orleans Area (UWGNOA) has joined the efforts to improve the situation of child care providers in Louisiana, and their Success By 6 initiative is participating in an advocacy effort specifically geared at providing quality health care coverage through a state funded health care plan to child care providers throughout the state of Louisiana. The purpose of this report is to better inform the reader of the controversial issue of providing child care providers with health insurance through a state funded plan as one solution to the retention crisis.

Our research covered five areas: the cost of being uninsured to both individuals and governments, barriers to retention, relevant legislation in each of the 50 United States and the District of Columbia, potential insurance models, and the strategy of the unionizing child care providers in an effort to improve the industry. Based on our review of relevant literature in these areas in conjunction with interviews with three child care directors in New Orleans, Louisiana, and J.J. Bartlett of the Fishing Partnership Health Plan based in Massachusetts, we have compiled the following list of recommendations for the UWGNOA:
• Take advantage of the current political climate, both at state and national level
• Administer the surveys (provided separately) at a statewide level, possibly utilizing a professional consultant, as discussed in the Appendix and use the results when advocating for a health care plan
• Build a broad based coalition of multiple stakeholders, possibly including a private insurance company willing to fund the survey/study portion
• Work to include elected officials in this coalition
• Organize child care providers, consider joining or creating a formal union
• Replicate some of the activities used during the Worthy Wage Campaign
• Pay special attention to the affordability of the plan to ensure that child care providers will actually participate
• Be prepared to be creative with alternative models such as starting with a specific Parish(es) and expanding to all Parishes, as opposition to a statewide plan is possible
• Consider joining forces with other industries to create a state funded plan for small business, which would allow the inclusion of all child care providers (i.e. not just Class A)

Advocating for a state funded health care plan is a massive effort, and the information provided in this report is meant to serve as the foundation from which UWGNOA can build. We highlight certain aspects that need to be considered and determined before UWGNOA can go forward with their work and present it to the Louisiana legislature. Retaining child care providers through a state funded health care plan is an extremely worthy cause, and this report aims to increase the chances of success for UWGNOA.
Chapter 1: Background

Introduction

The issue of low retention of child care providers has been a pressing subject relevant not just to the field of child development, but also to health care policy, government, and social welfare. This is a hot topic at the state level, as well as the national level. Leaders in the child care industry are concerned for the child care providers and the children for whom they care. Research has shown that a lack of health care benefits pushes well educated child care providers out of the child care industry in search of employment that will support them with both higher salaries and benefit plans. The purpose of this report is to better inform the reader of the importance of providing child care workers with the health care benefits they deserve.

The United Way for the Greater New Orleans Area (UWGNOA) Success By 6 initiative is participating in an advocacy effort geared at increasing the retention of child care providers by providing quality health care for providers throughout the State of Louisiana. UWGNOA is particularly interested in looking at a state funded plan for Class A licensed child care facilities. “Class A” refers to certified licensed facilities that are eligible to receive state funds. Throughout the report, UWGNOA’s current and future efforts...
The format for the report will flow as follows. Chapter 1 presents an in-depth look at child care providers and how retention in the work force affects facilities, benefits, child and staff well-being, and the alternate employment opportunities for which they are leaving the industry. Chapter 2 discusses the impact and costs of being uninsured for both the individual and governments. The 3rd chapter of the report will examine the barriers to retention in the child care industry as informed by researchers and practitioners in the relevant fields of education, health care, economics, and political science.

Chapter 4 will discuss recent legislation taking place in states throughout the United States relevant to health care plans for child care providers. The 5th chapter of the report will look at potential models for insuring the child care industry. Three models will be presented along with examples of each model. The pros and cons of each model will be considered in light of Louisiana’s specific needs. Chapter 6 of the report covers the relevancy of unionization as a strategy for improving the industry. The chapter will evaluate how other states have or are using child care unions and their potential for the future of Louisiana’s child care system.

The 7th chapter summarizes conclusions drawn throughout the report. Findings will be summarized along with a discussion of future research. Suggestions for future research in the industry of child care, particularly pertaining to health care, will be expressed. The report comes to a close discussing future policy implications by connecting literature to Louisiana specifically. Also, it will reflect how this report may aid and act as the foundation for potential research.

In the recent past and present, child care and early education has come to the forefront of the political climate in the State of Louisiana. Consideration of former Governor Blanco’s health care initiatives

<table>
<thead>
<tr>
<th>Class A Child Care Facilities</th>
<th>Class B Child Care Facilities</th>
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<tr>
<td>• No Corporal Punishment</td>
<td>• Some corporal punishment allowed with parent permission</td>
</tr>
<tr>
<td>• 12 hours Child Development (CD) training annually</td>
<td>• 3 hours CD training annually</td>
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<td>• 3 hours health and safety training annually</td>
<td>• 3 hours health and safety training annually</td>
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<td>• Can receive government funding</td>
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<td>• Slightly lower teacher child ratio</td>
<td>• Slightly higher teacher child ratios allowed</td>
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<td>• Of course then there are the non licensed facilities</td>
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along with the Pathways Program she put into place pertaining specifically to early childhood education in addition to current Governor Jindal’s stance on health care and early childhood education help shape our recommendations and suggestions for UWGNOA’s next steps.

Future recommendations for the United Way for the Greater New Orleans Area and the future of child care in Louisiana will be included in the final chapter. For example, this section will suggest creating a coalition/partnership among key stakeholders such as private insurance companies, child care facility directors, and local business owners. Also covered will be establishing the need for health care insurance for all child care workers, not just those in Class A licensed facilities. Finally, it will introduce to UWGNOA other possible ways to increase the retention of quality child care providers.

As part of our methodology three interviews were conducted with child care directors in New Orleans, Louisiana. The interviews were performed separately at each child care facility. The child care facilities all have strong relationships with the United Way for the Greater New Orleans Area and are classified as Class A licensed centers. Some of their comments can be found in sidebars throughout this report.

Appendix A of the report will contain detailed information regarding the survey instrument provided for the UWGNOA. The two surveys will help the UWGNOA achieve a deeper understanding of child care directors and their staff in relation to job retention and health care needs. The second Appendix is a copy of the Memorandum of Understanding (MOU) that was turned in to represent a level of understanding between the UEP Department at Tufts University and the United Way of the Greater New Orleans Area. Appendix C will consist of interview data collected throughout development of the project.

Background of the Child Care Industry

Who are they?

The child care providers and facilities being discussed throughout the continuum of the report are those that both nurture and care for children who have yet to enter formal schooling. They supervise children between the ages of infancy to age five (prior to entrance into Kindergarten). National estimates show that at any point throughout the year there are 2.3 million individuals paid to provide direct care to children, and when turnover is taken into account, the number of child care workers is closer to 2.5 million (The Poverty Institute, 2006). Women are the dominant gender working in the field of child care. The Poverty Institute
at Rhode Island School of Social Work (2006) reported that in the United States, 97% of the center-based workers and 99% of family child care workers were women.

Importance

Child care providers play an extremely influential role in a child’s development since they are the child’s main support system when the parents are at work or away for other reasons. Professionals in the field of child development stress the first year of a child’s life as a crucial time for the development of attachment (LaFreniere, 2000). “This first year represents the stage of trust versus mistrust” (Santrock, 2003, p. 232). When a child is securely attached to the parent, they often adjust better to changes in their environment and new interactions. When the main attachment figure is not present, the infant will seek comfort with a temporary attachment figure (Cassidy & Shaver, 1999). This remains true for children as they progress through the early childhood years. Staff turnover in child care facilities becomes negatively influential when these young children establish relationships with adults and then come in the following day or week to find their temporary attachment figure is no longer there. Without notification and explanation, children are left to question what caused the sudden separation. After repeated occurrences, the child begins to withdraw from establishing relationships with new child care providers. Negative temperament and behavior can result from a constant change in the child’s environment because they no longer feel secure and are unable to predict daily schedules or interactions (Santrock, 2003). It is important for child care facilities to maintain steady staffing to ensure cognitive and physical structure for the young children participating in the program.

High quality child care includes physical well-being and motor development, social and emotional development, language development, and cognition and general knowledge (Wiseman, Keller, Adams, and Smith, 2005). An important aspect of a quality child care facility is their child to staff ratio. States often regulate their center-based child care facilities with the number of children per child care worker. These ratios often vary according to the age of the children. Child development experts recommend that a single caregiver be responsible for no more than 3 or 4 infants (less than 1 year of age) and toddler’s (1 – 2 years of age) at a time, while they may take care of 6 or 7 pre-school aged children (2 – 5 years of age) at a time (US Department of Labor, 2007). Caregiver qualification, particularly on the level of general education, has been
revealed to be itself correlated with the effect of other quality factors (Kimmel & Connelly, 2003).

In addition to attending to children’s basic needs, child care workers also organize activities and design a curriculum that will stimulate a child’s physical, emotional, intellectual, and social growth (US Department of Labor, 2007). It is vital for children in child care facilities to have well qualified child care providers taking care of them in order to best meet their developmental needs. Quality child care providers help children build self-esteem and develop relationships with adults and peers. By exploring new interests and developing talents, child care workers help young children establish a sense of independence (US Department of Labor, 2007). This independence will be particularly beneficial once the child enters into formal school years.

Early childhood education has been shown to have numerous positive affects on children’s development and overall well-being. Setting such goals in the curriculum, child care centers can assist children entering kindergarten by helping them achieve beginning reading skills and prior knowledge (Snow, 1998).

The demand for child care has grown immensely over the years. This is largely due to the growth in the female labor force (Bianchi, 2000; Smith, 2006). In the thirty years from 1963 to 1993, the percentage of women in America’s workforce has shifted from 34% to 45% (Whigham-Desir, 1993). The demand for non-maternal child care has grown significantly due to rising wages for woman, stagnant wages for men, changing social attitudes and the welfare reform (Kimmel & Connelly, 2003). National averages show that in

Source: Minnesota Department of Employment and Economic Development 2005
2004, 71% of mothers with children under the age of 18 were working. For mothers with children under the age of three, 57% were in the work force (Starting Right Child Care, 2006).

Income

The Occupational Employment Statistics (OES) program falls under the Bureau of Labor Statistics of the U.S. Department of Labor. In the OES survey completed in 2000, out of the 700 occupations reporting mean wages, only 18 reported having lower mean wages than child care workers. Some of the occupations earning higher wages include crossing guards, services station attendants, tree trimmers, and bicycle repairers (Laverty, Siepack, Burton, Whitebook, and Bellm, 2002).

The problem of low wages for child care staff is not a new topic of concern. In 1997, child care providers pay was only at subsistence levels. A large portion of the staff was earning just around $5.15 per hour (Whitebook, Howes, and Phillips, 1998). Unfortunately, strives in improving the wages of child care workers have not progressed to what many had hoped it would over the years. In May of 2006, the U.S. Department of Labor reported annual earnings of wage-and-salary child care workers were just $17,630. The middle 50 percent earned between $14,790 and $21,930. The lowest 10 percent earned less than $12,910, and the highest 10 percent earned more than $27,050 (U.S. Department of Labor, 2007). Many parents, voters, and policymakers understand that low staff wages can negatively affect quality through high staff turnover and poorly trained teachers (Whitebook, Howes, and Phillips, 1988/1997).

Why is retention important?

