2022 Prenatal-to-3 State Policy Roadmap

Methods and Sources

Effective Strategies

CHILD CARE SUBSIDIES

What are child care subsidies and why are they important?

All references for this section are provided in the Notes and Sources section at the bottom of each webpage. Additionally, search the Prenatal-to-3 Policy Clearinghouse for an ongoing inventory of rigorous evidence reviews, including more information on child care subsidies.

What impact do child care subsidies have?

The following studies meet standards of strong causal evidence to demonstrate the impacts of child care subsidies for the health and wellbeing of young children and their families:

A. Enchautegui, M. E., Chien, N., & Burgess, K. (2016). *Effects of the CCDF subsidy program on the employment outcomes of low income mothers*. US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. https://aspe.hhs.gov/system/files/pdf/253961/EffectsCCSubsidiesMaternalLFPTechnical.pdf
B. Pilarz, A. R. (2018). Child care subsidy programs and child care choices: Effects on the number and type of arrangements. *Children and Youth Services Review*, *95*, 160–173. https://doi.org/10.1016/j.childyouth.2018.10.013
C. Krafft, C., Davis, E. E., & Tout, K. (2017). Child care subsidies and the stability and quality of child care arrangements. *Early Childhood Research Quarterly*, *39*, 14–34. https://doi.org/10.1016/j.ecresq.2016.12.002
D. Washbrook, E., Ruhm, C. J., Waldfogel, J., & Han, W.-J. (2011). Public policies, women's employment after childbearing, and child well-being. *The B.E. Journal of Economic Analysis & Policy*, *11*(1). https://doi.org/10.2202/1935-1682.2938
E. Danziger, S., Ananat, E.O., Browning, K. (2004). Childcare subsidies and the transition from welfare to work. *Family Relations, 53*(2), 219-228. https://www.jstor.org/stable/3700265
F. Lemke, R., Witte, A., Queralt, M., Witt, R. (2000). *Child care and the welfare to work transition.* National Bureau of Economic Research Working Papers (No. 7583). http://www.nber.org/papers/w7583
G. Zanoni, W., & Johnson, A. D. (2019). Child care subsidy use and children's outcomes in middle school. *AERA Open, 5*(4), 1–19. https://doi.org/10.1177/2332858419884540

How and why do child care subsidy policies vary across states?

In the absence of an evidence-based state policy lever to ensure child care subsidies effectively provide families the support they need, we present several choices that states can make to more effectively implement their child care subsidy program. We identify states as leaders in the implementation of child care subsidies if they:

- Set reimbursement rates at or above the 75th percentile of a recent market rate survey;
- Set high reimbursement rates that fully cover or come close to covering the estimated true cost of providing care;
- Use cost estimation models to set reimbursement rates;
- Require low family copayments and fees;
- Have families contribute a low share of the total cost of child care; and/or
- Set income eligibility thresholds near or above 85% of the state median income.

We collected states' most recently published market rate survey information and current reimbursement rates for center- and home-based care (or family child care homes, typically referred to as "registered" and regulated to serve a small group of children). We pulled this information for both infants (as close to a rate for a 1 year old as possible) and toddlers (as close to a rate for a 2 year old as possible) as of September 6, 2022. If a state's published, current reimbursement rates were enhanced due to COVID-19 for an extensive period of time, or if a state does not have the intention to end the enhancement after COVID-19, these rates were used in our reporting. However, if a state's published, current reimbursement rates were only temporarily enhanced due to COVID-19, these rates are not reflected in our data. Following this data collection, we verified the market rate survey and current reimbursement rate information with each state's relevant child care subsidy contact, most typically the Child Care Development Fund (CCDF) administrator and/or their team. Data for all but seven states were verified.[1]

