

2025 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., Queralto, 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. Zandoni, 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>
- H. Lee, W. F., Sojourner, A., Davis, E. E., & Borowsky, J. (2024). Effects of child care vouchers on price, quantity, and provider turnover in private care markets. Upjohn Institute Working Paper 24-394. Kalamazoo, MI: W.E. Upjohn Institute for Employment Research. <https://doi.org/10.17848/wp24-394>
- I. Rochford, H. I., Zeiger, K. D., & Peek-Asa, C. (2022). Child care subsidies: Opportunities for prevention of child maltreatment. *Child and Adolescent Social Work Journal*, 14, 1–11. <https://doi.org/10.1007/s10560-022-00887-9>
- J. Klicka, J. B., Maguire-Jack, K., Feely, M., Schneider, W., Pace, G. T., Rostad, W., Murphy, C. A., & Merrick, M. T. (2023). Childcare subsidy enrollment income generosity and child maltreatment. *Children*, 10, 64. <https://doi.org/10.3390/children10010064>

- K. Maguire-Jack, K., Park, Y., Feely, M., Schneider, W., Pace, G. T., Klika, J. B., & Thibodeau, E. (2023). Childcare subsidy employment and copayment requirements and child maltreatment. *Child Maltreatment*, 1-13. DOI: 10.1177/10775595231218174
- L. Michalopoulos, C. (2010). Effects of reducing child care subsidy copayments in Washington state, final report. Office of Planning, Research & Evaluation, Administration for Children & Families, U.S. Department of Health and Human Services. <https://www.acf.hhs.gov/opre/resource/effects-of-reducing-child-care-subsidy-copayments-in-washington-state>
- M. Michalopoulos, C., Lundquist, E., & Castells, N. (2010). The effects of child care subsidies for moderate-income families in Cook County, Illinois: Final report. Office of Planning, Research & Evaluation, Administration for Children & Families, U.S. Department of Health and Human Services. <https://www.acf.hhs.gov/opre/resource/the-effects-of-child-care-subsidies-for-moderate-income-families-in-cook>
- N. Halle, T., Tang, J., Maxfield, E. T., Gerson, C. S., Verhoye, A., Madill, R., Pina, G., Gottesman, P. B., Solomon, B., Caballero-Acosta, S., Lin, Y., Fuller, J., & Kelley, S. (2024). Expanding access to high-quality early care and education for families with low income in Maryland through child care subsidy policies. *Early Childhood Research Quarterly*, 69, 1-12. <https://doi.org/10.1016/j.ecresq.2024.05.005>
- O. Borowsky, J., & Davis, E. E. (2025). Payment rates and the stability of subsidized child care: Evidence from Minnesota's child care assistance program. *Early Childhood Research Quarterly*, 70, 222-233. <https://doi.org/10.1016/j.ecresq.2024.10.007>
- P. Breidenbach, A. L., & Heinz, H. (2025). Examining duration of family enrollment in subsidized child care after policy change: Disaggregated outcomes for diverse populations in New Mexico. *Early Childhood Research Quarterly*, 71, 123-134. <https://doi.org/10.1016/j.ecresq.2024.12.007>
- Q. Hong, Y. S., Henly, J., & Alexander, D. (2025). Reducing childcare subsidy instability through eligibility period extensions: Equity impacts of 12-month recertification requirements. *Early Childhood Research Quarterly*, 71, 151-162. <https://doi.org/10.1016/j.ecresq.2024.12.010>

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, researchers present several choices that states can make to more effectively implement their child care subsidy program. 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 based on a cost estimation model to set reimbursement rates

Researchers 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). Researchers 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 June 30, 2025. Following this data collection, researchers 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 three states were verified.¹

Researchers also collected information regarding the copayment fees for families receiving child care subsidies as of June 30, 2025 based on information published on state websites and/or in current 2025-2027 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 21 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 seven states (Florida, Georgia, Idaho, Indiana, Missouri, Nevada, and Ohio) 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 earning \$20/hour and for maximum child care copayment possible with each state's relevant child care subsidy agency. As above, data for all but three states were verified.

