

2023 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 identified three key policy levers that states can use to more effectively implement their child care subsidy program and provide families the support they need. The three key policy levers include:

- Setting income eligibility thresholds at or above 85% of the state median income (SMI)
- Limiting copayments to 7% or less of a family's income
- Setting reimbursement rates at or above the 75th percentile of the state market rate survey (MRS) or using a cost estimation model to set reimbursement rates

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 "licensed" 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 1, 2023. 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 six states were verified.¹

Researchers also collected information regarding the copayment fees for families receiving child care subsidies as of September 1, 2023 based on information published on state websites and/or in current 2022-2024 CCDF plans. Copayment information was collected for families at different income levels and family sizes to determine the highest copayment possible as a percentage of a family's income across the state. For the 18 states that base copayments on the number of children in care, the highest copayment for a family with one and two children in care were calculated. The reported copayment represents the highest copayment possible from these calculations. For states that account for program quality, geographical location, or provider reimbursement rates in their copayments, calculations were made with variations in these categories to determine the maximum possible copayment. Additionally, 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 three states (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. Overall, copayment waivers were reported if a state included the changes in the current copayment fee schedule or if the state stated temporary adjustments to fees during data verification. Following this collection, researchers verified family copayment fee information for families with incomes at 150% of the FPL with each state's relevant child care subsidy agency. As above, data for all but six states were verified. Although the calculated figures for maximum copayment data were not verified with state agencies, the calculation method for the copayment used was the one used for families with incomes at 150% of the FPL, which was verified in all but six states.

¹ These six states are: CT, GA, NH, RI, SC, and TX.

Data were collected for 11 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 September 1, 2022 and September 15, 2023 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 2022 thresholds (\$24,860 for a family of three).
3. The FPL percentages for Alaska and Hawaii were modified to reflect those states' higher federal poverty level guidelines (\$31,070 and \$28,590 for a family of three, respectively).
4. Initial income eligibility for a family of three was collected for every state using child care subsidy websites, copayment fee schedules, and income limit tables.
5. 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.

6. In Colorado, Florida, and Texas, the income eligibility limit is set by geographical regions. In each state, the most populous area was reported (Denver County, Miami Dade County, and Gulf Coast, respectively).
7. In several states, families under certain groups (e.g., TANF recipients, children with special needs, families experiencing homelessness) have different income requirements or are categorically eligible for child care subsidies. These limits are not included in reported data.
8. New Hampshire eligibility was reported as 85% of the SMI due to legislative action. This change was reported prior to a new schedule being released.
9. In Alaska, the Alaska Permanent Fund Dividend (PFD) payment, which the majority of families in the state receive, is not counted when determining eligibility.
10. For South Dakota, the income limit reported does not take into account that the state disregards 4 percent of earned income.
11. 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.
12. 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. Administration for Children and Families, Office of Community Services. (2022). *State Median Income (SMI) by Household Size for Optional Use in FFY 2022 and Mandatory Use in LIHEAP for FFY 2023*. Retrieved on April 19, 2023, from https://www.acf.hhs.gov/sites/default/files/documents/ocs/COMM_LIHEAP_Att1SMITable_FY2023.pdf
2. Department of Health and Human Services. (January 19, 2023). *HHS Poverty Guidelines for 2023*. Retrieved April 19, 2023, from <https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines>
3. Please refer to the state table at the end of this section.

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 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 a cost-estimation model that assumes characteristics associated with standard licensing regulations and living

wages for educators, developed by Prenatal to Five Fiscal Strategies. Data and associated methodology documents were shared prior to publication, which is forthcoming.²

4. *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.³
2. Current base reimbursement rates are as of September 1, 2023.
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 Centers⁴ and frequently used in state market rate survey calculations.⁵
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 Prenatal to Five Fiscal Strategies 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 (FY24) 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. Virginia 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. The current maximum reimbursable rates (effective October 1, 2022) are set at Level 1 of Quality Improvement (QRIS) as this is the first level at which providers are eligible for child care subsidies.