Consistency for children

High staff turnover rates negatively affect children in the child care system. Staff turnovers are associated with reduced quality as children are forced to establish personal bonds frequently with new staff members, and new caregivers need to be trained and become acclimated to the new work environment (Kimmel & Connelly, 2003). Caregiver stability has consistently been a cause for concern, yet now there is a related concern regarding meeting the increasing demand for child care slots due to recruitment and retention problems. The tight labor markers have increased the demand for child care, while at the same time reduced the supply of workers willing to work in this field (Kimmel & Connelly, 2003).
National studies have established a correlation between higher wages for providers and a more stable, qualified workforce and higher quality child care. When wages are low, an already high industry turnover rate of approximately 30% a year rises even higher. Often these job slots become filled with less-educated candidates, leading to overall lower quality child care settings, which in turn negatively affect the children participating in the programs (Poverty Institute, 2006). Staff replacement search times have been found to exceed four weeks, leaving centers understaffed and forced to work with lower staff to child ratios (Kimmel & Connelly, 2003). When staff is taking care of more children than they can handle, behavior and classroom management often falls apart. The stability the child experienced prior to the reduced number of staff begins to fade. This added stress from the environment is not only placed on the child care provider, but other staff as well. More importantly to note, the children begin to feel the negative stress of the environment, which can result in behavioral outbursts (Santrock, 2003).

Lack of Benefits

Health benefits vary, but more often than not are minimal for child care providers. Sometimes the only benefit a child care provider receives is free or reduced care for their own children. This problem has been a cause for concern for many years. In 1988, a study done by the Center for the Childcare Workforce found that only one out of three child care teaching staff received any health care coverage through their employer (Whitebook et al., 1988/1997). A survey on health care coverage for child care workers by The John W. McCormack Institute of Public Affairs found that 56% of center-based child care teachers cited health insurance concerns as a reason for considering leaving the child care field (Wilson, Werby, and Haig-Friendman, 1999). In the same survey, 60% of the directors of child care centers felt that offering health insurance helps decrease staff turnover. For the agencies that did not offer insurance, one third of the directors stated that health insurance benefits strongly contributed to staff turnover (Wilson et al.)

Where are they going?

As expressed above, child care providers are not staying in the industry due to inadequate pay and lack of benefits. Many child care facilities require their staff to further their early childhood education and become certified in the field. Studies show that once they achieve certification, child care workers are leaving
and finding placements in the formal education system (K-12) where teachers are provided higher salaries and health care benefits. For example, in the State of Louisiana, child care workers' average hourly wage is $6.81, but preschool teachers in the state make an hourly income of $9.71 (Center for Child Care Workforce, n.d.).

Child care facilities also compete with the fast food industry. Since many directors want their employees to obtain certification in the field, this acts as a deterrent to many workers uninterested in taking the time and effort to further their education. These workers know that they are able to start out at a restaurant like McDonald’s making a salary that they would be unable to receive until after they have completed their additional course work in the early education field.

As the following report will support, the retention in the field of child care is not a new topic. This is a problem that has been present in the field for many years. Unless the initiative is made to help better provide for members of the child care industry – such as UWGNOA’s advocacy efforts supporting a state funded health care plan – the problem is only going to get worse. In order to better understand the need for health coverage, we will now look at the costs involved in being uninsured on both the individual and governmental level.
Chapter 2
Uninsured – The Real Costs to People and Government

Uninsurance as a Human Phenomenon

The exact number of uninsured people in the United States is debatable – with estimates ranging from 20% of American adults, to 9 million children and 45 million adults, to 38% (85 million) of people under the age of 65 being uninsured at some time – what is not debated is the fact that millions of Americans are uninsured each year and that this number is steadily rising (Busch & Duchovny, 2005; DeVoe, Krois, Edlund, Smith, and Carlson, 2008; Kahn et al, 2007; Ward & Franks, 2007). Threats of an economic recession have limited both employer sponsored insurance plans and state Medicaid monies, thereby increasing the number of uninsured Americans. It has been projected that the uninsured population will increase another 25% by 2013 (Kahn et al, 2007). Statistics and trends can be thrown about to support the claim of a growing
uninsured population, but what gets lost in all the numbers is the fact that the conversation should be about people. Uninsurance, to a large degree, is a human experience that impacts families, children, communities and personal health. In this light, there are costs to being uninsured that go beyond dollars spent by individuals or governments, and these non-monetary costs deserve attention.

Who are the uninsured?

Demographic characteristics are often linked to uninsurance and are some of the barriers to obtaining health care. Common demographics are “minority race and ethnicity and having low socioeconomic status (SES)” and low educational attainment (Hadley & Holahan, 2003b; Shi & Stevens, 2005, p. 148). One estimate states that as of 2000, 33% of adults making less than 200% of the federal poverty level were uninsured (Busch & Duchovny, 2005). In addition, many children remain among the uninsured even when they qualify for Medicaid’s State Children’s Health Insurance Program (SCHIP), and this is found to be a result of parents lacking insurance. Thus, when parents are uninsured, children are often uninsured regardless of their eligibility for public programs targeted at children (DeVoe et al, 2008).

In general, vulnerable populations are much more likely to be uninsured and have unmet health care needs. Though logical, it is distressing that American citizens who are already so overburdened have the additional concern of being the most likely to be unable to provide health care coverage for themselves. It is noteworthy that child care providers as discussed in Chapter 1 are among the lowest paid type of workers and therefore very likely to be uninsured. Furthermore, child care providers take care of our country’s children, yet another vulnerable population. In sum, the child care industry and uninsurance often go hand in hand.

What does uninsurance mean to people?

Having a low income and being an ethnic minority are linked to high uninsurance rates, and being uninsured is a substantial barrier to obtaining needed health care (Cunningham & Hadley, 2007; Shi & Stevens, 2005). “Compared with those with private insurance, the uninsured were less likely to have a
usual source of care and had a lower likelihood of physician office visits” (Bernard & Selden, 2006, p. 15). This means that in addition to the risk of higher out-of-pocket expenses for health care by people without insurance versus those with insurance, uninsured people might also not receive needed medical care, putting their personal health at risk. Lacking insurance also results in less consistent sources of care, and “having a usual source of care has been shown to increase medical care access, satisfaction, continuity, and quality of care” (Cunningham & Trude, 2001, 716). There is an important distinction here in that it is not being of low SES itself that results in inconsistent, low quality care; instead, it is being uninsured that results in inconsistent, low quality care. An abundance of data supports the widely held belief that uninsurance is a significant barrier to obtaining health care.

Uninsurance not only means inconsistent health care, it may also mean reactive versus preventative health care. “Cross-sectional studies suggest that lack of health insurance compromises access to health care, utilization of preventative health services, and chronic disease management” (Ward & Franks, 2007, p. 708). As a result of the Emergency Medical Treatment and Active Labor Act, people know they cannot be turned away from emergency departments because they lack insurance (Rimsza et al, 2007). Research supports the claim that people use emergency departments more when they are uninsured; causing one to assume that emergency services are used for routine care by uninsured people. In one study tracking a Midwestern county in which a state funded community health center (CHC) was established, visits to the emergency department by uninsured people decreased by 25% from 1990 to 2000 (Smith-Campbell, 2005). Another study found that 29% of previously uninsured women who had not received cancer screenings did so after becoming eligible for public coverage (Busch & Duchovny, 2005). An example of the impact on chronic disease management is the fact that 20% of people living with HIV are uninsured and may not be receiving appropriate and opportune care (Committee on the Consequences of Uninsurance, 2003). Ultimately, receiving health care is about enabling people to live healthier and longer lives. Perhaps the most poignant statistic is the result of a mathematical model that predicts that providing insurance to uninsured 25 to 64 year olds would increase their overall life expectancy by about 7 months while increasing their years lived in perfect health by almost a full year (Muennig et al, 2005). All of these statistics support the idea that being uninsured results in costs to personal health, and conversely that being insured results in needs being met
and healthier lives.

Community Level Impacts

A 2003 report by the Committee on Consequences of Uninsurance entitled *A Shared Density: Community Effects of Uninsurance* makes the important link between the impact of being uninsured on individuals and the impact on their extended community. Below are key statements directly taken from this report:

- The Committee found that the adverse effects of uninsurance that accrue to uninsured individuals and families in a community, as well as the financial strain place on the community’s health care system, have important spillover effects on community health care institutions and providers (p. 1).
- Levels of subsidy for uncompensated care costs associated with care delivered to uninsured persons have eroded over the past 25 years. The effects of this erosion have been felt more strongly in communities with large or growing uninsured populations and by providers that serve a high number or proportion of uninsured persons (p. 4).
- The Committee hypothesizes that the burden of financing care for uninsured persons affects the health services available to all community residents, especially in urban areas where providers treat large numbers of uninsured persons and in rural areas where providers treat relatively high proportions of them (p. 6).
- The Committee finds that low- to moderate-income and uninsured residents have worse access to health care in communities with high uninsured rates than they do in communities with relatively low rates, although the causal influence of the local uninsured rate on access is unclear (p. 7).
- The Committee believes that it is both mistaken and dangerous to assume that the prevalence of uninsurance in the United States harms only those who are uninsured (p. 14).
- Health insurance is not the solution to all communal ills; nevertheless, the Committee hypothesizes that its presence or absence can make a substantial difference for a community’s economic fortunes (p. 11).

The report makes the salient connection between uninsurance and burdens to the community at large. Not only does uninsurance pose financial and health costs to the individual but also at the community level.

Insurance within Public Policy

While it is our position that health insurance should be seen as a human and moral issue, especially given the vulnerability of the uninsured population, there are undeniable financial costs to governments associated with providing insurance. How these costs are perceived, however, is not so clear cut. A common term within public policy regarding health insurance is “moral hazard,” and the theory of moral hazard has
framed much of our country’s health policy. As described by John Nyman (2007):

“Moral hazard refers to the additional health care that consumers purchase when they are insured. The conventional analysis holds that moral hazard represents a response to the insurance price of health care, which is set artificially low compared to the cost of producing that care. In response, consumers change their spending patterns to take advantage of the “bargain” represented by the insurance price, substituting additional health care for other goods and services in their budget” (p. 760).

“In insurance price” refers to publicly subsidized insurance, thus of low or even no cost to the individual. The theory in essence is saying that if people are provided with insurance coverage at little or no cost to themselves individually, they will use health services that they would not otherwise use if they were paying for the services themselves. This long held view of how individuals react to public insurance has driven public policy to focus on reducing moral hazard – and price – rather than on providing the best coverage possible.

In rejection of this antiquated and myopic yet prevailing view, John Nyman (2007) proposes that the conventional theory is flawed because in reality only ill people respond to the price reduction (i.e. insurance subsidy). He argues that income is only transferred when someone purchases insurance and that person becomes ill (versus remaining healthy), and that this transfer of wealth is in fact a welfare gain because the ill person’s welfare will then increase from the insurance coverage. “Indeed, insurance often provides access to needed and valuable care that would otherwise be unaffordable” (Nyman, p. 768). Nyman goes further to estimate that by insuring his approximated 40 million uninsured people in the United States, over $2,000 of benefits in excess of costs per person would be generated. This value may be disputed and Nyman does add that moral hazard can only become a welfare gain if insurance coverage includes cost sharing; however, his new theory is an essential departure from politics-as-usual if positive strides in health policy are to be made.

Financial Costs to Governments and Savings Opportunities

Armed with this new framework, it must then be recognized that governments are already carrying much of the financial burden of uninsurance. It was stated above that a model has predicted that insuring 25 to 64 year olds would add almost a year of perfect health to people’s lives. Perhaps most importantly from a cost-benefit perspective:
“These gains in health and life would be comparable to costs to programs or medical interventions that are thought of as good buys. Moreover, such expenditures would be considerably lower than investments in many other well-accepted social programs (e.g. airline and automobile safety) in terms of cost per life year gained” (Muennig et al, 2005, p. 62).

