Health Insurance:

Question: Provide access to quality health care for all home-based child care providers by using a state-wide insurance pool (involve chamber or association).

It would be very difficult to provide cost estimates for the provision of health insurance or health insurance premiums with out a model to work from.
What is provided here is a compilation of what is known to be established in states, of which there are very few, regarding health insurance for child care providers. It should be noted, with the unionization movement across the country, a number of states are also in the thinking stage.

These examples do not include all States that offer health insurance, but are meant to represent a range of approaches States have taken to provide benefits to early childhood providers.

From The National Child Care Information and Technical Assistance Center and through contacting State Child Care Administrators across the nation:

States that have some type of plan include New York, Rhode Island, North Carolina and Kentucky:

**New York**

The Health Care Reform Act of 2000 (HCRA) created an initiative—the Healthy NY Program—designed to encourage small employers to offer health insurance coverage to their employees and also make coverage available to uninsured employees whose employers do not provide group health insurance. It creates a standardized health insurance package that is offered by all health maintenance organizations, which is made more affordable through State sponsorship so that more uninsured small employers and uninsured employees are able to purchase health insurance coverage. For information about the Healthy NY Program, visit the Web at www.ins.state.ny.us/website2/hny/english/hny.htm or call 866-HEALTHY NY (866-432-5849).

**Rhode Island**

As of October 1, 2005, the Rhode Island Department of Human Services (DHS) Health Care Assistance Program for Family Child Care Home providers ended and was replaced by a program called the Child Care Provider RIte Care (CCPRC) Program. To find out if they qualify for the CCPRC program, providers must first complete an application for the RIte Care/RIte Share program. RIte Care is Rhode Island's Medicaid managed care program and RIte Share is the State’s premium assistance program. For additional information, visit the Web at www.dhs.state.ri.us/dhs/famchild/shcare.htm.

During the application process, the provider's family gross countable income is verified and considered for determining eligibility and family cost sharing. Providers must report all of the income they receive for child care services (not just what they receive as reimbursements from DHS) as well as income from any other employment, income of their spouse, and any other countable income in their household.

If the providers do not qualify for RIte Care/RIte Share, they may qualify for the CCPRC program. In order to qualify for participation, providers must receive at least $7,800 in reimbursements from DHS for child care services delivered to CCAP eligible children within the preceding 6 months of their request for health care assistance, and have countable family incomes less than 350 percent of the Federal Poverty Income Guidelines. For additional information, visit the Web at www.dhs.state.ri.us/dhs/heacre/drchiccf.htm or call DHS at 401-462-5300, ext. 122

**North Carolina**

The T.E.A.C.H. (Teacher Education and Compensation Helps) Early Childhood Health Insurance Program is an initiative to help fund the cost of health insurance for employees working in child care programs. Child care providers are eligible to have up to one-third of the cost of individual (not family) health insurance coverage reimbursed through a special fund, if they meet the conditions of the program. Funding for the T.E.A.C.H. Early Childhood Health Insurance Program comes from the North Carolina Division of Child Development.

Licensed family child care providers who have a T.E.A.C.H. Early Childhood scholarship to work on their 2- or 4-year degree in child development or early childhood education may participate. Licensed family child care providers who already have a 2- or 4-year degree in these fields may already be eligible. Family child care providers choose their own health insurance carriers.

Information about the T.E.A.C.H. Early Childhood Health Insurance Program is available on the Web at www.childcareservices.org/ps/health_ins.html. For additional information, call the Child Care Services Association at 919-967-3272.

**Kentucky**

ICare is a program to help the employer pay the insurance premiums. Each company must fall under certain eligibility requirements (See below). The employer is reimbursed a certain amount based on if the employee falls under what is called a "High-cost condition" (i.e. everything from anoxic brain injury to stroke)

- "Pay an average annual salary of no more then $51,510, which is 300 percent of the federal poverty guidelines for a family of 3. Salaries of any owners and employees who are ineligible are not included in this average."
- "Employ 2-25 people (full or full time equivalent)"

- "Pay at least 50% of the employee's premium for single coverage.