² Workman, S. & Capito, J. (2023). 51-state cost model [Data set]. Prenatal to Five Fiscal Strategies.

³ 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>

⁴ 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

⁵ 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>

9. 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.
10. 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.
11. Twenty-four states have two or more home-based licensing groups. The form of care reported for these states was the program with the least amount of provider regulations, only one provider required to be present, and with a maximum capacity of around six children. Our reported home-based care rates are not for large group homes.
12. In Arizona, we reported data for Small Group Homes as opposed to Certified Family Homes. Small Group Homes are regulated by the Arizona Department of Health Services, the same agency that regulates center-based care, whereas Large Family Child Care Homes are regulated by the Department of Economic Security.
13. In Florida, last year we reported rates for Large Family Child Care Homes. This year, we reported Family Child Care Homes data (not Large Family Child Care Homes data), which represents care arrangements with a maximum licensed capacity of six children.
14. In Iowa we reported Home A rates (not Home C rates) as this form of care is licensed for fewer children and only requires one provider to care for children, as opposed to two adults.
15. 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.
16. 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.
17. 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.

Sources for Measures 3-6:

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

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 meeting 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. Missouri's program is piloting and data were not available. South Dakota's state QRIS is still in planning and information was unavailable. Connecticut recently launched their QRIS and data were 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. 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.
7. 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.
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. 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, 2023, from <https://www.acf.hhs.gov/occ/form/approved-ccdf-plans-fy-2022-2024>
3. Connecticut Office of Early Childhood. (n.d.). *Elevate membership levels*. Retrieved on July 26, 2023, from <https://www.ctoec.org/elevate/membership/>

4. Me. Stat. §§ 10-148-31 (2023).
5. Great Start to Quality. (2022, August 16). *Reimagined FAQ's*. Retrieved on July 1, 2023, from https://greatstarttoquality.org/wp-content/uploads/2023/01/GSQ_FAQ_8.16.22_ADA_2.pdf
6. Bright & Early North Dakota. (2022). *Playbook 2022-2023*. Retrieved on July 1, 2023, from <https://www.brightnd.org/files/pdf/2022-2023%20Playbook.pdf>
7. Virginia Department of Education. (2023). *VQB5 participation requirements 2023-2024*. Retrieved on July 1, 2023, from <https://www.doe.virginia.gov/home/showpublisheddocument/42911/638137146903670000>

Measure 8: Maximum monthly copayment as a percentage of family income for all families

Definition:

Maximum possible monthly copayment as percentage of a family's income for a family at any income level; for states that base copayments on the number of children in care, maximum possible copayment for families with two children in care.

Notes:

1. **Numerator:** Monthly copayment fee for a family of any size at any income level for full-time care in any setting for a child of any age.
2. **Denominator:** Monthly income corresponding with copayment fee.
3. Copayment fees were calculated for several family sizes and family incomes until the highest possible percentage of family income was determined. In most states, these copayments represented the highest income bracket possible for family sizes of one or two.
4. Copayments were calculated for any income level in which a family can participate in child care subsidies. This includes incomes past the initial income eligibility.
5. Copayments for families of one person were reported in nine states. Family sizes of one are those in which a single child receives child care benefits when other people living in the home are not considered part of the household for income consideration. Copayments for this family size were only calculated in states that had this category within their copayment schedules.
6. In 18 states, copayments are based on the number of children in care. Copayments were calculated for families with one child and two children in care. The highest possible copayment as a percentage of a family income was reported.
7. In states where a percentage of family income was listed as a copayment cap, this percentage was reported, except otherwise noted.
8. In North Dakota, the copayment schedule lists 7% as a cap for family income. However, when the copayment was calculated for incomes in the lower end of income brackets, the copayment was higher than 7%. The calculated copayment above 7% was reported.
9. In Arkansas, the copayment fee is determined by the quality rating of the child care program. Copayments were calculated at varying quality levels and the highest copayment calculated was for a 2-star program.
10. In Indiana, copayment fees vary based on the number of years a family has received child care subsidies. The highest copayment possible was calculated in year 10+. However, families will be required to pay lower copayments if they receive child care subsidies for less years.

