At the Wage Floor:

Covering Homecare and Early Care and Education Workers in the New Generation of Minimum Wage Laws

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I. Introduction

In November 2012, fast-food workers in New York went on strike and the Fight for $15 was born. Over the last five years, the movement has lifted wages for more than 17 million workers across the nation by fighting for and winning numerous minimum wage policies (National Employment Law Project 2016). Substantial minimum wage increases are underway in California, New York, Oregon, and more than 30 cities and counties around the country. In states and cities covered by them, these new minimum wages will increase earnings for 25 to 40 percent of workers (Reich, Allegretto, and Montialoux 2017; Reich et al. 2016). After four decades of wage stagnation and rising inequality, the movement has delivered real, much needed, and meaningful progress in a remarkably short period of time.

Fast food has been iconic in the discussions of the minimum wage, from the influential mid-1990s research that found no negative employment impact of wage increases in the industry, to the fast-food workers who have walked out on strike in cities across the country in recent years (Card and Kruger 1995). But of course the reach of these wage increases extends well beyond fast food to underpaid workers in multiple industries. The dynamics of minimum wage increases vary across industries based on each industry's specific structure.

Nowhere are the distinct dynamics more pronounced and challenging than for those employed in human services industries. This paper focuses on an important subset of these workers: those who provide homecare and early care and education services to the very young, people with disabilities, and those who are frail due to age or illness. We explain the pressing need to raise these workers' wages and the unique structure of their industries that results in a funding squeeze for wage increases—at the root of this is the fact that most families are unable to afford all of the homecare and child care they need, never mind pay enough to ensure that workers earn a living wage, and public human services are chronically underfunded.

These workers provide a critical (but too often unrecognized) public good; as such, we argue that a significant public investment is a necessary part of the solution, both to deliver minimum wage increases to these workers and to cover the significant unmet need for care. We provide background about the shared and divergent challenges in the homecare and early care and education industries, as well as review emerging policy initiatives to fund wage increases for homecare and early care and education workers and identify principles for public policy going forward.

II. The Care Work Conundrum

Our focus on workers in both the homecare and the early care and education industries brings attention to a critical part of our nation's labor force that is often overlooked. Later in this paper we will provide a detailed and nuanced discussion of the distinctive aspects of each industry, but here we offer a simplified overview of care work to highlight dynamics impacting both industries. To make some of the dynamics clear, we reduce the complexity of these sectors and detail perspectives in the private market for care. (This reduction is quite substantial—public dollars play a significant role in these industries—but we believe it is also useful because, in some ways, the very problem here is that these markets are too heavily private.)

In general, in the *private* markets for both homecare and early care and education (ECE), there are three critical perspectives. Each perspective on challenges and concerns is unique. First, there are the buyers, the people (relatives of the recipients of care or the recipients themselves) who pay for the services. Second, there are workers, those who are paid to provide services. And third, there are recipients of the services.

Now, consider the situation from each perspective. From the perspective of someone purchasing care (e.g., a parent securing ECE for a toddler or a daughter trying to secure a home health aide for her aging father), the paramount simultaneous concerns are affordability (because in general, the cost of care is beyond the families' means) and quality (because quality has a direct impact on the well-being of the recipients).

Turn to the perspective of the worker. Her pay is so low (roughly $10 per hour) and her benefits so paltry that making ends meet is a constant concern. No matter how devoted and skilled, she faces the constant stress of a poverty-wage job. And, in truth, if she wants to stay in the sector and advance her skills, she still faces a very low-wage career.

Finally, there's the perspective of the person receiving care, for whom the paramount concern is the relationship with her caregiver or teacher. The stronger and more consistent the relationship, the greater the likelihood for high-quality services; for children this means more abundant opportunities for learning and growth, and for adults a higher quality of life.

But the low wages in care services nearly guarantee turnover. Each worker who leaves the industry erases established connections and requires the recipient of care to start from scratch again.

In sum, from the perspective of every actor in the private market for care, there are grave concerns. While these concerns appear distinct, they are in fact all of one piece and share a common solution. Even though care is often prohibitively expensive for purchasers, it is simultaneously so low wage that it generates destructive levels of workforce and care instability. To raise wages would

Throughout this paper, we talk about "care industries" and "care work." Our definition extends from nurturing and education at the start of life, to supporting the independence of those with chronic conditions or disabilities, to the intimate care required by those who have a self-care limitation.

Specifically, we include workers doing hands-on work in both the homecare and early care and education (ECE) industries. We define these terms to include:

- **Home health aides and personal care workers:** Paid workers that provide direct services and support for elderly or frail people, or people with disabilities, in the client's own home.
- **Early care and education workers:**
  - Teaching staff employed in child care centers and school-based programs.
  - Family child care providers and their assistants working in private homes.

increase the already extremely high cost of care for families. To reduce the cost of care would push already extremely low wages further down. This is the fundamental conundrum in the private market for care services in the U.S. But the conundrum is a function of the fact that care is treated as a largely private concern in our country. ***With consistent and adequate public investment***, wages could rise and quality increase without making care unaffordable.

It is an oversimplification of the current system to focus only on the privately-funded parts of the care services markets; there are substantial and complex public investments in care services in the United States, as will be detailed below. But more is needed: sufficient public investment is crucial in order to meet the intersecting needs for access to quality, affordable services and decent wages for workers. The care market conundrum cannot be resolved on the private side of the exchange.

III. The Case for Public Investment

Increasing the minimum wage, as the Fight for $15 has, brings this conundrum into the spotlight. Care wages hover just above the labor market floor, so the cost of care labor will rise along with minimum wages. But if increasing labor costs raises the cost of care, already stressed families will be even less able to afford it. Most clients and families who are paying for care out of their own pockets are not in a position to pay more; many are already struggling to pay even at current rates. Raising prices means that fewer families will be able to afford care; it may actually push them into the informal grey market in the search for cheaper care, possibly to the point of paying below the minimum wage. This is the core challenge of providing homecare and child care to everyone who needs it in the U.S.: most families are unable to afford all of the care they need and workers in these industries bear the burden of this as reflected in their abysmally low wages.

Only significantly higher public investment will create a sustainable bridge across this gap. Public investment is what the sector has long needed. The push for mandated minimum wage increases offers another chance to make the argument and make the investment. And across the country, leaders are doing just that, as illustrated by examples at the end of the report.