In short, insuring the uninsured is cost effective.

It is estimated that uncompensated care, that is medical care not covered by out of pocket expenses, public coverage, private plans or government funded CHC’s, is about $35 billion a year (Hadley & Holahan, 2003a). This cost must be absorbed somewhere. In addition to the resulting increase in the per hour cost of physician time, the bulk of the $35 billion is picked up by the federal and state government via CHCs and grants, which translates into higher state and local Medicare/Medicaid payments needed to maintain the same level of care amidst growing uncompensated care numbers – and this means greater state and local tax appropriations to cover these increases (Hadley & Holahan).

“Since most of the current subsidies for uncompensated care came from through Medicare and Medicaid payments and state/local tax appropriations to hospitals, it should be possible to transfer much of these funds to a new program to subsidize the cost of providing coverage for the uninsured since these programs’ constituents are not primarily uninsured people” (Hadley & Holahan, p. 78).

While creating such a program at the state level is no simple task – it does start simply with a reframing of how the cost of uninsurance to government is viewed.

“Given the growing evidence of the beneficial effects of having insurance on health, labor-force participation, earnings and education, the cost of expanding insurance coverage may be a relatively small or at least a very worthwhile investment when considered against the benefits of improved health, increased longevity, and potentially greater national income” (Hadley & Holahan, 2003b, p. 263).

Furthermore, governments can likely save money by providing coverage to the uninsured. As part of the study previously mentioned that tracked the Midwestern county, the local hospital saved $13.9 million because of decreased use of the emergency department (Smith-Campbell, 2005). Though based on a study of Medicaid/SCHIP enrollment of children, one study actually estimated that a 10% disenrollment from a public plan increased health care costs to the community at a rate of $2,121 per child, attributing the
increased community costs to increased use of emergency services (Rimsza et al., 2007). Other publications support the fact that emergency department services cost more than those performed in physicians’ offices, and this is important when keeping in mind that governments absorb much of the costs of uncompensated care.

State Plans Can Be Successful – Up to a Price Threshold

There is precedent for state governments creating targeted, state funded health care plans. One such plan was the HealthyforAll (HFA) Healthy NY (HNY) Subsidy Demonstration Program that was created in 2003 to alleviate the un-affordability of health insurance for small business in western New York. HFA HNY allowed employees of small businesses (2-10 employees) to enroll in a comprehensive plan for less than $40 a month, split between the employees and the employers (Kahn et al., 2007). A study following the impact of this plan found little changes among the employees who had insurance coverage prior the subsidized plan (supporting Nyman’s (2007) debunking of the moral hazard theory) but found positive impacts on preventative health care for those previously uninsured. The key lesson from this study is that people are willing to help pay for insurance up to a point, and that state subsidized models for targeted businesses can be successful (Kahn et al.).

This knowledge – combined with lessons from another study showing that employees will decline participation in a plan offered by their employer if the plan is still more expensive than forgoing care or relying on safety nets – can be used by the Louisiana state government to create a plan for child care providers that is successful as long as it is truly low-cost (Bernard & Selden, 2006). (See Chapter 5 for further discussion about insurance plan models for child care providers.)

Understanding the costs of being uninsured and the potential savings associated with providing health insurance is just one piece of the larger puzzle of reducing turnover in the child care industry. Knowing why child care providers choose to stay in or leave the industry will also help shed light on the issue of retention and the potential role health insurance can play in reducing turnover rates.

“We were hoping to find something that would be split 50/50 between the center and the employees. Most were about $450 a month per person. Any program we might be able to afford was just too limited to be worth the money.”

Pearlie Harris, Royal Castle
Chapter 3: Retention Barriers in the Child Care Industry

Although the focus of this report is on the potential role of health care benefits in the retention of child care providers, ignoring other major factors affecting retention would fail to put the need for action in a proper context.

Wages

“Wages of child care workers are notoriously low compared to other workers with the same level of education, and turnover rates are high” (Kimmel & Connelly, 2003, p. 4). This finding from a longitudinal study about child care providers explains why wages have attracted so much attention in relation to child care providers. Linking a further finding that child care providers receive lower wages than non-child care providers in each educational category (Kimmel & Connelly, 2003) makes it clear that educational level can not fully explain the low wage situation of child care providers. In part, the reason wages are low is because unfortunately, many parents of the children receiving services are financially unable to pay the full market rate for quality care. Also, child care facilities are subject to training and licensing requirements that impose
Since business costs remain high, and inputs remain low, employee wages consequently remain low.

In the child care industry, reducing caseloads and increasing pay and benefits are often beyond the reach of organizations (Nissly, Mor Barak, and Levin, 2005). Inability on an employer’s part to meet the needs and demands of employees for manageable and rewarding work environments leads to one of two impacts “... a professional may enjoy their job and be well supported in the workplace, but not compensated sufficiently to support themselves or their family. Conversely, an individual might not enjoy their job, but perceive that they do not have other alternatives, so stay even though they are not well compensated.” (Toquati, Raikes, and Huddleston-Casa, 2007, p. 265). Neither of these scenarios bode well for child care providers or children in need of out of home care. Dissatisfied employees in any industry are not desirable. If those who remain in the child care industry are those who cannot afford to leave, and those that can afford to leave do so, the children, and as a result the entire nation, will suffer. If child care facilities cannot increase wages or benefits on their own, other options to improve the work environment and outside funding options for increased compensation and benefits must be pursued.

Benefits

Increasing wages through reimbursement plans or other subsidies has been the focus of attempts to improve the situation of child care providers. Other options can, and must be considered and pursued in order for any real changes to occur. Some have posited that in order for change to happen, it must be pursued on multiple levels simultaneously (Folbre 2006; Whitebook et al. 2004). In other words, if wages are the only facet of the problem receiving attention, the likelihood of true and sustained change decreases; so issues including benefits (e.g., health insurance, paid vacation), organizational structure of the facility, encouraging further education and/or certification, and changing the general public outlook of the child care industry need to be examined and pursued.

“I really need to increase prices to cover costs, but I can’t because my parent’s just can pay more.”

Pearlie Harris, Royal Castle
Health Care

This report focuses on health care, and considering that the U. S. Census Bureau in 2000 reported that 16.9% of the state of Louisiana is uninsured, this issue touches the lives of many individuals and families in Louisiana (U.S. Census, 2000). In a longitudinal study of child care providers in the United States, Kimmel & Connelly (2003) found that having employer-provided health insurance positively correlated to being at the same job a year later. They also found that having health insurance through a spouse positively correlated to being at the same job a year later.

Beyond the impact to retention, there are multiple reasons why the issue of a lack of health insurance is of particular significance to the child care industry. Gratz & Claffey (1996) looked at adult health and the affect it has on child care and highlights some concerns. First, health concerns are an important factor in continuity and quality of care. As discussed in the introduction to this report, consistency in care is important for children from a developmental perspective. Second, the frequency of illness among child care providers is high due to exposure to children who are themselves ill. Third, child care providers report working when ill, thus exposing children to those illnesses.

Those findings have important implications in light of other knowledge about the child care industry. Child care providers are exposed to children’s illnesses on a daily basis which increases their likelihood to get ill themselves, and according to the National Child Care Study (1988/1997) this mutual exposure reciprocally affects child care providers and the children. Interestingly according to directors reports, those who are new to the child care industry are more likely to get sick than those who have been working in the industry for longer periods of time (Gratz & Claffey, 1996). Since the rate of turnover among child care providers is high, there are perpetually child care providers in the “new to the industry” category so the probability of getting sick and reciprocally spreading illness remains high for both child care providers and children.

Gratz & Claffey (1996) found that workers cited several reasons for coming to work even when ill including needing the income, not being ill enough to stay home, and not having sick benefits. On top of this, 55% of respondents (n=446) indicated that health insurance was not available through their employment; however, some of those individuals may have insurance through a spouse or a private insurance program (Gratz & Claffey). Limited access to health insurance is not a new phenomenon. In 1988, only 33%
(n=236) of “teaching staff” (those who directly work with the children, not directors or cooks or other staff) who were interviewed as part of the National Child Care Study reported receiving any employee sponsored health coverage. Furthermore they found that those who earned lower wages were less likely to have health coverage than those earning higher wages (The National Child Care Study, 1988/1997). Practically speaking, those who earn less money are less likely to be able to afford private insurance, which increases their odds of being uninsured altogether.

Lack of available health care continues to be a salient issue today in the child care industry. High costs have made it unaffordable for many child care providers to pay for health insurance (Folbre, 2006). This is often true even if a child care provider has a health insurance plan offered to them by their employer. If, for example, premiums are too high, they may be unable to take advantage of the health insurance plan. “Anecdotal reports suggest that teaching staff frequently do not utilize partially-paid health benefits due to their inability to afford the premium, a phenomenon that is common across industries” (The National Child Care Study 1988/1997, 20). In their study of how teachers’ education, compensation and intent to stay in the child care industry affected the quality of the service they provided, Toquati et al (2007) found that 39% (n = 375) of center-based providers received health insurance for themselves, and 30% (n = 290) received health insurance for their family (spouse and children). While these numbers do not necessarily represent the percent of the child care providers in the sample who have insurance (some may be insured through some other source such as a spouse or a private insurance plan accessed outside of employment) it still raises concerns about the stability of the child care workforce as related to health concerns.

One child care director in New Orleans, Louisiana, shared the importance of health care benefits to attracting educated staff members. She said that younger applicants, those with only a high school diploma or equivalent, ask for higher wages. They are likely to leave to work another job that pays more an hour.

“People just don’t want to go through all that, plus the long hours of working in child care, when they can now go to places like McDonalds and FedEx and be paid higher without having to go to school . . . Anyone with a more than an associate’s degree that applies wants benefits. And we need people with degrees!”

Pearlie Harris, Royal Castle
Applicants with further educational credentials ask about benefits, including health care. They are more likely to leave for a similar job that does provide benefits. (P. Harris, personal communication, March 19, 2008)

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Applicants with further educational credentials ask about benefits, including health care. They are more likely to leave for a similar job that does provide benefits. (H. S. Green, personal communication, March 19, 2008)

Education

Considering education in relation to the retention of child care providers introduces an interesting dichotomy. On one hand, education is desirable since on average better educated child care providers provide higher quality care (Torquati et al., 2007). On the other hand, education can prove detrimental because those with higher educational attainment are likely to leave the child care industry since they are qualified for similar jobs that provide them with greater income and benefits than the child care industry currently does. Comparing child care providers to elementary teachers often happens because many child care providers who leave the child care industry go to the school system, both public and private. Kimmel & Connelly (2003) found that this change of vocation was in part because the pay is better, the hours/work year are better, and school teachers are more likely to receive employer provided health insurance. Finding ways to address and correct incentives to leave the child care industry will make further education more profitable to the individual child care provider as well as benefit the industry as a whole by having a more qualified staff base.

According to some simulations, turnover decreases more due to increases in the educational level of the child care providers than just increases in wages (Kimmel & Connelly 2003). If it is better to increase educational level, it may be wise to invest in child care training of many varieties, not just those that require a college degree (Kimmel & Connelly). Increased educational training could be linked to increased wages or benefits to strengthen the draw for child care providers to obtain further educational training, which could decrease the likelihood that they will leave the industry. Interestingly, Kimmel & Connelly found that the rate
of return for education in the child care industry was similar to the rate of return in other industries. This means that increases in educational level correlate with a similar percent increase in salary/wages for those in and out of the child care industry, but the original gap in salary/wages means that the child care industry can never catch up (Kimmel & Connelly). Thus having an associate’s degree has less earning power within the child care industry than in other related industries.