Researchers also collected information regarding the copayment fees for families receiving child care subsidies as of September 6, 2022 based on information published on state's websites and/or in current 2022-2024 CCDF plans. In general, copayment information was collected for a three-person family with an infant in center-based care with family income at 150% of the current federal poverty level (FPL). However, for six states (Idaho, Indiana, Iowa, Missouri, Ohio, and West Virginia) the initial eligibility threshold for the receipt of child care assistance falls below this income level. For those states, copayment information was documented for a three-person family at the maximum income threshold for initial eligibility. Adjustments to copayment fees due to COVID-19 were considered using a similar methodology to reimbursement rates. If a state's published current copayment fee schedules were enhanced due to COVID-19 and were scheduled to be applicable for the foreseeable future, these fees were used in reporting. However, if a state had a non-published fee schedule or stated temporary adjustments to fees that differed from the published amounts, these data were not reflected in the copayment amounts. Following this collection, researchers verified family copayment fee information with each state's relevant child care subsidy agency. As above, data for all but seven states were verified.

[1] These seven states are: GA, HI, LA, MA, NY, RI, and VT.

Data were collected for 10 different measures to assess how states vary in their implementation of child care subsidies. The datasets, calculations, and sources referenced for each state are listed below.

To assess state progress to more effectively implement child care subsidies, we also performed an electronic search using Quorum State between August 16, 2021 and August 31, 2022 to assess legislative progress pertaining to child care subsidies, specifically related to progress towards lowering family copayments, increasing reimbursement rates, expanding eligibility for subsidies, and changing the methodology for assessing and setting reimbursement rates paid to providers in the subsidy system. The main search strategy used combinations of keywords for proposals related to altering child care subsidy systems (child care subsidies OR child care financial assistance OR CCDBG OR childcare subsidies OR childcare assistance OR child care WITHIN 10 OF subsidy OR child care WITHIN 10 OF subsidies OR child care WITHIN 10 OF assistance OR child care market rate survey OR child care WITHIN 10 OF market rate survey). Research staff conducted searches, analyzed results for relevant state legislation, and summarized the progress states made towards altering their child care subsidy system, particularly through lowering or capping copayment fees, increasing reimbursement rates, expanding eligibility for subsidies, or changing the methodology for determining reimbursement rates.

This section also contains the sources for the information presented in the individual state Roadmaps.

Measure 1 & 2: Income eligibility for child care assistance as a percentage of the state median income (SMI) & as a percentage of the federal poverty level (FPL)

Measure 1 Definition:
Initial income eligibility, for a family of three, to qualify for child care assistance as a percentage of the state median income.

Measure 2 Definition:
Initial income eligibility, for a family of three, to qualify for child care assistance as a percentage of the federal poverty threshold.

Notes for Measures 1 & 2:

1. SMI calculations are based on state income eligibility dollar amounts (for a family of three) and converted to the percent of SMI using the 2021 LIHEAP values for a three-person household.
2. Federal poverty level (FPL) calculations are based on 2021 thresholds ($21,960 for a family of three).
3. The FPL percentages for Alaska and Hawaii were modified to reflect those states' higher federal poverty level guidelines ($27,450 and $25,260 for a family of three, respectively).
4. Initial income eligibility represents the maximum income families can have when they apply for child care assistance. Many states allow families, once receiving assistance, to continue receiving assistance up to a higher income level than that initial limit.
5. Source data from National Women's Law Center are reported for February 2021. This table uses those data and table notes to update to the most recent available information based on that report. Data are for February 2021 unless otherwise noted and do not reflect any temporary changes or updates in response to

the COVID-19 pandemic. However, states update income eligibility rates at different times throughout the year, including to adjust for the 2021 FPL or 2022 SMI changes and many states updates income eligibility thresholds since February 2021. Income eligibility amounts were increased for Indiana, New Jersey, South Carolina, and South Dakota in March 2021; Rhode Island and Wyoming in April 2021; Missouri and Pennsylvania in May 2021; Alabama, Montana, and New York in June 2021; California, Florida, Illinois, Iowa, Kansas, New Hampshire, and North Carolina in July 2021; Hawaii and New Mexico in August; Arizona, Connecticut, Delaware, Georgia, Idaho, Massachusetts, Michigan, Minnesota, Nebraska, Nevada, North Dakota, Ohio, Oklahoma, Tennessee, Texas, Utah, and Washington in October 2021; Mississippi in November 2021; and Kentucky and Oregon in January 2022. Colorado's income eligibility threshold was increased in July 2022; due to difficulties confirming older data, this newer threshold is used. The data for these states are as of those dates.