But this will only happen if minimum wage activists and policy makers are clear about and committed to designing policy that reaches care workers and invests in improving their wages while significantly boosting public funding to cover the cost of the wage increases. With their eye on this issue, activists, advocates, and policy makers can fully embrace the challenge of raising wages in the care sector. From the outset, a focus should be on building the political will to devote substantial public resources to doing so.

There is a strong, well-documented economic case for systematic and significant public investment in care:

Investments promote the quality of care. Workers who are better paid stay in jobs longer and are less stressed. As a result, they form stronger relationships with those they care for and make stronger contributions to their health and development (Howes 2014; Whitebook and Sakai 2004). Studies have shown that when homecare wages are increased, worker turnover decreases significantly (Ko et al. 2015; Howes 2008). In homecare, evaluation has shown that workers who receive additional training can provide more effective services (California Long-Term Care Education Center 2016). In early care and education, decades of research has shown that programs rated as providing higher

quality services to children paid higher salaries and had lower rates of turnover among the workforce (Whitebook, Howes, and Phillips 2014; Whitebook et al. 2001). Thus, the stability of the early care and education workforce leads to better outcomes for children.

Care investments promote economic growth by boosting earnings and lifetime incomes, reducing poverty and reliance on public income supports, increasing tax revenues, and potentially increasing labor force participation of mothers and other unpaid caregivers (Bivens et al. 2016). The availability of high-quality and reliable early care and education increases worker productivity, decreases absenteeism, and reduces turnover among parents in the labor force (MacGillvary and Lucia 2011). Furthermore, the gains from high-quality early care and education experiences are borne out over a child's lifetime in better school, health, and economic outcomes, and lessening the need for other social interventions. Studies have shown that investing in high-quality early education yields a high return on investment of up to 13 percent through better education, economic, health, and social outcomes, yet those who care for and educate our youngest children remain among the lowest paid workers, earning less than those who watch our cars (parking lot attendants) (Heckman 2012). More and better care for seniors and people living with disabilities reduces negative health outcomes and allows them to remain in their homes (LaPlante et al. 2004; Allen, Piette, and Mor 2014). Increased investment in homecare also reduces the overall cost of long-term care (Robison et al. 2012).

Care investments promote equity. Women, and in particular women of color, are disproportionately represented in poorly-paid care work, so improving the quality of homecare and early care and education jobs shrinks the earnings gap between men and women, as well as the race gap among women (Cooper 2017; Huizar and Gebreselassie 2016). It also raises the family income of paid caregivers, thus reducing poverty among their children and other family members. Further, women provide far more *unpaid* care than men do, hurting their overall lifetime earnings and increasing their poverty rate, especially in old age (National Alliance for Caregiving (NAC) and AARP Public Policy Institute 2015). This is important because people in low-income households too often go without the care they need, receive care of poor quality, and live in families particularly burdened by both unpaid care and care expenditures disproportionate to their incomes. Improving care infrastructure would support and strengthen these families.

With regard to young children, studies show that the achievement gap can begin as early as infancy, when the physical conditions and stresses of poverty can take their toll on the development of the child's brain and therefore the ability to learn. A multitude of research suggests the answer to closing the achievement gap lies in promoting high-quality early childhood education (Nelson 2006). Yet, uneven access to high-quality early care and education persists, and the achievement gaps that are present at kindergarten entry between children from high- and low-income families are vast. The benefits accruing directly to the children receiving high-quality care and educational resources are large and have long-term effects, leading to improved educational outcomes and high-school graduation rates, and an increasingly productive workforce that will boost economic growth, provide budgetary savings at the state and federal levels, and lead to reductions in future generations' involvement with the criminal justice system (Bivens et al. 2016; W.S. Barnett and Masse 2007; Belfield et al. 2006). Public investments to improve the wages of the early care and education workforce can help to promote access to quality services for children, regardless of their family's ability to pay.

The case for greater public investment is strong. Higher wage floors bring this need to the forefront of advocates' and policy makers' attention.

A Brief Overview of the Industries

The nation's care workforce numbers at least 4.4 million and is growing rapidly. Care work includes just over 2.4 million homecare workers[1] and another 2 million workers in early childhood care and education.[2] These care workers generally earn very low wages with weak benefits, although importantly, in some regions of the country they have been able to improve the quality of their jobs through organizing and unionization (Dresser 2008) and sustained public investments (McLean, Dichter, and Whitebook 2017).

As shown in Table 1, the median hourly wage for care workers in 2016 stood at just $10.29 an hour and employer-provided health insurance was uncommon. And while these are some of the fastest growing occupations in the economy, their inflation-adjusted wages have been stagnant over the past decade. Moreover, the workforce is disproportionately women of color and immigrants.

Even workers that secure full-time hours in these jobs do not clear the poverty line for a family of three. Perhaps obvious, but it bears noting, given the average wage of $10 per hour, raising the wage floor to $15 presents a significant opportunity and benefit to these workers. Equally, without public investment, the wage increase is likely to significantly challenge providers and purchasers in this market.

Table 1
Employment, Job, and Worker Characteristics of Homecare and Early Childhood Education Workers, U.S.

		Homecare and Early Care and Education Workers	All workers
Median hourly wages (in 2016 dollars)	2006	$10.10	$18.76
	2016	$10.29	$18.40
Percent with employer-provided health insurance (2016)		46.8	74.1
Percent with public health insurance (2016)		25.5	10.4
Percent in households below 200 percent of poverty line (2016)		44.3	23.1
Demographics (2016)	Percent Women	93.4	48.4
	Percent Workers of Color	48.9	38.0
	Percent Foreign-born	23.3	18.1

Source: Authors' analysis of American Community Survey 2006 & 2016

A CLOSER LOOK AT HOMECARE

We begin with an overview of the homecare industry. As shown in Figure 1, currently in the United States about 32.7 million people have a self-care limitation due to a disability or illness. Of these, 57 percent are under age 65 and 43 percent are age 65 and older (Osterman 2017). While some of these individuals receive paid homecare, many are either unable to afford it or find it; the result is a significant amount of unpaid care provided by kin. Moreover, the aging of the population is putting additional pressure on the country's homecare system; predictions are that by 2026, the United States will need an additional 1.2 million homecare workers.[3] In some areas of the country, wages are too low to recruit enough workers to meet the growing need for homecare, leading to worker shortages (Thomason and Bernhardt 2017).