Another noteworthy finding in the longitudinal study of child care workers by Kimmel & Connelly (2003) was the impact of education on a child care provider’s ability to successfully care for children. Having more education makes it possible to handle more children at a time – this could have an impact on ratio requirements that have mandated lower teacher to child ratios as one way to measure the quality of the care being provided. Educational level proves pivotal for child care providers to be able to better fulfill the needs of those they serve, and “increasing the general level of education would thus increase quality directly and indirectly through the reduction in turnover” (Kimmel & Connelly, p. 20). However, encouraging education without some form of compensation would likely continue the trend towards leaving the child care industry for another job that provides more income and benefits for which further education qualifies them such as teaching in a school.

Turnover

As discussed in the introduction to this report, turnover has a negative impact on both children and other child care providers. While high turnover is not uncommon in low-wage industries, having a high level of turnover is more problematic in the child care industry than in most low-wage industries, such as fast food. As Kimmel & Connelly (2003) put it, “Child care workers are no more likely to turnover than other workers with the same level of education but turnover is thought to have more serious consequences in the childcare quality production process than for other employment situations” (p. 20). Recognizing the importance of consistent, quality care increases the concern about turnover in the child care industry specifically (The National Child Care Study, 1988/1997) and requires that multiple avenues for decreasing turnover be considered and pursued.
Attracting new employees to replace those that leave the child care industry proves difficult. Whitebook (2001) reported that it often takes more than a month to replace workers. The National Child Care Study (1988/1997) found that 93% (n=78) of directors said it took more than two weeks to replace departing staff, and 37% reported that it took over a month. Instead of focusing on ways to improve the facility or to perform necessary position-related tasks, the child care director’s attention is diverted to the search for new staff. Searching for new staff is also a drain on financial resources. Running ads in the newspaper or other job hunting mediums quickly adds up. It also takes time to interview those interested in the job. The nature of the job requires that applicants go through a security check process (P. Harris, personal communication March 19, 2008). Running security checks quickly gets expensive. In Louisiana, each background check costs $26. This is a cost the child care facility has to eat whether or not the applicant becomes or remains employed, which in the end only hurts the children. Whitebook et al. (2004) took a two year portrait of Alameda County, California, and their findings are reflective of the interviews we conducted with directors of child care facilities in New Orleans, Louisiana, in March 2008. They found that staff turnover negatively impacts directors’ and front line workers’ ability to do their job. They also reported that 41% of directors said the reduction of class size in local elementary schools hurt them. Child care providers left to fill the job openings created when local school systems decided that class sizes needed to be smaller or that the child to teacher ratio needed to be lower. Those who were qualified to work in the school system left the child care industry. This lowered the level of qualification of those individuals who remained in the child care industry. Reducing teacher to child ratios in the elementary schools had the unintended negative consequence of increasing, at least temporarily, the child to teacher ratios of the child care facilities. This can jeopardize qualifications for licensing of facilities and make it difficult for children to receive the attention and supervision that they need.

Intention to Remain in the Industry

Since the goal to improve the quality of child care has the interests of those children receiving care at heart, turnover continues to be a concern. Turning attention to ways to attract and retain child care providers has the potential to directly impact turnover and translate into success for those children in the child care
facilities and ultimately for society at large. Retention of center-based staff has been shown to increase if they work with well-trained colleagues at a center that experiences low turnover rates (Whitebook et al, 2004). These findings point to the importance of understanding the intention of child care providers to stay in the industry.

While intentions do not perfectly correlate with actions, they can provide strong insight about what is likely to happen in the future. Seeking to understand a child care providers intention to remain in the child care industry, or to leave the industry, can help in several ways. First, asking gives an opportunity for concerns to surface. Second, knowing the concerns opens up the possibility of taking steps towards addressing the concerns. Third, assessing intent and the reasons behind the intent can decrease unnecessary turnover if those concerns are properly addressed (Nissly et al, 2005). A survey commissioned by the United Way of Massachusetts Bay looked at the role of health care benefits on retention in the child care industry. They found that health care benefits not being offered were cited as a reason for considering leaving the child care industry as well as the finding that when health care benefits were offered, turnover decreased (Wilson et al, 1999).

Keeping the barriers to retention in mind, considering efforts made in other states can provide insight into potential steps Louisiana can take as they move toward a state funded health care plan. For example, it will be important to consider linking further education to increased wages and/or benefits in order to maximize the potential to decrease turnover. One way to look at what other states are doing is to examine relevant legislation.

“You know, when people stick with you for little money and no benefits, it’s like there’s nothing for them to hold on to . . . You really have to love what you’re doing and love the kids to stay here.”
Pearlie Harris, Royal Castle
Chapter 4: Relevant State Legislation

Since we are considering the potential role of health care benefits in the retention of child care workers, looking at what other states are doing in relation to state funded health care plans for child care workers can help define the issue further. Considering what others have to say in relation to an identified issue provides a base from which to build. Learning from others’ successes, and the challenges faced in implementing a policy proves beneficial in avoiding negative results as well as increasing the likelihood of having successful outcomes; however, it is important to remember that the specific context of the state of Louisiana must be considered when examining other states. Many factors contribute to the success, or lack thereof, for any given policy or legislative action, so it is rarely possible to successfully adopt a policy or program without any adaptation.

Methodology

For our systematic legislative search we used LexisNexis to search all 50 states and the District of Columbia. Our background research for the other sections of this report revealed that “child care” and “health care” are at times treated as one word, and at other times treated as two words. Knowing this, some
initial searching on LexisNexis was conducted to determine which form of those words would give us the most relevant hits. We discovered that neither “childcare” nor “healthcare” appeared as one word in any of the initial searches. We also discovered that “child care workers” did not show up in the legislation, but “child care provider” did. After selecting the search criteria, all 50 states and the District of Columbia were searched using the same procedure to ensure that our results would be consistent and valid. We searched each state’s statutes and advanced legal services, when available, using the keywords: (“child care provider” AND (“health care” OR “benefits”)). We modeled our search criteria on a similar project by Wong, Kaye, and Newcomer (2007) for in-home personal assistance caregivers.

Although each search resulted in many matches, only a small number of those hits were actually relevant. Some of the legislation addressed streamlining the process for reimbursement for child care providers serving families who receive subsidies from the federal government through Temporary Aid for Needy Families (TANF). Other legislation talked about including child care providers in decisions made about placing children in foster care. In short, the keywords captured a wide range of legislation unrelated to the purpose of this report, but sifting through the results uncovered some relevant legislation that can provide insight and possible options for Louisiana to pursue.

Focus on Health Care

At this point in time, we are not looking at the possibility of increased wages for child care workers in legislation nor as a potential solution to the problem of retention. Rather, we are focusing on the potential role of health care benefits for child care providers both as a way to decrease turnover in the child care industry as well as decreasing the costs of having an uninsured population. That said, many states have looked at wages of child care workers, and in this chapter the different schools of thought around wages and dealing with reimbursement issues will be discussed briefly to introduce the reader to a broad range of the concerns and proposed solutions related to the child care industry.

The legislative search led us to information about possible health insurance plans for child care workers, but most of the results had to do with other important and relevant information, such as the use of unions as well as the need to create an incentive for quality child care providers to enter and remain in the child care sector. Both of these will be discussed below.
Reimbursement

Multiple states (e.g. Delaware and Iowa) talked about increasing the speed with which child care providers are reimbursed for their services as a way to help child care providers. This idea, while worth pursuing, will not substantively improve the economic situation of child care providers. Faster reimbursement does not provide any additional benefits or increase wages; child care providers simply receive the money for which they have already performed the work sooner. Also, only child care providers who provide care to children from families receiving subsidized child care will benefit from expedited reimbursement.

Funding Further Education

Another angle aimed at improving the quality of child care concerned creating incentives for child care providers to further their education. For example, North Carolina has a program called T.E.A.C.H., which provides benefits, including health insurance, as well as higher wages for child care providers enrolled in the program (see Chapter 5 about potential models for further details on this program). Also, in 1999 Washington set aside money for the purpose of increasing child care quality and listed furthering education and training as a way to accomplish the goal to increase quality.

Using Unions

Several states including California, Washington, Oregon and New York have sought to create unions or used unions that already existed to pursue better working conditions for child care workers. One of the issues they specifically addressed is obtaining access to health care. Unfortunately, many of the efforts made by the unions in different states have stopped short of becoming law, and thus did not make it into this section. However, a more detailed account of the efforts made by unions can be found in the Chapter 6 in this report.

State Subsidized Insurance Plans

Another way that legislation has sought to address the need for health care benefits in general is to provide resources for state subsidized insurance plans. There are two ways that this is done. First, by providing coverage to specific target populations such as children or pregnant women. Second, by statewide
or universal health care plans.

**Specific Populations**

Most states provide subsidized health care for children, and many also provide subsidized plans for those below a state selected federal poverty threshold. Another target population that has received attention in the arena of health insurance is that of small businesses. Kentucky has a program called ICARE that helps provide health care benefits to small businesses that employ low income employees (Kentucky Office of Insurance, 2008). Oklahoma has a similar program that is available to small businesses and individuals who do not have health care benefits from their employer (Insure Oklahoma, n.d.). It is possible that some child care facilities would meet the requirements and could benefit from a similar program.

In 1997, Rhode Island won a victory for the child care industry specifically. Direct Action for Rights and Equality (DARE) along with others fought for and obtained changes in state policies influencing child care providers, which, among other things, won the fight for health insurance coverage for child care providers who serve subsidized families (Whitebook, 2001). The current focus in Louisiana is on a state funded health care plan for child care providers who work in Class A licensed facilities. Tying a state funded health care plan to child care facilities that already qualify to receive federal funding could be used as leverage to obtain a state funded health care plan.

**Statewide**

Another option is to ensure that all state residents have access to affordable health care. Massachusetts sought to ensure every individual in the state has health insurance by mandating the purchase of a health insurance plan. MassHealth in Massachusetts and MinnesotaCare in Minnesota seek to provide those with low incomes with health care coverage that would be otherwise unaffordable through partial subsidies. As part of MinnesotaCare families pay a reduced amount for their health care based on income, family size and number of family members on the plan (MinnesotaCare, 2008).

Statewide universal plans have great appeal for advocates for affordable health care; however, pursuing this as a beginning step may be less effective than starting with a smaller target population and building from there. The approach used by Rhode Island with their RIte Care program was to start small and expand. RIte Care started out serving target groups. They expanded to serve additional groups until the
program was replaced with a more universal model. It would be wise for Louisiana to continue the intended approach of lobbying for health care benefits for a specific portion of the child care provider population. Starting with a target group requires less commitment of resources and thus increases the likelihood that the proposal will result in success. Any success in obtaining health insurance for a specific target group can be used to expand to others in the child care industry and possibly other related target groups.

Commissioning Studies

New Hampshire, New York, Washington and Wisconsin each have legislation to look at the issue of retaining child care providers. Washington and Wisconsin are looking at the issue in a more global way by seeking to identify how widespread the issue is and what could help solve the problem of turnover among staff. New Hampshire and New York specifically chose to include health care benefits as a variable. New York is currently conducting their study; results are expected to be available in 2009. Results from New Hampshire’s study are discussed below.