You can find more information and the application at http://icare.ky.gov

In Connecticut some legislation was proposed in their last session but did not go forward regarding health insurance for family-based child care providers. In essence, the state would have provided grants to providers, who accepted children on child care assistance (subsidy), to purchase health insurance from the Municipal Employers Health Insurance Plan, any other program that is offered for small business professionals or insurance offered to members of a labor organization.

In addition there are a range of membership organizations that can provide health insurance to child care providers:

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

800-232-6273

www.nase.org

NASE is a resource for the self-employed and micro-businesses (up to 10 employees), providing a broad range of benefits and support to help the smallest businesses succeed. Founded in 1981, NASE represents hundreds of thousands of entrepreneurs and micro-businesses, including family child care providers. NASE's support structure in the marketplace for micro-businesses falls into four basic areas, which includes Value-Added Benefits. The Value-Added Benefits are legal services, retirement and investment planning, and payroll services—at discounted fees and rates. Access to a variety of health insurance plans also is offered, including major medical, prescription drug, as well as dental and vision plans.

**Association for Childhood Education International (ACEI)**

800-423-3563 or 301-570-2111

www.acei.org

ACEI is an international membership organization to promote a global community dedicated to the optimal education and development of children, from infancy through middle childhood. ACEI offers members a discount on many insurance programs. ACEI plans are administered through Forrest T. Jones & Company, Inc. Information about personal, life, and health/accident insurance programs offered to ACEI members is available on the Web at www.udel.edu/bateman/acei/insuranc.htm. Additional information is available on the Forrest T. Jones & Company, Inc. Web site at www.ftj.com or by calling 800-821-7303 or
816-756-1060.

**Look at ways to encourage registration versus requiring registration.**

In surveying the other states, the overwhelming incentives like Iowa are:

- having higher rates for child care assistance for those who are registered or licensed; and
- involvement in the federal food program.

<u>In addition:</u>

Forty-one States (AK, AR, AZ, CA, CT, DC, DE, FL, GA, IA, ID, IL, IN, KS, KY, MD, ME, MN, MO, MT, NC, NE, NH, NJ, NM, NV, NY, OH, OK, OR, PA, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV) and two Territories (CNMI, GU) report that they offer program- or provider-level incentives to encourage provider training and education.

- In Iowa, through the Child Care Resource and Referral system, training is offered or coordinated with other approved training organizations at a reasonable fee. Usually $5.00 –10.00.

Fourteen States (AR, DC, IA, KS, KY, ME, MT, NE, NJ, NY, OK, OR, SD, WI) report that they offer provider scholarships.

- In Iowa, we invest federal dollars in to the T.E.A.C.H. scholarship programs, operated by Iowa AEYC, to provide college scholarships to child care providers.

Ten States (CA, IA, KY, MD, NV, SC, SD, TX, VT, WV) describe QRS completion bonuses.

- Registered providers can enter the QRS system in Iowa which provides bonuses for providers who earn a rating of 2 through 5.

<u>Some examples of  incentives reported from other states are:</u>

- **Montana** promotes training and continuing education through merit pay awards of $250 to $700 for the completion of planned training hours and/or credentials and degrees, Child Development Associate Assessment Scholarships to help students pay the cost of Child Development Associate assessment and Best Beginnings Certified Infant Toddler Caregiver Stipend Program awards.

- Participation in **New Mexico's** Reach for the Stars program, a five-level Quality Rating System for licensed homes and centers, allows higher reimbursement rates to providers. Reimbursement rates increase incrementally beginning at level two and continuing through level five, which is for accredited programs. Becoming more knowledgeable about ways to support children's development of pre-literacy and pre-numeracy skills leads to attainment of higher levels.