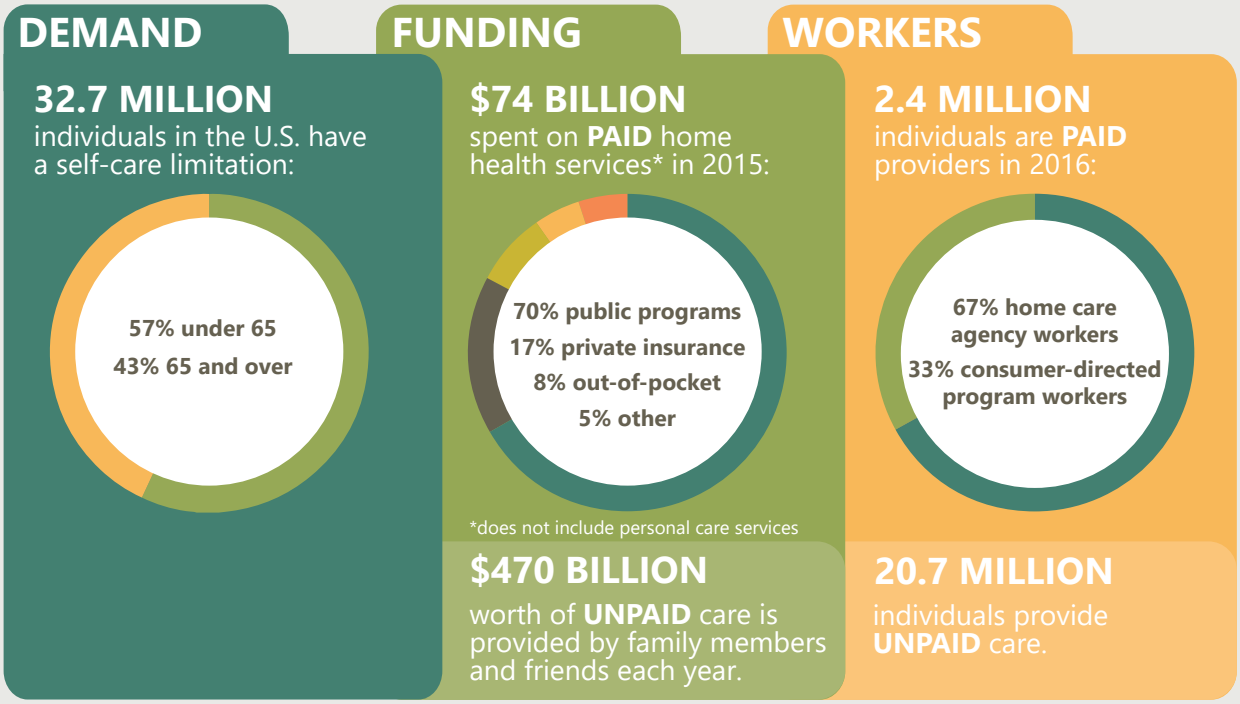
Homecare is funded either publicly, by the government, or privately, by the client or family hiring the homecare worker. Overall, public funding pays for 70 percent of paid homecare (PHI 2017). The majority of government funding comes from Medicaid, which under specific conditions and with some constraints pays basic (and sometimes insufficient) homecare services for low-income elderly people and independent living supports for people living with disabilities. Medicare also pays for a limited amount of short-term home health care for Medicare recipients. The remainder of public funding comes from state and local programs as well as some smaller federal health programs such as Veterans Affairs. There is private money in the market as well. Many of those who receive Medicare purchase services beyond what those programs will cover. Others who do not qualify for Medicaid or Medicare rely on supplemental insurance and/or pay for homecare themselves. It is very common for unpaid family members to provide care in each of these situations.[4] The value of unpaid care is estimated to be $470 billion annually (Reinhard et al. 2015).

The delivery of publicly-funded homecare varies significantly between states, but state programs typically resemble one of two models, or a combination of both. In the most common model, the state contracts with private homecare agencies. These agencies hire, train, and pay homecare workers. In other states, the care is "consumer directed," meaning that a government agency informs consumers of the amount of care they can buy and consumers themselves (or their family members) select workers to provide the care (Howes 2018). In some states, consumers are able to select a family member as their homecare provider. In consumer-directed systems, homecare workers are paid by the state, either directly or through a fiscal intermediary contracted to process payroll. In every state, in addition to the public market for care, there is a private pay market. Private purchasers of homecare services may buy those services from agencies, or directly connect to workers. While parts of this private market are fully "on the books," some of this market is quite informal and is often called the "grey market" of the homecare industry.

More than half of the states allow publicly-funded homecare to be provided by a family member of the client, although rules about which family members qualify vary by state. Estimates are that family members make up the majority of providers in consumer-directed programs (Howes 2014). This is important to keep in mind when we discuss the impact of low wages (and minimum wage increases); often, the client and the worker are in the same household.