6. Notes 8-18 are replicated from the source document with slight modification.
7. In Alaska, the Alaska Permanent Fund Dividend (PFD) payment, which the majority of families in the state receive, is not counted when determining eligibility.
8. In Colorado, counties set their income limits to qualify for assistance within state guidelines. The percentage reported reflects Denver County, the most populous geographic area in the state.
9. In Georgia, as of November 2021, the income limit to qualify for assistance was temporarily increased to $60,584; this is not captured in the table.
10. In Iowa and Massachusetts, higher income eligibility thresholds are used for special needs care.
11. In Ohio, families transitioning from TANF have higher income eligibility thresholds.
12. For South Dakota, the income limit takes into account that the state disregards 4 percent of earned income.
13. In Tennessee, the income limits shown apply to teen parents and families receiving assistance through Smart Steps—a program launched in June 2016 that serves parents who are working or pursuing postsecondary education and who are not receiving or transitioning from TANF. As of October 2021, the income limit to qualify for assistance for other families was increased to $40,704 (60 percent of state median income), to adjust for the updated state median income estimate.
14. In Texas, local workforce development boards set their income limits to qualify for assistance within state guidelines. The income eligibility limit presented in the table reflects the threshold for the Gulf Coast development board, the most populous geographic area in the state.
15. In Utah, the income limit shown in the table accounts for a standard deduction of $100 per month ($1,200 per year) for each working parent, assuming there is one working parent in the family, and a standard deduction of $100 per month ($1,200 per year) for all families to help cover any medical expenses. The stated income limit to qualify for assistance is $61,176 as of October 2021.
16. In Virginia, there are different income limits for different regions of the state. The income eligibility limit presented in the table reflects the threshold for Fairfax County, the most populous geographic area in the state. Additional sources used to verify this include the FFY 2022-2024 CCDF plan source, plus the Child

Care Subsidy Guidance Manual[2], and the Virginia Department of Education website[3]. Note that the eligibility threshold presented does not include temporary expanded eligibility (to 85% SMI) for families with at least one young child age 5 and under not yet in kindergarten. Note, Fairfax city has a higher eligibility threshold (250% FPL) than the rest of the county.

17. In Wyoming, the income limit takes into account a standard deduction of $200 per month ($2,400 per year) for each working parent, assuming there is one working parent in the family.

Sources for Measures 1 & 2:

1. Schulman, K., National Women's Law Center. (2022, May). *At the crossroads: State child care assistance policies 2021.* Retrieved on July 27, 2022, from https://nwlc.org/resource/at-the-crossroads-state-child-care-assistance-policies-2021/
2. Administration for Children and Families, Office of Community Services. (2021). *State median income (SMI) by household size for mandatory use in LIHEAP for FFY 2021.* Retrieved on July 27, 2022, from https://www.acf.hhs.gov/sites/default/files/documents/ocs/comm_liheap_im2002smiattachment_fy2021.pdf
3. Department of Health and Human Services. (February 1, 2021). *2021 poverty guidelines.* Retrieved July 1, 2022 from https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines/prior-hhs-poverty-guidelines-federal-register-references/2021-poverty-guidelines

Measures 3-6: Child care subsidy reimbursement rates for infants in center-based care (measure 3), for toddlers in center-based care (measure 4), for infants in family child care (measure 5), and for toddlers in family child care (measure 6)

Definition for Measures 3-6:

1. *Current Base Reimbursement Rate:* The current subsidy amount (in dollars) paid to providers for full-time monthly care for infants in center-based settings typically paid for care meeting basic licensing standards.
2. *75th Percentile of the Most Recent Market Rate Survey:* The price (in dollars) at or below which 75 percent of child care slots at providers included in the market rate survey reported charging for full-time monthly child care services. (If states do not weight by provider capacity, this figure represents the dollar value at or below which 75 percent of the providers included in the market rate survey reported charging for full-time monthly child care services.)
3. *Estimated Cost of Base-Quality Care:* The estimated cost of full-time monthly child care based on cost-estimation models that assume characteristics associated with standard licensing regulations.

[2] Virginia Department of Social Services. (2020, October). *Child care subsidy guidance manual.* Retrieved July 27, 2022 from https://www.dss.virginia.gov/files/division/cc/assistance/parents_guardians/program_guidance/Child_Care_Subsidy_Guidance_Manual.pdf

[3] Virginia Department of Education. (n.d.). *Paying for child care.* Retrieved July 27, 2022 from https://doe.virginia.gov/cc/parents/index.html?pageID=4

4. *Estimated Cost of High-Quality Care*: The estimated cost of full-time monthly child care after adjusting base care costs to account for multiple indicators associated with increased child care quality (such as teacher pay, student/teacher ratios, etc.).
5. *Year of Market Rate Survey*: The year of the market rate survey used to set current reimbursement rates.

Notes for Measures 3-6:

1. Full-time care is defined as 9 hours per day, 5 days per week.[4]
2. Current base reimbursement rates are as of September 6, 2022.
3. All rates are monthly and rounded to the nearest dollar. Weekly rates were converted to a monthly rate by multiplying by 4.33. Daily rates were multiplied by a conversion factor of 20.9167, based on methodology recommended by the Early Childhood National Centers[5] and frequently used in state market rate survey calculations.[6]
4. States vary in how they define the ages of infants and toddlers. In determining rates, we considered an "infant" to be close to one year of age and a toddler to be close to two years old.
5. The cost-estimation model from CAP does not distinguish between infant and toddler costs in family child care settings.
6. The District of Columbia does not report/calculate rates at the 75th percentile level. It uses a cost estimation model rather than a market rate survey to assess child care prices and/or costs. The current (FY22) full-time base reimbursement rates for child development facilities are set at the developing level of Capital Quality (QRIS). The District of Columbia has indicated that very few facilities are at the developing level, as most have received a higher quality designation and therefore have received higher reimbursement rates.
7. New Mexico does not report/calculate rates at the 75th percentile level. It uses a cost estimation model rather than a market rate survey to assess child care prices and costs. Although it is indicated that Albuquerque Metropolitan Area is the most populous region according to the state 2022-2024 CCDF plan, reimbursement rates are not specific to each region. Therefore, researchers reported statewide rates for New Mexico, and statewide rates are used in all calculations.
8. North Carolina uses a tiered reimbursement rate system based on the state's star rating system (QRIS). Researchers reported 3-star rates as the base reimbursement rates because child care providers below 3-star are not allowed to participate in the child care subsidy program.
9. North Dakota's reimbursement rates are not county specific, though Cass County is indicated the most populous region according to the state 2022-2024 CCDF plan. Therefore, researchers reported statewide rates for North Dakota, and statewide rates are used in all calculations.

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[4] Murrin, S., Office of the Inspector General, US Department of Health and Human Services. (August 2019). *States' payment rates under the child care and development fund program could limit access to child care providers*. OEI-03-15-00170. Retrieved August 1, 2021 from https://oig.hhs.gov/oei/reports/oei-03-15-00170.pdf

[5] National Center on Early Childhood Quality Assurance and National Center on Subsidy Innovation and Accountability (January 2018). *Guidance on estimating and reporting the costs of child care.* Retrieved on August 1, 2021 from https://childcareta.acf.hhs.gov/sites/default/files/public/guidance_estimating_cost_care_0.pdf