Data were collected for 8 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, researchers also performed an electronic search using Quorum State between September 1, 2024 and August 15, 2025 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 5 OF assistance OR child care market rate survey OR child care WITHIN 10 OF market rate survey OR CCDF OR "Child Care Development Fund" OR child care assistance OR child care scholarship). A separate search was conducted to collect broad child care policy proposals (child care director OR Quality Rating and Improvement System OR child care WITHIN 5 OF appropriation OR child care WITHIN 5 OF fund OR child care WITHIN 10 OF governance OR child care workers OR early education workforce OR child care workforce OR early education workforce OR child care WITHIN 5 OF wage OR early childhood professional OR child care professional OR child care WITHIN 10 OF cost share OR family child care WITHIN 10 OF training OR home child care WITHIN 10 OF training OR child care WITHIN 10 OF partnership OR child care WITHIN 20 OF categorical eligibility OR child care WITHIN 20 OF presumptive eligibility). 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

¹ These three states are: NV, NH, and SC.

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 2025 LIHEAP values for a three-person household.
2. Federal poverty level (FPL) calculations are based on 2025 thresholds (\$26,650 for a family of three).
3. The FPL percentages for Alaska and Hawaii were modified to reflect those states' higher federal poverty level guidelines (\$33,310 and \$30,650 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, the income eligibility limit is set by geographical regions. In this state, the most populous area was reported (Denver County).
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. In Alaska, the Alaska Permanent Fund Dividend (PFD) payment, which the majority of families in the state receive, is not counted when determining eligibility.
9. For South Dakota, the income limit reported does not take into account that the state disregards 4 percent of earned income.

Sources for Measures 1 & 2:

1. Administration for Children and Families, Office of Community Services. (2025). *State Median Income (SMI) by Household Size for Optional Use in FFY 2024 and Mandatory Use in LIHEAP for FFY 2025*. Retrieved on April 19, 2025, from https://acf.gov/sites/default/files/documents/ocs/COMM_LIHEAP_IM%202024-02_Att4SMITable_0.pdf
2. Department of Health and Human Services. (2025). *HHS Poverty Guidelines for 2025*. Retrieved April 19, 2025, 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 High-Quality Care*: The estimated cost of full-time monthly child care based on a cost-estimation model that assumes characteristics associated with Caring for Our Children ratios and group sizes, and living wages for educators, developed by Prenatal to Five Fiscal Strategies.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 June 30, 2025.
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, researchers considered an “infant” to be close to 1 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. The dataset provides two cost scenarios, the first one using licensing standards for ratio and group size, and the second using Caring for our Children requirements. Data presented are from the second scenario.

² Workman, S. & Capito, J. (2025). Estimating the true cost of child care in all 50 states [Data set]. Prenatal to Five Fiscal Strategies. https://www.prenatal5fiscal.org/national_cost_models

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>

6. 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. The reported home-based care rates are not for large group homes.
7. 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 (FY25) 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.
8. 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.
9. 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 are set at Level 1 of Quality Improvement (QRIS) as this is the first level at which providers are eligible for child care subsidies.
10. Colorado does not report/calculate rates at the 75th percentile. It uses a cost estimation model rather than a market rate survey to assess child care prices and costs.
11. Massachusetts does not report/calculate rates at the 75th percentile. It uses a cost estimation model rather than a market rate survey to assess child care prices and costs.
12. Kentucky does not report/calculate rates at the 75th percentile. The state only reports rates at the 80th percentile. Researchers reported the 80th percentile as the equal access target.
13. 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.
14. 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.
15. In Arizona, researchers 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.
16. In Florida, in 2022 researchers reported rates for Large Family Child Care Homes. Since 2023, researchers have 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.
17. In Iowa, researchers 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.
18. 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.
19. 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.