FIGURE 1

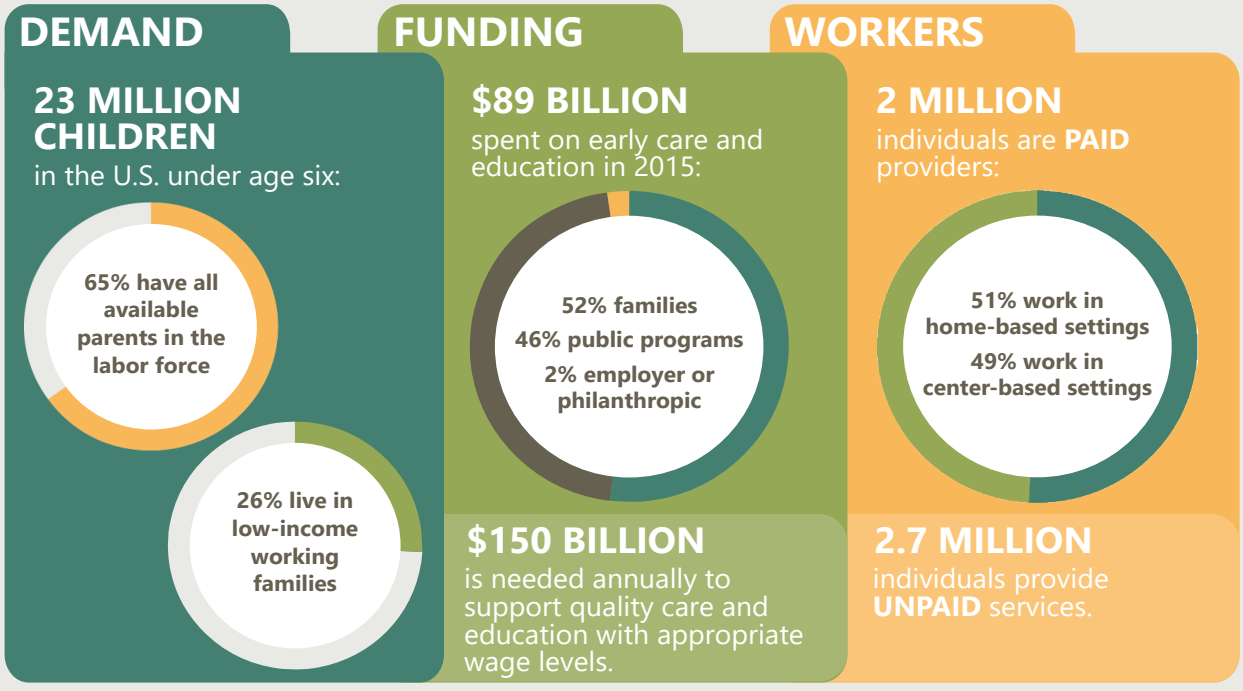
U.S. HOME CARE SYSTEM



SOURCE: Osterman 2017, PHI 2017, Reinhard et al 2015

FIGURE 2

U.S. EARLY CARE & EDUCATION SYSTEM



SOURCE: Annie E. Casey Foundation 2016, National Survey of Early Care and Education Project Team 2013, Build Initiative 2017

As shown in Table 2, the median hourly wage of homecare workers in 2016 was $10.06. About half of homecare workers live in low-income households (below 200 percent of the federal poverty line) and one-third rely on public health insurance. The vast majority are women (88.9 percent) and over half are people of color (61.2 percent).

Table 2
Employment, Job, and Worker Characteristics of Homecare Workers, U.S.

		Homecare Workers
National employment		2.4 million*
Median hourly wages (in 2016 dollars)	2006	$10.46
	2016	$10.06
Percent with employer-provided health insurance (2016)		35.8
Percent with public health insurance (2016)		33.5
Percent in households below 200 percent of poverty line (2016)		53.7
Demographics (2016)	Percent Women	88.9
	Percent Workers of Color	61.2
	Percent Foreign-born	29.3
Education (2016)	Percent with Less than High School	17.0
	Percent with High School	35.6
	Percent with Some College	37.8
	Percent with College or Advanced Degree	9.6

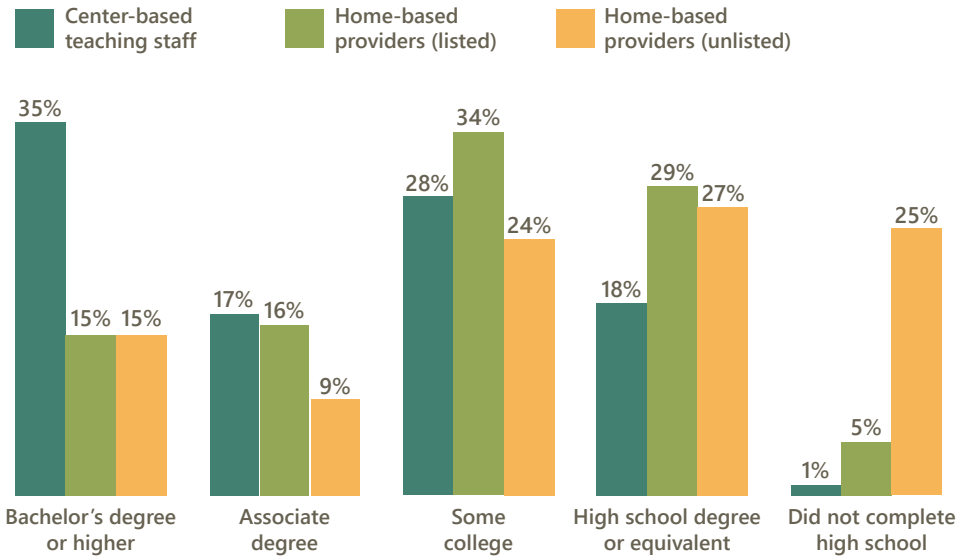
Source: Authors' analysis of American Community Survey 2006 & 2016, except where noted
** 2016 estimate from PHI*

A CLOSER LOOK AT EARLY CARE AND EDUCATION

As llustrated in Figure 2, every day in schools, homes, and centers across the United States, approximately 2 million adults are paid to care for and educate more than 12 million children between the ages of birth and five (Whitebook, McLean, and Austin 2016). This almost exclusively female workforce is responsible for safeguarding and facilitating development and learning of our nation's youngest children. Nonetheless, a wide variety of regulations and qualifications are prescribed to the workforce across and within states, depending on the age of children served, the location of the service, auspice and funding streams. For example, federally-funded Head Start and many state-funded public Pre-K teachers are required to hold bachelor's degrees, though few receive compensation on a par with their counterparts teaching in elementary school settings. As a consequence, the workforce itself varies dramatically with respect to qualifications and wages for center and home-based educators (see Figures 3–5, page 10). In addition, an equal number of unpaid

FIGURE 3

Education Level of ECE Workforce by Setting



Source: Early Childhood Workforce Index, 2016

FIGURE 4

Earnings of ECE Teaching Staff by Job Title

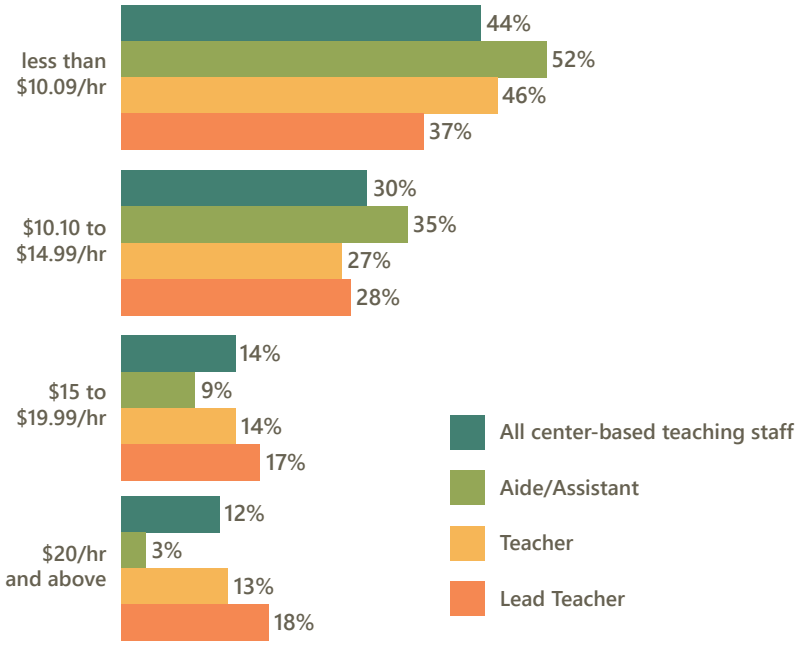
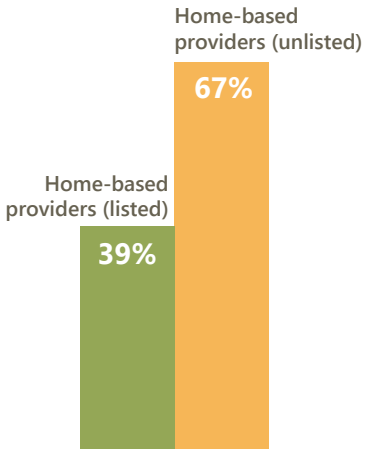