- **Oregon's** tiered reimbursement system to subsidy providers, the Enhanced Rate Program, is incorporated within the Oregon Registry Steps and provides enhanced subsidy for documented training and education. Oregon Compensation and

Retention Equal Stability programs also are linked to achieving steps on the Oregon Registry, and are available in seven counties. The programs also provide scholarships and wage stipends to support the professional development and retention of child care providers.

- Project T.O.P.S.T.A.R. (**Tennessee's** Outstanding Providers Supported Through Available Resources), a program within the Tennessee Family Child Care Alliance, provides technical assistance and professional development to family child care providers. The program offers highly trained and motivated mentors to assist new providers or those who want to improve the quality of their care through hands-on, one-on-one support. Working as a team, the mentor guides the protégé to set three goals as the focus of their 20-hour commitment.

- **Indiana** has raised its child care assistance rate every two years.

- In **Missouri** most of the grant programs require that the provider be licensed, or has a deadline for them to become licensed, in order to participate, which might include funding to start up or expand a facility, become accredited, etc

DHS provides this in response to a question from Representative Heaton regarding home-based child care requirements in Missouri.

For interim committee from Doris Halford, State Child Care Administrator for Missouri:
The 12 clock hour requirement for training applies only to licensed providers as it's part of the licensing rules to maintain licensure. It does not apply to our registered providers (i.e. family, friends, and neighbors, or exempt providers which are faith based or operated by school districts). They currently have no training requirements. We have no statutory basis to require training for these providers, but have considered putting some requirements in their contracts. What has hindered us at this point is the fact that we have about 5000-6000 registered providers and we don't think our current training capacity can support that mandatory requirement, so currently any training on their part is voluntary or tied to participation in the food program. There are currently no set types of approved training. The way it's currently handled is that providers submit requests to one person in the licensing section at the Department of Health and Senior Services (DHSS) (a separate Department from ours which is the Department of Social Services (DSS)). This person makes the decision on whether it's approved or not based on her own judgment. As you can imagine this is a rather cumbersome and potentially inconsistent process. We've been in discussions with the folks at DHSS and that is probably going to change within the next year to a more standardized training approval process possibly contracted out to our Professional Development Organization (OPEN) at the University of Missouri-Columbia.

Provided by:

Jeffrey Anderson
Iowa Department of Human Services
Bureau of Child Care and Community Services
515-281-7266
"Every child, beginning at birth, will be healthy and successful"

How do other states address urban/rural differential on payments?

A request was sent to the other states inquiring about if such a differential was in place and if so, what was the percent difference in the rates?

Of the states reporting:

**Michigan** uses shelter areas. Shelter areas group common counties by demographics, cost of living, etc.

**Oklahoma** has Enhanced (Metro) and Standard rates. The market rate survey is used to determine rates by county and then counties acre grouped into two rate areas. Providers in the lower rate area generally believe a single rate should be provided. For me, the most difficult concept to communicate about rate setting is that rates are based upon the market, not the actual cost of care or the value we place on a providers time.

**Oregon** has differential rates based on zip codes and it's a little complex.

**South Dakota** did Urban and Rural rates at one time. We did not use a percentage..... The counties were grouped into rural and urban with the rate then set at the 75th percentile. We did this for a number of years and then switched to county rates. Each county having their own rate seems to work better as the families in larger counties where most of our children reside get a better deal. Even though the rates are not to drive the costs, we often received complaints from the rural counties that they did not think this was fair. Providers seem happy with the county method, although some will still complain if they border a county with a higher rate.

**Ohio** has six sets of pay rates based on the results of the most recent market rate survey. The differences are not strictly related to urban vs. rural.

**California** uses regional market rate ceilings that do not include a differential specifically designated for urban versus rural child care providers. Based on the market rate survey, market profiles were developed for each zip code and those market profiles were rolled up to a county ceiling. The market profiles took numerous things into consideration, that may have included, but was limited to: population density, housing density, median age, proportion vacant, proportion rentals, mean household size, median household income, median gross rent, median home value, median real estate taxes, proportion of households in poverty, proportion of households in poverty receiving public assistance, and percentage of students receiving free or reduced lunch.