[6] Burns & Associates, Inc. (2018). *Arizona Department of Economic Security 2018 Child Care Market Rate Survey.* Prepared for the Division of Employment and Rehabilitation Services Child Care Administration. Retrieved August 1, 2021 from https://des.az.gov/sites/default/files/dl/2018-Child-Care-Market-Rate-Survey.pdf?time=1592940902480

10. Ohio offers type A (7-12 children) and type B (<6 children) family child care reimbursement rates. Researchers reported on type B rates due to the volume of type B family child care in the state as compared with type A.
11. Oklahoma uses a tiered reimbursement rate system based on the state's star rating system (QRIS). Researchers reported 2-star rates as the base reimbursement rates because 1-star child care providers are not permitted to participate in the child care subsidy program.
12. Rhode Island's reimbursement rates are not county specific, though Providence County is indicated the most populous region according to the State 2022-2024 CCDF plan. Therefore, researchers reported statewide rates for Rhode Island, and statewide rates are used in all calculations.
13. Virginia does not report/calculate rates at the 75th percentile level and is in the process of implementing a cost estimation model.
14. Base-quality child care cost estimates are modeled primarily using state licensing regulations and default characteristics in the Provider Cost of Quality Calculator (a tool developed for the US Department of Health and Human Services' Office of Child Care) for infants in center-based child care.[7] Detailed information on the methodology associated with the base quality child care cost estimates is available from the Center for American Progress (CAP).[8]
15. High-quality child care cost estimates take the "base-quality" settings and adjust state specific costs for the following characteristics:[9]
    a. Fewer children per teacher
    b. Increasing salaries
    c. Providing retirement benefits
    d. Increasing contributions to health insurance
    e. Providing more time for teachers to plan lessons
    f. Making the classroom bigger
    g. Increasing resources for classroom materials
16. In the CAP cost-estimation model, there is an additional high-quality child care option that increases teachers' salaries to have parity with kindergarten teachers. In "The True Cost of High-Quality Child Care" report[10], high-quality child care refers to this option of the cost model. We chose to use the version of high-quality that increases teacher salaries but not to the point of parity with kindergarten teachers.

Sources for Measures 3-6:

Please refer to the state table at the end of this section.

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[7] US Office of Child Care. (January 24, 2019). *Provider cost of quality calculator (PCQC)[Data Tool]*. Last accessed September 15, 2021 at www.ecequalitycalclator.com. Additional information available: https://childcareta.acf.hhs.gov/pcqc

[8] Workman, S. & Falgout, M. K., Center for American Progress. (June 28, 2021). *Methodology for the 'The True Cost of High-Quality Child Care Across the United States'.* Retrieved June 30, 2021 from https://cdn.americanprogress.org/content/uploads/2021/06/28062526/METHODOLOGY_True-Cost-of-High-Quality-Child-Care.pdf?_ga=2.81336400.679511692.1632503742-1840403989.1632503742

[9] Ibid.

[10] Ibid.

Measure 7: Status of state Quality Rating Improvement System (QRIS) participation and child care subsidy reimbursements linked to higher quality standards

Definition:

A description of the state's current QRIS participation status requirements for child care providers and whether the state increases child care subsidy reimbursements for providers rated at a higher level of quality by the state's QRIS.

Notes:

1. States typically use QRIS as a means to systematically assess key standards of child care environments and communicate the quality of care in settings. States may require that all licensed providers participate in their QRIS or that providers participate in the state QRIS to receive subsidy reimbursements. Additionally, some states reimburse at higher levels for providers meting higher quality standards (e.g., higher rating levels in the state's QRIS).
2. The state's current QRIS participation status falls into one of the following four mutually-exclusive categories: (a) QRIS participation is mandatory for all licensed providers, (b) QRIS participation is mandatory if a provider serves children receiving subsidies, (c) QRIS participation is voluntary for all providers, or (d) No QRIS
3. The "Yes/No" value reflects whether the state provides a higher child care subsidy reimbursement to providers rated at a higher level of quality by the state's QRIS
4. Where possible, data are pulled for states that are planning or piloting QRIS programs. Connecticut's program is piloting and data were not available. South Dakota and West Virginia's state QRIS are still in planning and information was unavailable.
5. Alabama allows providers to opt out of the QRIS, but must maintain level one qualifications to remain licensed. They describe their QRIS as "partially mandatory" and are counted as mandatory.
6. Louisiana is counted as a "yes" for tying subsidy rates to QRIS quality tiers but refers to their system as bonuses. These bonuses are paid quarterly based on a provider's star rating and the number of subsidy payments a provider receives. States that provide bonuses for accreditation or alternative quality systems are not counted as a "yes" in this category.
7. Kentucky provides bonuses equivalent to reimbursing providers at QRIS levels 2-5 at a higher level based on enrollment of children receiving subsidies. This is counted as similar to tiered payment rates based on quality.
8. Although Mississippi and West Virginia pay providers different rates depending on whether they meet alternative quality criteria, neither state has a QRIS and the states are not counted as a "yes" in this category.
9. North Carolina describes their QRIS as voluntary and partially mandatory, however all licensed providers are entered at a level 1 in the QRIS system. Participation at level 2 or higher is voluntary. If a provider served children with subsidies they must be at least at a level 3 in the QRIS. Because all providers are entered into the QRIS system, North Carolina is counted as mandatory for all providers.
10. During the 2021 legislative session in Texas, HB 2607 was enacted requiring all subsidy provider to participate in the Texas Rising Star program. Texas is currently in the process of amending administrative

rules that govern the program to create a new pre-star, entry level and provide additional guidance on providers' required participation.

11. Missouri piloted Quality Assurance Reports, which are described as follows in their CCDF plan: "The Quality Assurance Report pilot provides early learning programs a review of policies and procedure, health and safety practices, child screening and assessment practices, staff qualifications and professional development, and classroom environment attributes. A quality review informs the program of recommended training, coaching, and/or consultation to facilitate continuous quality improvement."
12. Some states reimburse providers at a higher level for holding a national accreditation; however, this is not captured in this measure.

Sources:

1. The Build Initiative & Child Trends' Quality Compendium. (2022, July). *QRIS Compendium profile report* [Data set]. Retrieved on July 1, 2022, from https://qualitycompendium.org/view-state-profiles
2. Office of Child Care. (2022, May 16). *Approved CCDF plans (FY 2022-2024).* U.S. Department of Health & Human Services. Retrieved on July 1, 2022, from https://www.acf.hhs.gov/occ/form/approved-ccdf-plans-fy-2022-2024

Measure 8: Monthly copayment amount as a percentage of family income for an infant in full-time center-based care

Definition:

Monthly copayment rates for an infant in center-based care as a percentage of income for a family of 3 at 150% of the 2022 Federal Poverty Level (FPL); and whether providers are allowed to charge parents the difference between the state child care subsidy reimbursement rate and the provider rate.

Notes:

1. **Numerator:** Monthly copayment fee for a family of 3 at 150% of the 2022 FPL for an infant in full-time center-based child care.
2. **Denominator:** Monthly income for a family of 3 at 150% of the 2022 FPL.
3. In 6 states, initial income eligibility limits are below 150% of the FPL. For these states, household income and subsequent copayment fees were based on the maximum household income allowed to initially qualify for subsidy receipt instead of the household income at 150% of the FPL. These 6 states are: Idaho (145% FPL), Indiana (127% FPL), Iowa (145%), Missouri (138%), Ohio (142%), and West Virginia (146%).
4. Full-time care is defined as 9 hours per day, 5 days per week.[11]

[11] Murrin, S., Office of the Inspector General, US Department of Health and Human Services. (August, 2019). *States' payment rates under the child care and development fund program could limit access to child care providers.* OEI-03-15-00170. Retrieved August 1, 2021 from https://oig.hhs.gov/oei/reports/oei-03-15-00170.pdf