FIGURE 5

Household Income by Home-Based ProviderType



Household income $35,000/yr or less

Source: CSCCE analysis of the 2012 National Survey of Early Care and Education

caregivers, typically family members other than parents, care for young children (Administration for Children & Families, Office of Child Care 2015).[5] Given the high cost of care in most states, it is widely assumed that many families relying on unpaid caregivers would utilize formal early care and education services if cost barriers were removed, which in turn would increase the size of the paid ECE workforce (National Academies of Sciences 2018).

Unlike public education for children from kindergarten through 12th grade, early care and education is not a universal entitlement. As a consequence, most families pay out-of-pocket for some portion of the cost for early care and education services. Using the long-standing affordability standard that no family pay more than 10 percent of their income for child care, the cost of care is out of reach for most families.[6] Full-time care averages $9,000 nationally and can be more than double this amount depending of where the family lives and the age of the child (Child Care Aware of America 2017). This cost burden varies by family makeup and income. Twenty-six percent of all families across the country spend more than 10 percent of their income on child care costs and for poor families the burden is greatest—over half of poor families with young children pay nearly 20 percent of their income on child care costs (Mattingly, Schaefer, and Carson 2016). Child care consumes so much of a family's budget largely because child care and early education is a labor-intensive industry, requiring a low child-to-teacher ratio (Child Care Aware of America 2017).

The federal government funds some services for families with incomes below a certain threshold and/or children with identified risks, primarily through the Child Care and Development Block Grant (CCDBG) and Head Start. In 2016, total federal spending on the CCDBG was $5.7 billion (Schmit and Walker 2016), an insufficient amount as the program served only 11 percent of eligible children nationwide; many more are not eligible for subsidy but still struggle with costs. (United States Government Accountability Office 2016). Although CCDBG is a single federal program targeting low-income families in each state, it functions as separate state programs in practice because states have considerable flexibility to set rules for how the CCDBG funds are distributed, including eligibility. In 26 states, the income limits were lower in 2016 as a percentage of the federal poverty level than they were in 2001 (National Women's Law Center 2016). While the recent commitment by the federal government to double the size of the CCDGB budget is a welcome investment and will expand access to services, it remains insufficient to fully meet the need and is not currently designed to address wages of ECE workers. The federal Head Start and Early Head Start programs offer free or low-cost early learning experiences for children living in poverty, but these too reach only a fraction of those who are eligible. At the state level, prekindergarten programs in the 2014–2015 school year were operated by 42 states and the District of Columbia, but these programs reached only 29 percent of four-year-olds and 5 percent of three-year-olds (W. Steven Barnett et al. 2016); many base eligibility on family income and require fees.

Most early care and education in the U.S. is delivered in the private market. As in any market system, children's options (access to and quality of services) are largely determined by the income of their family, thus driving and consolidating economic inequities. Due to this high demand, for those who have access to the CCDBG child care subsidies, the government sets subsidy/reimbursement rates to providers at depressed levels to maximize the number of children served. This drives the low wages, though, and as a consequence those who provide care and education subsidize the sector through their own low wages.

IV. Challenges to Raising Wages in These Sectors

In industries such as restaurants or retail, employers have the option of responding to minimum wage increases by modestly raising their prices to cover their increased labor costs, and a growing literature suggests that this is indeed the main adjustment mechanism that they choose.[7] But in the homecare and early care and education industries, there are significant constraints on the ability to raise the price of care to cover the cost of increased wages.[8] In contrast to other industries, wages are a much greater share of overall costs, and as a result covering wage increases has a greater impact on price.[9] Further, both industries are comprised of private-pay, public-pay, and grey markets, each of which poses its own particular challenges. Wage compression—in which there is minimal variation in pay between those with different levels of education and experience—can also pose challenges in sectors where wages across job roles are low, even among those with higher levels of education, training, and experience. Here we highlight some of the most pressing challenges in each industry that stem from insufficient public support and limitations in families' ability to pay.

Homecare

Public vs. private vs. unpaid markets: Public funding covers a significant share of total homecare costs, and therefore expanding the public stream could fund wage increases for significant shares of the homecare workforce. In some states there is an efficient infrastructure to deliver public investment to cover the costs of worker wage increases for a substantial share of the home health workforce. In these states (notably California, Washington, and Oregon, among others), the Medicaid system providing homecare services for seniors is consumer directed, meaning that clients select care providers and the state then directly pays those workers. If the state raises the minimum wage, the state directly bears the cost. In the majority of states, where agencies employ workers and the state pays the agency for provision of care, states will also need to increase the payment rates. If states do not raise rates, agencies bear the cost of the minimum wage increase as their contracts require them to provide the same level of care to clients. If payment rates are insufficient, agencies may choose to end their contracts with the state. Clients buying private care will also face increasing prices when wages go up and there is not a system to subsidize or support that cost increase for private purchasers. Without additional public support, families and individuals turn to the grey market (where wage standards are often ignored), to unpaid family care providers, who already provide the majority of homecare in the United States, or needs go unmet.

Different funding streams set different rates for the same work: The complexity, contradictions, and interactions of the underlying system of paying for and providing homecare also create barriers to funding wage increases. For example, homecare workers in California may receive different pay rates for the same client and the same work if they are paid through the In Home Supportive Services (IHSS) program rather than through the developmental disability services system. The costs and delivery structures for public investment for minimum wage increases, then, will be unique to specific sectors and modes of service delivery even within states. This does not pose an insurmountable problem, but it does require an approach that is attentive to these differences in the field.