New Hampshire has completed their study and published the results (see Health Insurance Working Group n.d.). They found that low wages and lack of benefits contribute to high turnover rates among child care providers. They also found that small businesses in New Hampshire have a hard time providing health insurance benefits to employees and child care facilities fall under the category of small businesses. They further note that child care providers’ wages make health insurance simply unaffordable. Staffing issues were consistently cited as the biggest barrier to success in the field, and they cite both low wages and lack of affordable benefits as the reason for the difficulty in finding and keeping staff.

With the efforts of other states in mind, understanding specific models for insuring the child care industry will provide a practical and relevant perspective for the goal of creating a health care plan. When considering possible models, looking at both their strengths and weaknesses in general and specific to Louisiana, will help pave a path on which to move forward. Each model will be illustrated by a case study in the following chapter in order to provide further relevance and understanding.
Chapter 5:
Ways to Insure the Child Care Sector

Recognizing the need to insure child care providers is only the first of many hurdles that will need to be overcome in the quest to insure the child care industry. Two further hurdles are identifying a model that best meets the needs of those who will use it (Eggleston, 2000) and identifying a funding stream because “an identified funding stream can make or break a program” (Burton, Mihaly, Kagiwada, and Whitebook, 2000, p. 34). Efforts have already been made among child care workers to band together for the purpose of purchasing supplies and services, including insurance (Warner et al., 2004). Also, receiving health insurance is only a success if the quality of that service is sufficiently high. Thus “. . . consumers probably prefer to pay some out-of-pocket deductibles and co-payments rather than have their healthcare providers receive large financial rewards for skimping on care or discriminating against expensive-to-treat patients” (Eggleston, p. 191). Keeping in mind the need for a model that meets the needs of the intended recipients at a sufficient quality level will help as we look at potential models.
Thus far, this report has explained why the child care industry needs and would benefit from having a health care plan. The importance of quality child care for children, the cost of being uninsured, and some of the problems and potential solutions relating to the retention of child care providers were addressed to give a proper perspective to the pressing need. Looking at what other states are doing, as well as reading relevant literature reveals that there are many ways to look at and address the issue of attracting and retaining quality child care providers. This report focuses on the potential role of health care benefits as a means to attract and keep quality workers; however, the method of providing those benefits must still be decided.

Day Care Action Council of Illinois looked at what other states were doing to insure the child care workforce in 2003 (see Newville, 2003). Their working paper presents three models that could be used to insure child care workers: Medicaid/SCHIP, Subsidy, and Cooperative. Presenting the different models will allow Louisiana to consider what will best meet the needs of their specific situation and give multiple options to pursue should one option prove unviable.

The Medicaid/SCHIP Model

The Medicaid/SCHIP Model uses funds from one or both of the programs to make health care benefits available to target populations not currently covered, including parents and care takers of children already enrolled in the program. The target population for this model is usually low-income individuals and their children. The health care offered tends to be the highest quality, have the highest costs, rely almost entirely on government funding and provide recipients little choice.

The Subsidy Model

The Subsidy Model uses public funds to help make employer-sponsored insurance or private insurance affordable. With this model, recipients have great freedom in choosing their health insurance plan. Along with that choice comes the danger of varying quality of the care. The insurance is paid for under a cost sharing structure, meaning that the child care provider, the employer and public funds pay for the cost of premiums. Two elements of this model
pose problems for child care providers in Louisiana. First, subsidy models usually work as a reimbursement option, which would require that child care providers pay for health care services upfront. It seems unlikely that child care providers would be able to foot the bill upfront even knowing they will eventually see that money again. Second, this model favors a target population with access to employer-sponsored insurance. Child care providers in Louisiana rarely have access to employer-sponsored insurance.

The Cooperative Model

The Cooperative Model results when a group of individuals and/or a group of small businesses join together to buy private insurance. Joining together allows them to act as a larger company to get better group rates and increases the likelihood of being able to get reasonable rates for some of the more difficult to insure in the child care population.

Choosing a Model

When considering which model to use, many factors must be examined. Child care providers tend to work for small facilities, not big companies, limiting the utility of an employer funded model. As discussed previously, child care providers are paid low wages making it difficult for them to afford high co-payments or high deductibles. States have effectively subsidized health insurance plans for similar populations, making this model a potentially viable candidate for child care providers in Louisiana.

Selecting a model that relies heavily on public funding increases the importance of creating political favor and capital in order to create and keep the program running. The balance between cost and quality will most likely prove difficult to find. Luckily having a well defined target population helps in this process of selecting an appropriate model. The current goal being considered is to create a state funded health insurance plan for child care providers in Class A licensed facilities. That is a well defined group, and they are already linked to a federal funding stream since they qualify to receive subsidies.
Case Studies

Looking at two case studies that also surfaced in the legislative search will help further illustrate how health insurance can be pursued on behalf of child care providers.

Rhode Island’s RItc Care

RItc Care Health Insurance for Family Child Care Providers (Rhode Island) was created shortly after the 1996 Personal Responsibility and Work Reconciliation Act (Welfare Reform) and falls under the Medicaid/SCHIP Model. A study commissioned by the state recommended that child care providers receive health care benefits equivalent to those of state employees. They learned that a bill is more likely to pass if it can find its way into the budget proposal of a government agency. By capitalizing on current political events (Welfare Reform) Rhode Island was able to get a program administered by Rhode Island Department of Human Services (DHS). The plan was supported by state-only funds and had no co-pays or premiums for child care providers below a certain income level.

North Carolina’s T.E.A.C.H. Early Childhood Health Insurance Program

T.E.A.C.H. Early Childhood Health Insurance Program (North Carolina) falls under the Subsidy Model. Both family and center-based child care providers can be covered under this program, but we will focus on center based requirements to participate in the program. As opposed to the previous example, this model does not necessarily seek to help those who fit in the low-income category. Instead this program is linked to enrichment. This program formed as a result of independent surveys that revealed that a large percentage of the child care industry that was uninsured. It was piloted originally in just a few counties in North Carolina. In order for a center to qualify to participate, 1-3 staff members must be participating in the T.E.A.C.H. Early Childhood Program (or have an entire teaching staff with a degree in early childhood education or child development). This requirement is intended to increase the quality of child care by raising the educational level of child care providers, and uses health care benefits as an incentive.

In T.E.A.C.H. Early Childhood, a qualifying center chooses a private health insurance plan on its own, and they are reimbursed up to 1/3 of monthly premiums per eligible employee. Money
for this reimbursement comes from federal dollars. Children and spouses are not covered under the program; individual premium rates are used in this program. That means that rates vary by individual based on age, health and/or lifestyle. Since rates vary and reimbursement is only up to 1/3 (but not guaranteed to be a 1/3) this plan may still prove unaffordable even with the subsidy. A follow-up study (as cited in Newville, 2003) found that this program that couples health care benefits with increased education reduced turnover rates and improved recruitment into the child care industry.

There are no examples of using the Cooperative Model in the child care industry of which we are aware. In Massachusetts, a population that also did not have access to health care in large numbers was fishermen. Like child care providers many are self-employed or work for small businesses. In 1997, several small groups of fishermen banded together and created Fishing Partnership Health Plan. An outside individual helped the group of fishermen negotiate with the insurance companies to set up the initial health care plan and an independent group still manages the plan for the fishermen. Premium prices are calculated using a complicated process that considers many factors and uses community rating. Using community rating means that the health status of individuals cannot be used to determine premium prices. This way no individual pays the full cost of their individual health status, which helps those who may be difficult to insure. All fishermen in Massachusetts and New Hampshire are eligible to apply for Fishing Partnership Health Plan; however, enrollment remains low due to limited funding. Subsidy amounts are based on individual fishermen’s income.

These examples provide inspiration and a reminder that there is still plenty of work left to do before a viable health care plan will be available to child care providers in Louisiana. While pursuing the end goal of a state funded health care plan, being creative in how to get there will likely prove invaluable. An important strategy to consider will be to unionize the child care industry in Louisiana. The following chapter will give a history of union activity as related to the child care industry and discuss some of the efforts and successes of those unions.
Chapter 6:
The Unionization of Child Care Providers

A History of Organizing:

Three Decades of Experience, 1970-2001

The United States has a rich history of movements, organizing and unionization. Labor unions have existed in this country for over a century, and despite cycles of varying positive and negative perceptions of unions, a recent article tracking polls and trends shows that overall the American public holds favorable views of unions and their ability to represent workers’ rights (Panagopoulos & Francia, 2008). Unionization is not new to the child care industry, and our country’s turbulent relationship with unions in general is paralleled in the child care industry.

Most Americans view unions as necessary to protect workers (Panagopoulos & Francia, 2008). It logically follows then that unions are perceived as representing a group of people
otherwise unable or less able to speak and advocate on their own behalf. While not always the case, groups of people who form unions are often more vulnerable than the general population. As discussed by Peggie R. Smith (2006) in the Kansas Law Review:

“The child care industry has more workers whose earnings fall below the poverty line than any other industry, and more than fifty percent of all providers earn poverty-level incomes . . . Racial-ethnic women are far more likely than white women to work in child care. Although they represent only thirteen percent of all paid workers in the labor force, racial-ethnic women amount for a third of all paid child care workers” (Smith, p. 333-334).

These demographics of the child care industry make unionization a logical strategy in their efforts to earn and maintain their rights as workers.

The framework of portraying child care providers as workers began with the Compensation Movement. The Movement, known later as the Worthy Wage Campaign, took hold on a national level in response to President Nixon vetoing the Comprehensive Child Care Act in 1971. The defeat of this legislation reflected the nation’s view that child care should be home-based and not standardized or commercialized. The public truly believed that children developed best in a home setting and opposed any regulations promoting child care as an industry. The debate of what child care means and how to frame it began the first of what has commonly been agreed among scholars and activists to be three periods within the Movement, the first being from 1970-1985 (Whitebook, 2002). The major objective of the Movement during this time was to shift popular opinion from seeing child care as solely about child development into the view of “child care work as political activity” and forcing the conversation towards workers’ rights (Whitebook, p. 10).

During this timeframe, several key players came to the forefront. Membership of the National Association for the Education of Young Children (NAEYC) grew dramatically, and the formation of such groups as Madison Child Care Workers United (MACWU) and the Boston Area Day Care Workers United (BADWU) represent localized precursors of national organizations like the Child Care Employee Project (CCEP) formed in 1980, which ultimately became the Center for the Child Care Workforce (CCW) (Whitebook, 2002). Though not formal unions, these organizations lead the crusade for increased compensation, benefits and standards in the child care industry. The advocacy groups proved essential to documenting that a problem existed and
portraying child care providers as workers whose rights were being compromised. Little could have been accomplished on behalf of the child care providers without this effort to first document and disseminate the existing crisis.

While the first stage of the Compensation Movement focused on the documentation and diffusion of information, the second phase from 1985-1995 sought to create a link between providers’ compensation and the well being of children. “Child care advocates and other stakeholders once again began to organize around federal child care policy, building a broad coalition around the Act for Better Child Care (ABC), which ultimately became the Child Care and Development Block Grant (CCDBG)” (Whitebook, 2002, p. 23). These policies reflected the fact that general society was now becoming more aware of the importance of child care and also its status as a professional industry. A landmark study entitled the National Child Care Staffing Study was first conducted in 1988 and updated in 1997. In addition to findings related to the extremely low wages earned by child care providers, limited health coverage of workers “despite heavy exposure to illness in child care employment,” and the fact that 35% of child care centers employ welfare recipients, the 1997 update to the study found that “child care centers continue to experience very high turnover of teaching staff, threatening their ability to offer good quality, consistent services to children” (The National Child Care Study, 1988/1997, p. 8). The study specifically made the link between compensation and the quality of child care centers. This link became an important step in building the argument for a more regulated and higher paid industry in addition to justifying the need for the more formal organization of child care providers.