5. Federal poverty level (FPL) calculations are based on 2022 thresholds ($23,030 for a family of three). The annual income threshold for a family of 3 at 150% of the 2022 FPL is $34,545, except for Alaska and Hawaii.[12]
6. The FPL thresholds for Alaska and Hawaii were modified to reflect those states' higher federal poverty level guidelines ($28,790 and $26,490 for a family of three, respectively). For 150% of the 2022 FPL, these are equal to annual incomes of $43,185 (Alaska) and $39,735 (Hawaii).
7. All copayment fees reflect fee schedules in place as of September 6, 2022. If a state's published current copayment fee schedules were enhanced due to COVID-19 and were scheduled to be applicable for the foreseeable future, these fees were used in reporting. Four states met these criteria: Michigan, New Jersey, New Mexico, and Utah. However, if a state only had temporary adjustments to fees because of COVID-19 enhancement, these data were not reflected in the copayment amounts.
8. Many states exempt families from copayment requirements if they meet specific criteria. Among the most common of these criteria are families below a certain income level for their family size (e.g., 100% of the FPL), families receiving TANF, children receiving protective services, children in foster care, and homeless families.
9. For families not exempt from copayment requirements, amounts are based on a sliding fee scale, determined by each state and dependent on income level and family size. Copayment amounts vary, partly because of differences in the price of child care between states and territories. Higher copayment amounts do not necessarily mean that a state pays a smaller proportion of the price of care.
10. Family daily copayment was converted into monthly copayment by multiplying 20.9167, and family weekly copayment was converted into monthly copayment by multiplying 4.33. Though Arizona, Florida, and Nevada use different daily and/or weekly conversion rates at their state agencies, researchers maintained consistent methodology across states—using a 20.9167 (daily conversion) and 4.33 (weekly conversion).
11. As of 2022, eleven states do not allow providers to charge the difference between the reimbursement rate and the provider rate: Colorado, the District of Columbia, Maine, Massachusetts, Nebraska, New Mexico, Ohio, Oklahoma, Rhode Island, Washington, and West Virginia.
12. Maryland implemented reduced copayments in May 2022 as a relief measure. The state did not indicate an end-date for this policy. Researchers reported $3.00 weekly family copayments based on 3 units of care per week.

Source:

1. National Women's Law Center. (2020, February 12). *State by state fact sheets: child care assistance policies 2019*. Retrieved on June 2, 2020, from https://nwlc.org/resources/state-by-state-fact-sheets-child-care-assistance-policies-2019/
2. Please refer to the state table at the end of this section.

Measures 9 & 10: Distribution of the total cost of care & Cost of child care for parents

[12] Department of Health and Human Services. (January 12, 2022). *Annual update of the HHS poverty guidelines.* Retrieved July 27, 2022 from https://aspe.hhs.gov/sites/default/files/documents/4b515876c4674466423975826ac57583/Guidelines-2022.pdf

Measure 9 Definition:

The distribution of the total cost of care at the market rate price for an infant in full-time center-based child care in a family of three with an annual income at 150% of the FPL.

1. *Total Cost of Care*: The price of care for an infant in full-time center-based care at the 75th percentile of market rates (also referred to as the "market rate price") in the most populous geographic area in the state. The distribution of this total cost of care is comprised of three components: the base subsidy reimbursement rate, which includes both the state contribution plus the family copayment fee, and any difference between the reimbursement rate and the total cost of care at the 75th percentile (either charged as an additional fee to the family or an unreimbursed cost to the provider).
2. *State Contribution:* The component of the base subsidy reimbursement paid by the state to the provider.
3. *Family Copayment Fee:* The component of the base subsidy reimbursement paid by the family to the provider.
4. *Difference Between Market Rate Price of Care and Reimbursement Rate: Either*
    a. *Additional Fees Paid by the Family*: The difference between the base subsidy reimbursement rate and the market rate price of care, assumed to be equal to the full price of care charged by the provider to private pay families. In states that allow providers to charge families this difference, this amount is paid by the family to the provider as an additional fee; or
    b. *Unreimbursed Costs*: The difference between the base subsidy reimbursement rate and the market rate price of care, assumed to be equal to the full price of care charged by the provider to private pay families. In states that do not allow providers to charge families this difference, this amount is assumed to be absorbed by the provider as unreimbursed costs.