Early Care and Education

The private and public markets in early care and education are intertwined: While some providers serve only families who receive a child care subsidy, most serve a mix of families who receive subsidy and those who do not; many of the non-subsidized families served by these providers are income-eligible for subsidies, but do not have access to them due to limited public funding. By law, rates paid by private fee-paying families cannot be less than the government reimbursement rates. Thus, when the state raises voucher reimbursement rates, which is an important strategy to help programs serving families with subsidies to cover increasing labor costs, programs can only avail themselves of these higher rates if they also charge private fee families the same amount, further burdening families who may not be able to pay more. As a consequence, absent an expansion of funds to make subsidies available to all subsidy-eligible but currently private paying families, well-intentioned increases to subsidy reimbursement rates exacerbate inequities among low-income families.

Stability and level of public payments: Reimbursement levels for all types of government payments for early care and education are set at such a very low threshold in order to maximize the number of families served, that even with increases in reimbursement rates, providers are challenged to meet higher wage amounts. The majority of public funding for early care and education is distributed via vouchers for individual eligible children. Depending on changes in family circumstance, a child's family may move in and out of subsidy eligibility, or make a decision based on other family circumstances to remove a child, sometimes on short notice, from any given program—making it challenging for providers to budget with any security on future income from subsidy payments. In contrast to a contract with a government entity designating a certain number of children to be served on an ongoing basis (which is the typical mechanism for Head Start and public Pre-K programs), voucher payments for child care offer no guarantee to providers that another family will replace the one who left. As a consequence, voucher payments offer a shaky foundation on which to structure wage increases.

Wage compression: Low wages paid to almost all early childhood practitioners belie differences in their educational attainment and differentiated roles, as lead or assistant teachers in center and school settings, and their responsibilities, as owners and assistants in home-based settings. While pay is somewhat higher for those who have higher levels of education, the educational premium is small compared to that in other occupations across the labor force. Raising the wage floor is a critical strategy for improving wages and represents one component of a comprehensive compensation strategy necessary to provide a skilled and stable early care and education workforce. Raising the minimum wage alone, without sufficient reimbursement rate relief and additional revenue, may narrow the wage difference between early educators with differentiated roles and responsibilities and exacerbate the existing wage compression that plagues the center-based segment of the sector (Whitebook, Howes, and Phillips 2014; Whitebook, McLean, and Austin 2016).[10] Self-employed, home-based providers face a related problem. Their earnings are not recognized as governed by federal or state wage and hour laws, but those of their paid assistants are. Home-based providers who employ assistants will experience an increase in their labor costs when minimum wages go up. Increases in rates paid by public sources may cover only increased costs for assistants without addressing the provider's need for higher earnings themselves. Funding to get workers to $15 needs to be augmented by resources that can support workers above that floor as well.

V. Emerging Public Investment Strategies to Help Solve the Funding Squeeze

Solutions to improve wages for care workers will require an infusion of public funding into existing programs. In some cases, new funding mechanisms will be needed to reach beyond the coverage of existing programs and raise the wages of workers throughout the sector.

States and local governments are responding to the challenges created by the minimum wage increases in a variety of ways. In some cases, states or cities have budgeted additional funding to cover the increased wage costs of homecare and ECE programs through existing mechanisms. In other cases, policy makers have created entirely new programs or combined existing funding streams to increase efficiency. In what follows, we describe several case studies describing the different types of strategies local and state governments have taken to raise wages for care workers.

State Initiatives

CALIFORNIA

In California, the issues for care workers were central to the discussions on raising the minimum wage at the state and local levels from the beginning. There was recognition that new minimum wage policies would significantly increase the cost of some state-funded programs; these included the IHSS program that provides homecare subsidies to low-income seniors and individuals with disabilities, other service programs for people with developmental disabilities, and several different child care subsidy programs. The final statewide minimum wage policy included a slower implementation timeline than advocates' original proposal in order to ease the burden on the state budget by phasing in the cost over multiple years, with wages rising to $15 in 2022 and 2023 for smaller businesses. It also included a provision to allow the state to temporarily delay scheduled minimum wage increases if an economic downturn led to a large loss of state revenue.

In both the IHSS and child care programs, funding the increasing wages was made even more challenging because of cuts that had been made to the programs in response to the state's budget crisis during the Great Recession. The state had the additional budgetary challenge of restoring previously cut funding along with paying for higher wage rates required by the new minimum wage policy. In the case of the IHSS program, the 2016–17 state budget included funds to restore previous cuts in service hours, cover overtime pay that a recent change in Fair Labor Standards Act regulations required for the first time, and cover the cost of the minimum wage increase.

In the case of ECE, California likewise included funds (spread over several years) to (1) restore some of the previous cuts and (2) increase reimbursement rates to reflect the projected costs to early care and education providers due to increases from the state minimum wage (Legislative Analyst's Office 2017). The 2017–18 budget allocated funds to update child care subsidy eligibility requirements and to allow families to retain their eligibility for child care subsidy for a 12-month period in order to create stability for providers, children, and their parents. Simultaneously, the state added additional slots for full-day State Preschool for low-income families. Despite these recent increases, California child care program funding remains half a billion dollars below 2007–08 pre-recession levels and serves 66,000 fewer children than in 2009–10 (Schumacher 2018).

MAINE

A campaign is currently underway in Maine to both raise worker wages and provide homecare to all seniors and people with disabilities who need it. In early 2018, Maine People's Alliance successfully submitted enough signatures to include a statewide referendum on universal homecare on the November 2018 ballot. If approved by voters, the program would provide homecare for more than 10,000 seniors and individuals with a disability, increase wages for workers, and provide training to professionalize homecare work. The program would cost $310 million a year and would be funded through taxes on income and wages above the maximum amount of wages subject to the Social Security tax.

Local Initiatives

SUPPORT AT HOME PROGRAM IN SAN FRANCISCO

In 2016, San Francisco developed a two-year pilot project, Support at Home, to assist low- and middle-income seniors and individuals with disabilities in covering homecare costs while also setting a higher minimum wage for homecare workers. The $2 million dollar pilot program covers 120 to 140 individuals. The program pays a portion of homecare costs, based on a sliding scale determined by the client's income and rent, for both Medicaid recipients and individuals who do not qualify for Medicaid homecare services. It also requires that the homecare worker be paid at least $15 an hour, setting their wage higher than the current San Francisco minimum wage law requires. Because it benefits both homecare clients and workers, the program received broad support and advocates were able to secure $1.65 million per year for two years in the San Francisco budget.