Arguably the most notable strategy during the Movement’s second phase was the Worthy Wage Campaign. Defined as a public awareness campaign launched in 1991, CCEP published the following:

**Worthy Wage Campaign Principles**

Whether we call ourselves child care workers, family child care providers, preschool or early childhood teachers, teacher assistants or caregivers, we are working in a field where most employees are underpaid and undervalued—a field that is continually losing its best workers because of poor wages and benefits. The Worthy Wage Campaign is a five-year grassroots effort to empower ourselves and
mobilize to reverse this child care staffing crisis. It is organized around the following three principles:

- To create a unified voice for the concerns of the early care and education workforce at the national, state and local levels;
- To increase the value and respect for those who provide early care and education through improving their wages, benefits, working conditions and training opportunities;
- To promote the accessibility and affordability of high-quality early care and education options that meet the diverse needs of children and families. Each year the focal point of the Campaign is a nationwide Worthy Wage Day (Whitebook, 2002, p. 28).

The Campaign and annual Worth Wage Days brought the child care industry its first real sense of organization. The Campaign brought together different stakeholders and created a forum through which child care providers could reach both the media and policy officials. As a result of the Worthy Wage Campaign efforts, the state of Rhode Island became home to the Daycare Justice Coalition, an activist organization winning such victories as better pay schedules and pushing for a state funded health care plan for teachers and providers that was passed in 1997 (Whitebook) (Refer to Chapter 4 for more detailed information about states’ legislation). The second phase was really about making connections between communities and movements, and child care unions began to take shape as the Movement transitioned to its next phase.

The third, and final, phase of the Movement was from 1995-2001; however, as discussed below, the United States is likely in the midst of a fourth phase. During the third phase, the child care industry made strides in achieving a coveted “seat at the table” when regulatory decisions were made (Whitebook, 2002, 37). One of Whitebook’s critiques of the Worthy Wage Campaign focuses on its failure to create a structure that brought together a power base from which the Movement could move forward. Though not specified by Whitebook as the sole strategy, the growth of unions in the third phase and into present times is a strategy that should not be ignored. Before anything on the national level could take hold, several local unions emerged, most notably of these were in Seattle and Philadelphia.
“In Seattle, the Worthy Wage Campaign joined with Service Employees International Union (SEIU), Local 925, to create the Child Care Union Project. In Philadelphia, spearheaded by staff at the worker cooperative center Childspace, many activists chose to affiliate with 1199, a local within the American Federation of State, County and Municipal Employees (AFSCME) that has largely organized health care workers” (Whitebook, p. 44-45).

The United Child Care Union (UCCU) grew out of local efforts in Philadelphia, and is the self described “only union in the country just for child care” (United Child Care Union, n.d.). UCCU is now a national union partnered with AFSCME.

**Unionization in the 21st Century**

Local unions played an important role in enabling institutions to organize in a manner that most benefitted the child care providers. Though local initiatives in some cases in the past resulted in national expansions, unionization today among child care providers remains most powerful at the state level. Unions with a state-specific focus allow the union to mobilize around state policy, the driving force of regulations for the child care industry. Much like the Compensation Campaign, modern union efforts still organize around portraying child care providers as *workers* and thus deserving of particular rights.

“Unions have been an important voice in the effort to increase public investment in child care and they share with the broader child care advocacy community a concern for improving the lot of child care providers. But unions have also begun to play a role in state campaigns for increased public investment in child care that is more akin to their traditional role: worker representative” (Chalfie, Blank, and Entmacher, 2007, p. 5).

As with any implementation or innovation process, unionization is just one strategy – but an important one with growing precedent.

Unionization is not an easy task in general and proves particularly difficult in the child care industry due to the fact that no single employer exists. Child care centers can be private, for-profit or non-profit; fractionalization is the hallmark of the industry. Despite the impediments to unionizing implicit in the child care industry, particular models have been used with some success. A model used by local SEIU chapters focuses on providers’ relationship with their respective states...
as a result of receiving funding and child care assistance payments as part of welfare policy, Temporary Assistance to Needy Families (TANF). As a result of this exchange of money and formal relationship, SEIU argued that this creates an “employer of record” thereby allowing bargaining to take place between the two parties. In essence, child care providers, or the centers on their behalf, are positioned as public employees and become the bargaining unit (Chalfie et al., 2007). The key factor here is the pre-existing financial relationship with the state, regardless of the regulatory status, a relationship clearly exhibited with Class A child care facilities in the state of Louisiana.

Developing the bargaining unit and determining how this unit is formed and categorized (i.e. based on regulatory status, geography, etc.) is the first step to creating a union. Unions must elect a representative to speak on their behalf, identify bargaining issues and prepare a bargaining mandate. The bargaining issues typically defined by child care unions are subsidy rates and payment procedures, health benefits, training, grievance procedures and health and safety regulations. Winning the bargaining mandate or bargaining rights is the most complicated part of the process and can take one of two forms. The first is collective bargaining or collective negotiations, which obligate both sides to meet with the intention of reaching an agreement, and if no agreement is made a neutral third-party steps in. This type of mandate gives the union much more power or equality when bargaining with state officials. The second type of mandate is called meet-and-confer authority, which merely requires the state to meet with the union and does not mandate that an agreement be reached.

“Nevertheless, even a requirement on a state (or locality) to meet and confer with a union representative . . . about subsidy rates and other issues can be, as some advocates who have had previous difficulties being heard by state agencies have noted, a considerable advance over no negotiation mandate at all. Moreover, should an agreement be reached and memorialized, the parties will proceed as if they had a collective bargaining agreement” (Chalfie et al., 2007, p. 10-11).
States with Unionization Experience

As documented in a report published by the National Women’s Law Center in 2007 entitled “Getting Organized,” there were considerable advances in 2005 and 2006 with the unionization of child care workers in fourteen states. Below are the key takeaways for each state documented in this report. It should be noted that much of the following pertains to home-based providers; however, their victories may be easily transferred to, if not easier for, the unionization of center-based child care providers.

1. Illinois
   a. Governor Rod Blagojevich signed an executive order in February of 2005 permitting subsidized providers to organize. It required the state to enter collective negotiations.
   b. SEIU won the right to represent 49,000 subsidized providers, and legislation was passed making subsidized providers public employees, the state being their public employer – only for the purposes of granting collective bargaining rights.
   c. The union is not permitted to strike.
   d. SEIU and the state agreed on a $250 million contract that includes:
      i. Subsidy rate increases – 35% over 3 years beginning April 2006, with additional individual increases of 5-25% granted to those who meet certain training/quality standards
      ii. Health insurance – the state will contribute a fixed $27 million towards premiums to obtain health insurance beginning in the third year, and the state will transfer funds to the union to cover the “employer” portion of the premiums, which can be used in the third year by the union to either self-fund insurance or to purchase from an outside vendor
      iii. Grievance procedures – payments must be processed in a timely manner and grievances must be settled by binding arbitration.

2. Washington
a. Governor Christine Gregoire issued an executive directive in September of 2005 allowing both subsidized and unsubsidized home-based providers to organize and directing the Department of Social and Health Services to meet-and-confer with union representatives.

b. SEIU won stronger collective bargaining rights in March of 2006, but only for subsidized providers.

c. Legislation was passed making subsidized providers public employees, the state being their public employer – only for the purposes of granting collective bargaining rights.

d. Two bargaining units were created – one for subsidized providers and one for unsubsidized employers, the latter only granted meet-and-confer authority for purpose of influencing regulatory requirements.

e. In November 2006, the SEUI, on behalf of first bargaining unit of subsidized providers, and the state agreed to a $50 million, two-year contract that includes:
   i. Subsidy rate increases – 10% over the two years
   ii. Health insurance – subsidized, licensed providers will have access to coverage if they care for at least 4 children receiving child care subsidies (through TANF), the state contributing $555 a month per provider
   iii. Other – increased training opportunities and subsidized meals

f. Despite this victory of subsidized home-based providers, Washington state senate did not pass a similar collective bargaining bill for center-based providers (SEIU Local 925, 2008).

3. Oregon

a. Governor Ted Kulongoski signed a executive order in October of 2005 a second in February of 2006, both applying to different types of home-based providers. These bargaining units are defined by their regulatory status instead of their subsidy status.

b. A meet-and-confer was mandated between both of the groups covered in the
executive order and the states two child care regulatory bodies; however, the providers are not considered employees of the state and cannot strike.

c. Two individual contracts negotiated for by AFSCME and SEIU separately, signed in September 2006 and February 2007, respectively, generally include:
   i. Subsidy rate increases
   ii. Health insurance – though not provided by either contract, though the AFSCME agreement with state agencies includes a provision to explore options to help providers gain access to affordable health coverage. SEUI sought $3M for coverage, which was denied.
   iii. A Provider Bill of Rights – included in the AFSCME contract, it establishes protection for providers when working with state agencies.
   iv. Training – providers will have a greater voice and more access.

d. Governor Kulongoski signed another executive order in February of 2007 granting both unions collective bargaining rights in future negotiations.

4. Iowa

a. Governor Tom Vilsack signed two executive orders in January of 2006 recognizing AFSCME and SEIU as two bargaining unions for home-based child care workers; however, the SEIU unit did not materialize.

b. Per the orders, meet-and-confer authority was granted to Iowa’s Department of Human Services, the providers’ employee status is not stated but the state must discuss “issues of mutual concern” such as reimbursement rates, payment process, training, and health and safety.

c. AFSCME developed their contract proposal, passed in December 2007, generally includes (AFSCME WORKS Magazine, 2008):
   i. Reimbursement rate increases – 2% increase
   ii. Bill of Rights

5. New Jersey

a. Governor Jon Corzine signed an executive order in August of 2006 granting
collective bargaining rights to Child Care Workers Union, a partnership between Communications Workers of American (CWA) and AFSCME, for home-based child care providers.

b. The order provided that the state must meet with CCWU and that any agreement that is reached is binding by the state, but providers are not considered state employees and cannot strike.

c. Negotiations have yet to result in a contract.

6. Michigan

a. Child Care Providers Together, a partnership between United Auto Workers (UAW) and AFSCME, has been certified to represent child care providers.

b. This certification did not come from an executive order by Governor Jennifer Granholm, she instead approved an “interlocal agreement.” This agreement allows state agencies to cooperate and form the Michigan Home Based Child Care Council. The Council is now responsible for administering the subsidy program, improving quality and recommending changes to regulations.

c. The Council is authorized to bargain collectively with Child Care Providers Together, who has proposed a three year contract that generally includes (CCPTM, n.d.):

   i. Raises – 13% to 35% over the three years

   ii. Dues – providers’ dues will be deducted from state payments

   iii. Training incentives

   iv. Payment – accurate and timely

   v. Healthcare – a “road map” to affordable health care, exploration of the options

   vi. Provider Bill of Rights

d. A contract is yet to be ratified.

7. Wisconsin
a. Governor James Doyle signed an executive order in the fall of 2006 permitting Child Care Providers Together, partnered with AFSCME, to meet-and-confer with state agencies on behalf of child care workers.

b. The list of bargainable items include quality standards, training/certification requirements, reimbursement and payment procedures, health and safety and “any other matters and regulations that would improve recruitment and retention.”

c. The Wisconsin chapter of the union is still in its planning phases.