20. 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. The state began combining rates for infants and toddler 75th percentile rates in 2025, so infant rates are now used for both infant and toddlers.
21. Oregon's 2024 75th percentile rates were reported for Large Family Child Care Homes. In 2025, researchers began reporting Small Home-Based Care data (not Large Family Child Care Homes data). For reimbursement rates, in 2025 researchers changed from reporting Certified Family rates to Registered Family rates, which represents care arrangements with a maximum licensed capacity of 10 children.
22. Alabama's 75th percentile rates were reported up to 2024 in a combined age group of children under 2.5 years. In 2025, researchers began reporting rates for infants and 2-year-old toddlers.
23. Connecticut's market rate survey was listed as the survey taking place in 2024. In 2025, researchers corrected the survey year to 2023.
24. Florida's 2023-2024 market rate survey does not include private centers as did previous surveys. Researchers reported licensed/exempt as the rates for center-based care.
25. In 2025, Massachusetts approved the use of a cost model to set reimbursement rates. The adjusted rates are retroactive to July 1, 2024.
26. In 2025, Maine began allowing providers to receive the entire reimbursement rate even if private rates are lower.

Sources for Measures 3-6:

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

Measure 7: 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 calculate 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. Before 2025, copayments were calculated for a "family size of one," defined as a single child receiving benefits without an adult counted in the household. In those states, calculations were also made for a "family size of two" with two children. Beginning in 2025, copayments are calculated only for families that include at least one adult.

- a. Nevada was previously considered not to meet the 7% limit for copayments. Despite not making a change in their copayments, the state is now meeting the 7% limit due to the change in calculation.
 - b. Copayments from 2024 for Michigan, Missouri, and Washington were recalculated with the new formula, which demonstrated that the states did not reduce copayments.
 - c. To calculate the difference in copayment for West Virginia, researchers recalculated 2024's copayment using the new formula. Thus, numbers reported for 2024 vary from those previously published.
- 6. In 21 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 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.
- 9. 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.
- 10. 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.
- 11. New Mexico is waiving copayments until further notice. The copayment listed reflects this waiver.
- 12. In Florida, copayments vary per county. Reported family copayments are for Miami-Dade County.
- 13. Louisiana's copayments are determined per child in care, but the state manually limits copayments to 7% of family income regardless of the number of children in care.

Sources:

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

Measures 8: Distribution of the total cost of care

Measure 8 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.

Notes for Measures 8:

1. Most populous geographic areas were collected from CCDF 2022-2024 plans as the new CCDF 2025-2027 plans do not include this information.
2. Seven states have income eligibility limits below 150% FPL (Florida, Georgia, Idaho, Indiana, Missouri, Nevada, and Ohio). The state-specific maximum initial income eligibility value was used for the seven states.
3. Full-time care is defined as 9 hours per day, 5 days per week.⁶
4. Federal poverty level (FPL) calculations are based on 2025 thresholds (\$26,650 for a family of three).⁷ The annual income threshold for a family of three at 150% of the 2024 FPL is \$39,975.
5. The FPL thresholds for Alaska and Hawaii were modified to reflect those states' higher federal poverty level guidelines (\$33,310 and \$30,650 for a family of three, respectively). For 150% of the 2025 FPL, these are equal to annual incomes of \$49,965 (Alaska) and \$45,975 (Hawaii).
6. 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.
7. 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. As of 2025, 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
9. 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.
10. Colorado, the District of Columbia, Massachusetts, 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 four states was assumed to be the reimbursement rate.
11. Kentucky does not report the 75th percentile. The total cost of care for the state represents the 80th percentile, the only rate reported in their most recent market rate survey.

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. (2025). HHS Poverty Guidelines for 2025. Retrieved April 19, 2025, from <https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines>

12. Arkansas, Indiana, Kansas, Louisiana, Maryland, Missouri, Nebraska, New York, North Dakota, Texas, and Vermont 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.
14. Michigan waives family copayments for children enrolled programs at level 3, 4, and 5 of the state's quality program. The modeled family does not have a waived copayment.
15. In Florida, copayments vary per county. Reported family copayments are for Miami-Dade County.
13. In Texas, Local Workforce Boards are allowed to determine whether providers are allowed to charge families additional fees if the private rate is higher than the reimbursement rate in their regions. Although not all Boards allow this, researchers calculated the distribution of the cost of care with the assumption that providers were allowed to charge the difference to families.

Sources for Measures 1-8:

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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.