11. In Maryland, the highest copayment for a child in full-time care is \$3, regardless of income. The maximum possible income was calculated for a family at the state's minimum wage.
12. New Jersey is waiving copayments until June 30, 2024 and New Mexico is waiving copayments until further notice. The copayments listed reflects these waivers.
13. Oklahoma is reducing copayments to 50% until September 2024. The copayment listed reflects this waiver.
14. In Texas, copayment fees vary per geographical region. Copayments in all regions were calculated and the highest possible was found in the Central Texas region.

Sources:

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

Measure 9: 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 three 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 three 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 three states are: Missouri (139%), Ohio (132%), and West Virginia (129%).
4. Full-time care is defined as 9 hours per day, 5 days per week.⁶
5. Federal poverty level (FPL) calculations are based on 2023 thresholds (\$24,860 for a family of three). The annual income threshold for a family of three at 150% of the 2023 FPL is \$37,290, except for Alaska and Hawaii.⁷
6. The FPL thresholds for Alaska and Hawaii were modified to reflect those states' higher federal poverty level guidelines (\$231,070 and \$28,590 for a family of three, respectively). For 150% of the 2023 FPL, these are equal to annual incomes of \$46,605 (Alaska) and \$42,885 (Hawaii).

⁶ 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>

⁷ Department of Health and Human Services. (January 19, 2023). HHS Poverty Guidelines for 2023. Retrieved April 19, 2023, from <https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines>

7. All copayment fees reflect fee schedules in place as of September 1, 2023. If a state’s published current copayment fee schedules were enhanced due to COVID-19 or if a state reported a waiver in place, these fees were used in reporting. This included Oklahoma, New Jersey, and New Mexico.
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 September 1, 2023, 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. In 2023, the state enacted legislation to make the reduced copayments permanent. Researchers reported \$3.00 weekly family copayments based on 3 units of care per week, consistent with the reduced copayments from May 2022.

Source:

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

Measures 10 & 11: Distribution of the total cost of care & Cost of child care for parents

Measure 10 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 11 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 three at 150% of the FPL.

Notes for Measures 10 & 11:

1. **Cost of Child Care for Parents – Numerator**: Total monthly child care costs (copayment fee plus any additional fees) for a family of three 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. Three states have income eligibility limits below 150% FPL (Missouri, Ohio, West Virginia). The state-specific maximum initial income eligibility value was used for three six states.
4. Full-time care is defined as 9 hours per day, 5 days per week.⁸
5. Federal poverty level (FPL) calculations are based on 2023 thresholds (\$24,860 for a family of three).⁹ The annual income threshold for a family of three at 150% of the 2022 FPL is \$37,290.
6. The FPL thresholds for Alaska and Hawaii were modified to reflect those states' higher federal poverty level guidelines (\$231,070 and \$28,590 for a family of three, respectively). For 150% of the 2023 FPL, these are equal to annual incomes of \$46,605 (Alaska) and \$42,885 (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.

⁸ 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>

⁹ Department of Health and Human Services. (January 19, 2023). HHS Poverty Guidelines for 2023. Retrieved April 19, 2023, from <https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines>

9. As of 2023, 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, New Mexico, and Virginia currently use a cost-estimation model rather than a market rate survey and do not have values for the 75th percentile (market rate price). The total cost of care for these three states was assumed to be the reimbursement rate.
12. Arkansas, Florida, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maryland, Missouri, Nebraska, New Jersey, New York, North Carolina, North Dakota, Texas, Utah, Vermont, Washington, 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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