8. Rhode Island – legislation passed and vetoed

a. SEIU won bargaining rights in 2005 (providers would not be considered state employees).

b. Governor Donald Carcieri vetoed the bill for making providers “virtual” employees and stated that “‘by forcing the state to negation [higher] reimbursement rates with a providers’ union’ the bill would increase costs and thus ‘could force the state to consider reducing eligibility for families and children’” for Rhode Island’s free health care program.

c. Efforts are at a standstill.


a. In May of 2006, a bill generally allowing home-based providers to be represented by a union was passed and deemed providers employees of the state solely for the purposes of bargaining and negotiating. United Federation of Teachers (UFT) would represent New York City and Civil Service Employees Association (CSEA), an affiliate of AFSCME, would represent the rest of the state.

b. Governor George Pataki vetoed the bill in June 2006 due to the deeming of providers as state employees.

c. New Governor Eliot Spitzer signed an executive order in May of 2007 granting bargaining rights to Voice of Organized Independent Childcare Educators (VOICE), in partnership with CSEA/AFSCME and the American Federation of Teachers (AFSCME WORKS Online Xtras, 2007). The new order lists as bargainable issues
working conditions, subsidies, and benefits or payments. Any agreement reached must be in writing and will be binding on the state. Providers are not considered state employees (New York State, n.d.).

10. California - legislation passed and vetoed
   a. Legislation was passed allowing UCCU, in partnership with AFSCME and SEIU, to act as a bargaining agent for child care workers, while not deeming providers public employees for any purpose.
   b. Any state agency or contractor that administered state subsidies was required to negotiate with the union. The bill met opposition from such state agencies/contractors for its requirement of them to process union due payments.
   c. Governor Arnold Schwarzenegger vetoed the bill in June of 2006 stating that an increase in reimbursement rates would take money away from other child care programs, market rates for private providers and the state budget.

11. Massachusetts - legislation passed and vetoed
   a. Legislation was passed in 2006 allowing SEIU to collectively bargain on behalf of subsidized child care workers.
   b. Governor Mitt Romney vetoes the bill only saying that it would “inappropriately shift the focus of child care away from the interests of children and families.”
   c. A ballot initiative campaign was then run, placing a similar proposal on the November 2006 ballot. This would have again allowed for a bargaining unit. The proposal was opposed by the State Department of Early Education and Care and lost 52% to 48%.
   d. A new governor has been elected, but new efforts have yet to form.

12. Minnesota
   a. AFSCME and SEIU have organized on the local level with goals of going statewide.

13. Ohio
AFSCME has organized on the local, county level with goals of going statewide.

14. Pennsylvania

a. UCCU has organized in Philadelphia and is increasing membership statewide.

Health coverage is of particular interest to UCCU and commission the Keystone Research Center to conduct a study about the health care needs of Pennsylvania’s child care workers. They are working to develop health care options (United Child Care Union, History).

The Benefits of Unionization despite the Barriers

Unionization does present some drawbacks. Some of these include increased work for management, directors’ efforts to remain neutral, tensions about how organizations and campaigns should be structured and the limitation of unions to represent all child care providers, thereby excluding some (Tepperman & Foss, 2004; Whitebook, 2001/2002). Despite these real downsides to unionization, as the above state-level successes show, unionization can create many benefits for child care providers.

At a broad level, unionization strengthens commonality among providers and builds coalitions between providers, teachers and parents (Folbre, 2006). Unions can become a collective voice for an industry that is fragmented by nature. The level of systemic change needed to accomplish something like the passing of a state funded health care plan takes a range of players being present at the table, and these players need power. While unionization is not the only way, unionization is the most formal type of coalition – and coalition building remains essential for systemic change. Unions’ collective bargaining power is undeniable and should be considered as a possible tool or strategy to be used by the child care providers of Louisiana with aid of the United Way for the Greater New Orleans Area.

“There’s a problem with consistency in coalitions or campaigns. There are a lot of starts and stops. Often the groups don’t have the right audience and what they’re saying is not falling on the right ears . . . People don’t know the importance of what we do. We need an in with politics, and we need funding. We need something that follows through.”

Pearlie Harris, Royal Castle
Whether some or all of the elements of this report are implemented in the efforts to obtain health care for child care providers, it is important to at least consider the efforts, successes, failures, and challenges faced by others pursuing a similar goal. Based on our research we have compiled a list of recommendations for the United Way for the Greater New Orleans Area as well as other parties interested in improving the child care industry, specifically by providing health care.
Considering the current political climate is important when seeking to create change of the magnitude proposed in this report. Both the former and current Governors of Louisiana have specifically talked about the importance of health care for the people of Louisiana. At an October 19th, 2006, meeting of the Collaborative, a group assigned to look at the health care situation in Louisiana, former Governor Blanco said, “Today I’m leading our state down a clear path towards universal health insurance coverage” (State of Louisiana, 2006). In his regular session opening speech on March 31st, 2008, current Governor Jindal spoke of the need to improve education, starting with early education, and access to health care. He recognizes the negative impact of being uninsured as it relates to use of emergency care, as evidenced in his comment that “Louisiana currently ranks fourth worst in the country for non-emergency use of emergency rooms. We must provide better primary and preventative health care to keep our people from ending up in the emergency room and save thousands of lives and hundreds of millions of dollars” (Office of the Governor, 2008). Since the political climate appears favorable to this issue, those pursuing a state funded health care plan for child care workers in Louisiana should take advantage of this window of opportunity. Also, knowing the specific concerns voiced by Governor Jindal can help in framing the issue in a way that maximizes the chance of successfully passing legislation and creating a health care plan.

Based on our review of relevant literature in regards to the impact of being uninsured, possible
Providing for Providers

insurance models, the potential strategy of unionization and our personal interviews with the child care facility directors, we have compiled the following list of recommendations for the United Way for the Greater New Orleans Area to consider as they build their efforts to insure the child care industry via a state funded health care plan.

Recommendations

- Take advantage of the current political climate, both at state and national level
- Administer the surveys (provided separately) at a statewide level, possibly utilizing a professional consultant, as discussed in the Appendix and use the results when advocating for a health care plan
- Build a broad based coalition of multiple stakeholders, possibly including a private insurance company willing to fund the survey/study portion
- Work to include elected officials in this coalition
- Organize child care providers, consider joining or creating a formal union
- Replicate some of the activities used during the Worthy Wage Campaign
- Pay special attention to the affordability of the plan to ensure that child care providers will actually participate
- Be prepared to be creative with alternative models such as starting with a specific Parish(es) and expanding to all Parishes, as opposition to a statewide plan is possible
- Consider joining forces with other industries to create a state funded plan for small business, which would allow the inclusion of all child care providers (i.e. not just Class A)

In writing this report, we experienced some limitations that should be considered when conducting future research about a state funded health care plan for child care providers. This report was written in conjunction with a graduate course at Tufts University, and therefore was limited to the preset time frame of a semester. Funding was also a limitation and only allowed us to visit and personally interview child care facility directors in New Orleans. More time and funding would have enabled us to personally interview interested stakeholders throughout the state. It was beyond our means to administer and analyze the survey, which is a vital component to the broader goal of advocating for a state funded plan.

Keeping these limitations in mind will help when conducting future research. Possible areas for
future research include having a deeper understanding of the current political climate and Governor Jindal’s history with health care, which can aid in framing the issue. Future research could also look at the history of child care unions in Louisiana and identify past barriers specific to the state. Results from the research conducted in New York will be available in 2009, and these should be considered along with already available lessons from other states’ initiative such as in New Hampshire. There is the potential to parlay research based on Louisiana Pathways Child Care Career Development System regarding who enters and remains in the industry into support for a state funded health care plan as a possible solution to the problem of retention.

We believe that child care providers in Louisiana deserve more than they are currently receiving for the necessary and beneficial services they provide. Retaining child care providers through a state funded health care plan is an extremely worthy cause. Providing health care to this population has the potential to not only decrease turnover but to improve the lives of those in the industry by improving the quality of their health care. Ultimately, helping child care providers helps us all; by investing in them, we invest in our future.
Appendix A:

Survey Instrument

Background

The United Way for the Greater New Orleans Area’s (UWGNOA) Success By 6 initiative is engaged in a support effort geared at improving the quality of health care for child care providers in the state of Louisiana. To support its efforts, the UWGNOA thought it best to obtain information regarding the current health care situation for administrators, directors, and providers working in Louisiana child care facilities through the use of a survey instrument.

The original plan for the survey was to design such an instrument that would help inform UWGNOA of how the lack of health care coverage for child care providers affects staff retention rates. As we began to search deeper into our research, we found that the survey would be an extremely influential tool. The results of the survey would help UNGWOA when they reached the stage of taking their findings to the state legislature to explain why health care benefits are strongly needed in the field of child care.

Survey Design

The survey instrument was initially to be designed in one of two ways. The first was
through extensive research in the area of survey design and the implementation of past health care plans and surveys. A few of the literary supports we found most useful were CAHPS (example surveys regarding health care), Agency for Healthcare Research and Quality, and Health Care for All. The second design option was via past health care surveys directed at child care providers. We became aware of a past research survey completed by the United Way of Massachusetts Bay’s Success By 6 in collaboration with the Center for Social Policy at the McCormack Institute of Public Affairs, University of Massachusetts Boston during an interview in the early stages of our work.

We contacted the United Way of Massachusetts Bay (UWMB) and requested permission to utilize their survey design and original questions. They responded by mailing a report entitled Health Care Coverage: Are We Shortchanging Those Who Care for Our Children?, which analyzed the results of the surveys conducted in Massachusetts, along with the actual survey instruments obtained from UWMB provided our team with the design and a majority of the questions for the two surveys prepared for UWGNOA’s Success By 6 initiative.

The surveys that will be sent out to a sample of Class A child care facilities throughout the state of Louisiana seek information from four major areas. These areas include access to health care coverage and affordability; emergency room usage; the role of state funding; and staffing and retention. One survey instrument directs questioning towards the administrators and directors of the child care facilities. The other survey is geared towards center-based child care providers. Both surveys aim to gain an understanding if the providers currently have access to health insurance benefits. They inquire about the quality and affordability of present health care coverage and whether current child care providers have access to needed medical care. The surveys key role for UWGNOA is to gain a deeper understanding of the impact of having, or not having, health insurance for child care providers and on the retention of these workers.

Sample Questions

Center Administrators/Directors

The survey provided to child care center administrators and directors is designed to
question what type of services they, or the facility itself, are providing for staff. It also asked key questions pertaining to the population that participates in the center’s programs. Below is a breakdown of the five sections and sample questions (Center for Social Policy & Center for Survey Research) pertaining to each section:

- **A – Background information on child care facility**
  - A3. What type of care is provided at this site? Please check all that apply.
    *(Sample choices: Infant, toddler, head start, preschool, school age)*
  - A4. About what percentage of the children at this site are State subsidized, including those in contracted slots and those who receive vouchers or Community Partnerships for Children funding?"

- **B – Type of staff working at the child care facility**
  - B2. What kinds of support staff are employed at your center? (Check all that apply)
    *(Sample choices include: no support staff; clerical; transportation; cleaning; cooking; other)*

- **C – Staff eligibility and benefits**
  - C1. Please fill in the following chart about the people who work at your center. *(Questions in the chart pertain to whether or not the center offers health insurance or additional financial support to administrators, directors, or teachers)*

- **D – Facilities financial distribution to staff (benefits, health insurance)**
  - D2. About what percent of your center’s annual budget is spent on health insurance for your employees?
  - D3. Thinking about all employees with individual health insurance, what is your center’s typical monthly contribution per employee for those employees with **INDIVIDUAL COVERAGE**?

- **E – Self directed questions**
  - E1. Are you male or female?
  - E3. Do you currently have health insurance at this job?
  - E5. How many years have you been working in child care?