RAISING WAGES FOR CHILDCARE WORKERS IN SAN FRANCISCO

In 2000, in response to a living wage campaign, San Francisco developed WAGES+, the most extensive wage subsidy program for early care and education workers in the country. WAGES+ created a new funding mechanism dedicated to increasing payments explicitly for the purpose of raising earnings of early care and education practitioners in licensed home and center/school-based programs that served low-income children. In essence, the program became a third party payor to underwrite the costs of improving compensation for workers across the early care and education sector.

The program expanded over time in accordance with San Francisco's evolving higher minimum wage requirements and other employer mandates. Jointly funded with varied funding streams overseen by the Office of Early Care and Education (OECE) and the Department of Children, Youth and their Families, WAGES+ provided funding for wages, health programs, and retirement programs for licensed family providers and their assistants and for teaching and support staff at licensed centers. In order for a provider to participate, at least 25 percent of children enrolled in the provider's program must have lived in families with incomes below 75 percent of the state median. Wage supplements were scaled by job title and educational level in order to create job ladders, reward job tenure, and incentivize formal educational attainment. Wage supplement levels provided a significant boost and the model provided a strategy to address both the wage floor and the wage compression issues. However, the earning levels remained below those in comparable industries for workers with similar

levels of formal education. In 2015–16 the program provided wage supplements to 900 teachers in 80 child care centers, along with 276 family child care providers and 76 of their paid employees. This covered a large proportion of the early care and education workforce in San Francisco, including about three-quarters of licensed centers serving low-income families.

The program, later re-christened *C-WAGES,* no longer exists as a free-standing element of the San Francisco child care system; it has been redesigned as part of a larger citywide plan called the Early Learning Scholarship to align, coordinate, and increase funding to support the early childhood workforce and to provide more effective early care and education services to children. The Early Learning Scholarship has a long term of goal of pay parity between early childhood professionals with bachelor's or higher degrees and kindergarten teachers, who currently earn an average of $65,000 per year (Knight and Palomino 2016). The program also seeks to include mechanisms that increase compensation. Providers participating in the new program must continue to meet quality metrics and pay at least the new San Francisco minimum wage. Subsidy amounts are calculated based on the OECE's recommended wage scale, which suggests minimum rates based on level of education and responsibilities, and ranges from $14.00 an hour for an assistant teacher to $26.30 for a site supervisor. Centers are encouraged to provide compensation higher than the suggested minimums, but do not receive additional funding to do so. The integration of the wage program into a larger citywide plan acknowledges the essential need to address wages as a key component of any comprehensive attempt to improve subsidized child care; it also reduces the bureaucracy of the previous program structure, which included multiple funding streams and associated paperwork and reporting requirements. Just launched, the program will assess how these changes affect wages, familial access, and quality of child care in the county. The program recognizes the need to both raise the floor and reward experience and education, and hopes to eventually reach funding levels that allow for fully rewarding the education and training and experience levels of many of the ECE staff.

ALAMEDA COUNTY ECE BALLOT INITIATIVE

In the California Bay Area, Alameda County is working to simultaneously address the issues of low wages and affordability in early care and education. The Alameda County Board of Supervisors as placed a measure on June 2018 ballot to expand subsidized child care, improve the quality of child care services, and increase worker wages to at least $15 an hour in participating programs. The plan would increase the sales tax by half a percent, raising $140 million in tax revenue annually. About 60 percent of these funds would be used to create new ECE scholarships for low- and middle-income families, reducing the waiting list for subsidized child care by several thousand. About one-third of the funds would be set aside for supplementing worker wages and improving the quality of child care services, with the remaining funds set aside for facilities and evaluation. Center- and home-based programs that provide early care and education services to children from low- and middle-income families would be eligible to apply for the program. If selected, child care providers would receive funds based on the number of eligible children they serve. In order to participate, providers would agree to follow specific wage and benefit standards for workers and participate in a quality assessment and improvement process to ensure that they meet the program's quality standards. While the ballot measure explicitly states that the program's entry-level wage will be at least $15 an hour, a task force has been created to develop recommendations for a wage scale for workers with higher levels of training and experience, and to develop strategies for providing benefits and professional supports to

workers that will be considered for inclusion into the program's implementation policies. Finally, the ballot measure would require participating ECE providers to enable workers to direct membership contributions via payroll deduction to an ECE professional organization, which will serve to connect workers to training and increase their capacity to advocate for ongoing improvements in the child care system.

PREKINDERGARTEN EXPANSION IN NEW YORK CITY

New York City provides an example of local government simultaneously expanding publicly subsidized ECE programs and investing in higher wages for workers. In 2014, NYC expanded on the existing state-funded preschool program to create Pre-K for All, a universal, full-day Pre-K program that is open to all four-year-olds, regardless of family income. While this program was not a wage initiative per se, it added additional Pre-K classrooms, and thus a demand for Pre-K teachers, in public schools and community-based programs. In public elementary schools, Pre-K teachers are paid on the same salary scale as other public school teachers, starting at about $56,000 a year for bachelor's degree level teachers (United Federation of Teachers n.d.). Many preschool teachers who had been working in lower-paying positions at private child care centers were hired for the newly created Pre-K classrooms in public elementary schools, resulting in a large increase in their annual salaries.

Community-based programs were essential to accommodating the demand for services created by the NYC Pre-K expansion, but staff in these programs are not paid according to the public school salary scale. In response to concerns about the substantial wage gaps between equally qualified Pre-K teachers in the community-based and public school settings, NYC allocated additional funds and established higher starting salaries for these Pre-K teachers. This move reduced, but did not eliminate, the gap between universal Pre-K teacher salaries in community-based child care centers and public elementary schools. At the same time, once salaries for teachers in the Pre-K classrooms increased, disparities between them and other teachers working with younger children arose. The union representing teaching staff in these programs negotiated with NYC to increase wages of represented teachers in non-Pre-K city-funded programs.

The expansion of universal Pre-K and new starting wage standards, accompanied by public funds, led to significant wage increases for many ECE workers. NYC has plans to expand universal Pre-K to three-year-olds, which will open up more opportunities for better jobs in the field. The NYC example further illustrates the complexity and disparities that exist within the current ECE system, and highlights the importance of coordinating policy changes with broader systems reform.

Much more will need to be done in order to address these problems across the NYC child care system, but city leaders have the opportunity to employ lessons learned and address these challenges as they seek to expand and strengthen ECE services.