Measure 10 Definition:

Share of child care costs (at the market rate price) for an infant in full-time center-based care paid by a family of 3 at 150% of the FPL.

Notes for Measures 9 & 10:

1. **Cost of Child Care for Parents – Numerator***:* Total monthly child care costs (copayment fee plus any additional fees) for a family of 3 at 150% of the 2022 FPL for an infant in full-time center-based child care.
2. **Cost of Child Care for Parents – Denominator**: The total price of care for an infant in full-time center-based care at the 75th percentile of market rates (also referred to as the "market rate price") in the most populous geographic area in the state.
3. Six states have income eligibility limits below 150% FPL (Idaho, Indiana, Iowa, Missouri, Ohio, West Virginia). The state-specific maximum initial income eligibility value was used for these six states.
4. Full-time care is defined as 9 hours per day, 5 days per week.[13]

[13] Murrin, S., Office of the Inspector General, US Department of Health and Human Services. (August 2019). *States' payment rates under the child care and development fund program could limit access to child care providers*. OEI-03-15-00170. Retrieved August 1, 2021 from https://oig.hhs.gov/oei/reports/oei-03-15-00170.pdf

5. Federal poverty level (FPL) calculations are based on 2022 thresholds ($23,030 for a family of three).[14] The annual income threshold for a family of 3 at 150% of the 2022 FPL is $34,545.
6. The FPL thresholds for Alaska and Hawaii were modified to reflect those states' higher federal poverty level guidelines ($28,790 and $26,490 for a family of three, respectively). For 150% of the 2022 FPL, these are equal to annual incomes of $43,185 (Alaska) and $39,735 (Hawaii).
7. Child care subsidy reimbursement rates are comprised of two components: the state's contribution and the family's copayment fee. Subsidy reimbursement rates do not reflect only the state's contribution and instead reflect the state's contribution PLUS the family's copayment fee (if applicable). Family copayment fee amounts are generally determined by the family's household size and income level.
8. In states where providers are allowed to charge families for an additional fee for child care, families owe the provider the difference between the total cost of care and the state's reimbursement rate. In states where providers cannot charge this additional fee, providers absorb these additional costs.
9. As of 2022, eleven states do not allow providers to charge the difference between the reimbursement rate and the provider rate: Colorado, the District of Columbia, Maine, Massachusetts, Nebraska, New Mexico, Ohio, Oklahoma, Rhode Island, Washington, and West Virginia
10. The total cost of care is assumed to be the value of care at the 75th percentile of market rates in the most populous geographic area in the state.
11. The District of Columbia and New Mexico currently use a cost-estimation model rather than a market rate survey and do not have values for the 75th percentile (market rate price). Virginia is in the process of implementing a cost estimation model and also does not report values for the 75th percentile. The total cost of care for these three states was assumed to be the estimated cost of base-quality care for an infant in center-based care from cost-estimation models.[15]
12. Arkansas, Florida, Idaho, Illinois, Kansas, Kentucky, Louisiana, Michigan, New Jersey, Oregon, Texas, Utah, and Wisconsin have base reimbursement rates that are higher than the 75th percentile (market rate price). For these states the total cost of care reflects the base reimbursement rate.
13. The US average reflects the state value averaged across the 51 states.

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Note: The area listed below the state name reflects the most populous geographic region in the state. Rates were obtained for providers in these regions, similar to the process used in state Child Care Development Fund (CCDF) plans.