**Center-Based Child Care Providers**

The survey for center-based child care providers is organized differently than that of the center directors and administrators in that the line of questioning is directed more prominently toward the individual, rather than the center as a whole. The providers are asked to complete a
total of 58 questions comprised of fill-in-the-blank, multiple choice, and short answer. Similar to the previous survey, this is also divided into sections identified by headings. Each heading and sample questions (Center for Social Policy & Center for Survey Research) pertaining to each is displayed as follows:

- **Your Job (Questions 1-8)**
  - What type of care does the center you work for provide?
  - Is the center open only during the school year or is it open year round?

- **Your Health Care Coverage (Questions 9-21)**
  - Do you have any kind of health insurance coverage at all?
  - How do you get your health insurance?

- **Health Care Eligibility (Questions 22-26)**
  - Are you currently eligible to receive any kind of health insurance through another person, such as a spouse, partner, or parent, even though you currently do not have it?

- **Your Health Care (Questions 27-32)**
  - In the past 12 months, did you go to a doctor or other healthcare provider for regular or routine care, such as a “check-up” or annual physical?

- **Your Health (Questions 33-36)**
  - In the past 12 months, about how many days were you unable to work because you had an illness or injury?
  - What did you do on those days when you were unable to work?

- **Your Children (Questions 37-44)**
  - In the past 12 months, was there ever a time when any of your children needed any type of medical care which usually provided by a doctor, nurse, or other health care professional?
  - When medical care was not received, how much of a reason was the cost of care?

- **Health Care Costs (Questions 45-48)**
  - How much of a reason was health insurance concerns in your thinking about leaving childcare?

- **About You (Questions 49-58)**
  - What is your age now?
  - What is you highest level of completed education?
Methodology

There are a total of 1,266 Class A child care facilities in the state of Louisiana. Beginning at the Department of Social Services (DSS) website for Louisiana, we searched their child care section which led us to information regarding each Parish (Louisiana’s equivalent of a county). For every Parish, each individual center name was pulled up along with their respective contact information. The DSS page included details regarding each center’s Director(s) name and phone number; hours of operation; transportation details; recent findings of state inspections; and whether they were identified as Class A, Class B, or “N/A.” Once a Class A licensed facility was identified, the “Program Type” field was next to be researched. If the “Program Type” read anything other than “child day care,” it was not included in the total population. Some of the other Class A facilities excluded from our total population were child adoption placement centers, regional DSS sites (adoption/foster care), maternity homes, and child residential facilities. An additional type of facility excluded from our total population of Class A licensed child care facilities were those run by Head Start. Head Start facilities are federally funded and therefore typically already offer health insurance benefits for their child care providers. Although we did include some child care facilities that may happen to include Head Start classes in their program, none of the facilities in our total population receive health care benefits from Head Start funding.

Both the center-based child care survey and center administrator/director surveys will be provided for the United Way of the Greater New Orleans Area. To go along with the two surveys, the total population of 1,266 Class A licensed child care facilities will be included. The UWGNOA will be commissioning consultants to perform both the administration and analysis process. This will maintain consistency between beginning and end process of the analysis. An Excel file of all the facilities listed by Parish will be presented.

Based on a conversation with a statistician, there are often low response rates for surveys when they are mailed. To ensure better results, mailings are often sent twice. The consultants performing the administration may want to select the sampling so that it is representative of rural versus urban and above versus below poverty sample is reflective of the entire state. Based on
such sampling, they will need to determine a targeted response rate, which usually ranges between 30 and 40 percent. These rates correspond with mailing in the range of 600 and 800 surveys (that would need to be doubled to account for mailing twice). All is dependent upon the sampling method selected as well as the software (e.g. SPSS). Finally, UWGNOA needs to evaluate the importance of the survey and its value in their efforts to gain a deeper understanding of child care providers, administrators, and directors and how the lack of health care has and continues to affect them.
I. Introduction

Project number: 10
Project title: The Impact of Health Care Benefits for Child Care Workers in Louisiana
Client: Success by 6 & United Way for Greater New Orleans Area

This Memorandum of Understanding (the “MOU”) summarizes the scope of work, work product(s) and deliverables, timeline, work processes and methods, and lines of authority, supervision and communication relating to the Field Project identified above (the “Project”), as agreed to between (i) the UEP graduate students enrolled in the Field Projects and Planning course (UEP-255) (the “Course”) offered by the Tufts University Department of Urban and Environmental Policy and Planning (“UEP”) who are identified in Paragraph II(1) below (the “Field Projects Team”); (ii) Success by 6 & United Way for Greater New Orleans Area, further identified in Paragraph II(2) below (the “Client”); and (iii) UEP, as represented by a Tufts faculty member directly involved in teaching the Course during the spring 2008 semester.
The Client's contact information is as follows:

Client name: Success by 6 & United Way for Greater New Orleans Area  
Key contact/supervisor: Todd Battiste & Joycelyn Jenkins  
Email address: ola.or  
Telephone number:  
FAX number:  
Address: 2515 Canal Street, New Orleans, LA 70119  
Web site: www.unitedwaynola.org

The goals of the Project are:

The Tufts Field Projects team will work with the Client to advance understanding of and to continue the analysis of the possibility of state funded health care benefits for child care workers in Class A licensed facilities in the state of Louisiana. The analysis also should consider the role of and fiscal impact on the state budget if Louisiana were to offer a state-funded health care plan, as well as other options for affordable coverage. Finally, the Field Projects team should examine the importance of on-the-job healthcare benefits to current child care workers.

The methods and processes through which the Field Projects Team intends to achieve these goals are:

- Research states that currently provide state funded health care benefits to child care workers.
- Related research to properly compare income and benefit levels of child care workers to other similar occupations.
- Analyzing the fiscal impact on Louisiana’s state budget of providing state funded health care benefits to child care workers in Class A licensed facilities.
- Confer with individuals with applicable experience such as analyzing government budgets, developing healthcare insurance plans and administering or participating in state funded health care plans.
- Develop and conduct a survey to examine the importance of health care benefits to current child care workers in Louisiana in relation to job retention.

The work products and deliverables of the Project are:

- An analysis of Louisiana state government’s potential fiscal role in providing health care for child care
workers, including the cost for the state to provide an appropriate level of health care benefits to child care workers.

- A comprehensive list of other states currently providing health care insurance for their child care workers, along with a summary of other states debating the financial needs of their child care workers.
- A survey of the type described above.

(6) The anticipated Project timeline is:

February 13, 2008: Two page conceptual outline
February 27, 2008: Comprehensive outline of report
March 5 or 12, 2008: Oral presentation to class regarding result to date
March 17-21, 2008: Site visit (including facilitating survey)
April 4, 2008: First draft of report due
April 23, 2008: Final presentation – date to be confirmed
May 2, 2008: Final Project due

(7) The lines of authority, supervision and communication between the Client and the Field Projects Team are:

- All email communication, which will constitute the majority of the Field Projects Team to Client communication, goes through Chantal Nadeau.
- Phone communication takes place as needed via a conference number.
- Draft deliverables will be emailed to the Client and returned via email or fax as necessary.
- Todd Battiste and Joycelyn Jenkins jointly oversee the Project.
- Justin Hollander and Meghan Welch supervise the Course.

(8) The understanding with regard to payment/reimbursement by the Client to the Field Projects Team of any Project-related expenses is:

- The Client will book and pay for the Field Projects Team’s accommodations during site visit.
- Field Projects Team is responsible for booking flights for site visit, as well as out of pocket expenses such as ground transportation and food – all of which will be reimbursed by UEP upon return up to $2,500.
- All other Project related expenses incurred by Field Projects Team members will be reimbursed by UEP up $100.

III. Additional Representations and Understandings

(1) The Field Projects Team is undertaking the Course and the Project for academic credit and therefore compensation (other than reimbursement of Project-related expenses) may not be provided to team members.
Because the Course and the Project itself are part of an academic program, it is understood that the final work product and deliverables of the Project (the “Work Product”) – either in whole or in part – may and most likely will be shared with others inside and beyond the Tufts community. This may include, without limitation, the distribution of the Work Product to other students, faculty and staff, release to community groups or public agencies, general publication, and posting on the Web. Tufts University and the Field Project Team may seek and secure grant funds or similar payment to defray the cost of any such distribution or publication. It is expected that any issues involving Client confidentiality or proprietary information that may arise in connection with a Project will be narrow ones that can be resolved as early in the semester as possible by discussion among the Client, the Field Projects Team and a Tufts instructor directly responsible for the Course. It is also understood that the Client will likely distribute the Work Product to local and/or state agencies and other interested parties at their own cost. Distribution by the Client requires notification via email to all three parties of the Field Projects Team.

The Field Projects Team retains ownership and use of data and research materials used in drafting the report, and of the report itself. The Client may request permission to review all research data and notes, particularly in relation to survey results and fiscal analysis. The Field Projects Team will determine such access. The Client may not alter the final report; however, they may create a new product that cites the Work Product following the format of their discipline (e.g. Chicago Style, APA Format, etc.).

It is understood that this Project may require the approval (either through full review or by exemption) of the Tufts University Institutional Review Board (IRB). This process is not expected to interfere with timely completion of the project.
IV. Signatures

For Successby 6 & United Way for Greater New Orleans Area
By: Joyvelyn J. Jenkins
Date: 05/04/2008

Representative of the Field Projects Team
By: Chantal Nadeau
Date: 06/26/2008

Tufts UEP Faculty Representative
By: Justin Hollander
Date: 07/05/2008
### Appendix C: Interviews/IRB

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
<th>Place</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>J.J. Bartlett</td>
<td>4th February 2008</td>
<td>I.J.’s Office</td>
<td>2:00pm - 3:00pm</td>
</tr>
<tr>
<td>Joyceyynn Jenkins</td>
<td>18th March 2008</td>
<td>Betty’s Pancakes</td>
<td>10:00pm - 12:00pm</td>
</tr>
<tr>
<td>Ms Helen Smith Green</td>
<td>19th March 2008</td>
<td>HUME Center</td>
<td>10:00am</td>
</tr>
<tr>
<td>Ms Marla Miller</td>
<td>19th March 2008</td>
<td>Grace Church</td>
<td>11:00am</td>
</tr>
<tr>
<td>Ms Pearlie Harris</td>
<td>19th March 2008</td>
<td>Royal Castle Child Development Center</td>
<td>12:30pm</td>
</tr>
</tbody>
</table>
Re: IRB Study # 0803051
Title: Health Care Benefits as a Retention Solution in Louisiana's Child Care Industry
PI: Nicole Smith
Co-Investigator(s): Aline Dallaire
IRB Review Date: 4/1/2008

April 2, 2008

Dear Nicole,

I have reviewed your application for the new study listed above. This study qualifies as a review under the following guideline: 2. Non-identifying educational tests, survey, interview observation of public behavior.

Any changes to the protocol or study materials that might affect the exempt status must be reviewed by the Office of the IRB for guidance. Depending on the changes, you may be required to undergo an expedited or full review.

If you have any questions, please contact the Office of the IRB at (617) 627-3417.

Sincerely,

Yvonne Wakeford, Ph.D.
IRB Administrator
REFERENCES


Cunningham, P. J., & Hadley, J. (2007). Differences between symptom-specific and general survey questions of unmet need in measuring insurance and racial/ethnic disparities in access to care. Medical Care, 45(9), 842-850.

Cunningham, P. J., & Trude, S. (2001). Does managed care enable more low income persons to identify a usual source of care? Medical Care, 39(7), 716-726.