VI. Principles for Moving Forward

With the federal minimum wage stuck at $7.25 an hour, state and local strategies to raise wages have become a key tool for addressing growing income inequality in the United States. But the promise of these new laws will not be fully realized without addressing the unique challenges of raising wages for homecare and child care workers. The above case studies demonstrate that with careful planning and political will, states and cities can find the resources to lift the wage floor for care workers.

Short Term: Five Principles

For policy makers looking to follow their lead in the near term, here are five principles for moving forward:

1. **Cover care workers in minimum wage laws, without exception:** Homecare and child care workers should be fully included in minimum wage laws, regardless of idiosyncrasies of funding streams.
2. **Develop plans for public funding increases from the start:** In the most successful minimum wage increases, stakeholders come together to address the need for additional public funding from the outset, as part of the policy design of the proposed law. This includes higher reimbursement rates and increased access to subsidy.
3. **Support increases to worker compensation above the required minimum wage, especially for workers with more training, education, and experience:** In order to attract and retain highly skilled staff to homecare and early care and education positions, public policy should support a wage scale that acknowledges and incentivizes the educational attainment and ongoing learning necessary to improve and sustain the quality of services across settings and program types. In doing so, workforce development programs should be designed to provide advancement for existing workers in order to maintain diversity in staffing that is reflective of the families served.
4. **Reform child care subsidy eligibility rules and parent fee schedules** to align with increasing wage levels, in order to prevent families who receive a minimum wage boost in their earnings from losing subsidies or facing fees that offset the benefit of higher, though still low, earnings.
5. **Ensure comprehensive ongoing data to inform policy and investment:** Assess available data about homecare and early care and education workers to determine the gap between existing earnings and new legal minimums, and to project additional funds necessary to address equity and compression in earnings across the industries. Ensure comprehensive ongoing data collection to inform policy and investment, and to assess their impact.

Long Term: Full Public Funding

Short-term policy solutions to help bridge the gap as minimum wages rise can and should be built into the existing systems, policies, and programs that purchase, subsidize, and regulate care. In the long run, however, we need an efficient and universal system that delivers care as a right and rewards the workers who provide services. Aligning funding streams and recognizing the public good of workers providing care, as well as directly investing in these workers, are some steps toward a universal and more public system of care. For early care and education, funding programs akin to K-12 education, in which every child is guaranteed access to services, may be the best long-term solution. Similarly, in homecare, public policy solutions such as a long-term care financing system are needed for those whose income places them outside the range of existing long-term care programs, but who cannot afford the cost.

Ultimately, our goal should be to fully fund the public good—meaning that we invest public resources to fully meet the need for homecare and early care and education in our society, regardless of ability to pay. This is both the right thing to do for the recipients of services and the people—mostly women, and disproportionately women of color—delivering services. It is also the only comprehensive way to address the lack of access to care and the low wages that currently prevail in both the public and private pay markets. At a time when so many are concerned about automation and the disappearance of work, caregiving jobs are here to stay. They deserve a greater public investment from us in the form of living-wage jobs.

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Endnotes

1 Using U.S. Bureau of Labor Statistics data on these occupations, the Paraprofessional Healthcare Institute (PHI) found 2.4 million personal care aides and home health aides, including 800,000 who work as independent contractors. Paraprofessional Healthcare Institute (PHI 2017).

2 The child care workforce includes those working in their own homes ("family child care providers") and working in children's homes, and the workforce of both "child care workers" and "preschool teachers" employed in child care centers. According to the most recent National Survey of Early Care and Education Programs, this workforce of 2 million is evenly divided between center- and home-based care providers (National Survey of Early Care and Education Project Team and Office of Planning, Research, and Evaluation 2013).

3 Sum of projected employment change 2016–2026 for personal care aides and home health aides (US Bureau of Labor Statistics 2017).

4 In reality, a given client may very well combine all three—drawing on public funding until it is exhausted, perhaps paying for additional hours privately, and then relying on family for the rest.

5 The NSECE distinguishes between listed and unlisted home-based providers. The "listed" providers are defined as individuals appearing on state or national lists of early care and education services, such as licensed, regulated, license-exempt, or registered home-based providers. "Unlisted paid" individuals receive payment for the care of at least one child but do not appear on state or national lists. However, it is somewhat difficult to assess the difference between listed and unlisted paid providers because states have varied criteria determining which providers are required to be regulated or licensed and which are exempt. For more information, see Administration for Children & Families, Office of Child Care 2015.

6 The U.S. Department of Health and Human Services had historically considered child care to be affordable if it consumes 10 percent or less of a family's income, but in 2015 recommended this threshold be reduced to 7 percent (Department of Health and Human Services 2015).

7 The price increases are typically modest because the increased labor costs are spread across many different sales (i.e., of meals or products); because labor is usually only a small portion of overall operating costs; and because for a given employer only a portion of the workforce is low wage and therefore due a wage increase.

8 In homecare and ECE industries, labor is already a much higher share of total cost than in many private sector industries. Regulations set terms in both homecare and child care that make shifting product inputs impossible (i.e., staff-to-child ratios set by law, specific care services purchased). In addition, it would be undesirable to adjust to higher wages by, for example, increasing workload or scrimping on the quality of care.

9 UC Berkeley Labor Center and CWED analysis of US Census Annual Services Report.

10 Wage compression is already an issue due to the low educational premium among ECE practitioners. For example, among teachers with a bachelor's degree working in center-based programs with infants and toddlers, only 25 percent earned $15 or more per hour; and only 50 percent of those with a bachelor's degree and working with three- to five-year-olds earned $15 or more per hour (Whitebook, McLean, and Austin 2016).

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CSCCE Center for the Study of Child Care Employment

UC Berkeley Center for the Study of Child Care Employment

Established in 1999, the Center for the Study of Child Care Employment (CSCCE) is focused on achieving comprehensive public investments that enable the early childhood workforce to deliver high-quality care and education for all children. To achieve this goal, CSCCE conducts research and policy analysis about the characteristics of those who care for and educate young children and examines policy solutions aimed at improving how our nation *prepares, supports, and rewards these early educators* to ensure young children's optimal development.

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COWS is a national think-and-do tank that promotes "high road" solutions to social problems. These treat shared growth and opportunity, environmental sustainability, and resilient democratic institutions as necessary and achievable complements in human development. COWS is nonpartisan but values-based. We seek a world of equal opportunity and security for all.