April 17, 2023 – HER NOPREN Early Childhood Workgroup
Effective State-Level Policies to Strengthen the Early Years

PRENATAL-TO-3 POLICY IMPACT CENTER

Research for Action and Outcomes

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Our Earliest Experiences Shape Our Lives

• All children deserve to be born healthy and raised in nurturing environments, with limited exposure to adversity

• Nurturing relationships in the earliest years lead to healthier brains and bodies, which influence health and wellbeing over the life course

• Chronic adversity harms children’s neurological, biological, and social development, and can have lifelong consequences

• Millions of children lack the opportunities to a healthy start they deserve

• Children of color are most likely to face adversity and least likely to have the opportunities all children deserve
State Policy Choices Shape Opportunities

- State policy choices can empower parents and support children’s healthy development
- We must care for the caregivers so that they can care for the children
- Systems of support require a combination of broad based economic and family supports AND targeted interventions
- Variation in state policy choices leads to a patchwork of supports for families, depending on where they live
Eight Prenatal-to-3 Policy Goals

Families have access to necessary services through expanded eligibility, reduced administrative burden and fewer barriers to services, and identification of needs and connection to services.

Parents have the skills and incentives for employment and the resources they need to balance working and parenting.

Parents have the financial and material resources they need to provide for their families.

Children are born healthy to healthy parents, and pregnancy experiences and birth outcomes are equitable.

Parents are mentally and physically healthy, with particular attention paid to the perinatal period.

Children experience warm, nurturing, stimulating interactions with their parents that promote healthy development.

When children are not with their parents, they are in high-quality, nurturing, and safe environments.

Children’s emotional, physical, and cognitive development is on track, and delays are identified and addressed early.
<table>
<thead>
<tr>
<th>Policy Goal</th>
<th>Outcome Measure</th>
<th>Worst State</th>
<th>Best State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Needed</td>
<td>% Low-Income Women Uninsured</td>
<td>47.8%</td>
<td>3.8%</td>
</tr>
<tr>
<td>Services</td>
<td>% Births to Women Not Receiving Adequate Prenatal Care</td>
<td>23.3%</td>
<td>5.1%</td>
</tr>
<tr>
<td></td>
<td>% Eligible Families with Children &lt; 18 Not Receiving SNAP</td>
<td>26.7%</td>
<td>2.0%</td>
</tr>
<tr>
<td></td>
<td>% Children &lt; 3 Not Receiving Developmental Screening</td>
<td>73.9%</td>
<td>40.2%</td>
</tr>
<tr>
<td>Parents’ Ability to</td>
<td>% Children &lt; 3 Without Any Full-Time Working Parent</td>
<td>39.0%</td>
<td>14.8%</td>
</tr>
<tr>
<td>Work</td>
<td>% Children &lt; 3 in Poverty</td>
<td>33.1%</td>
<td>8.6%</td>
</tr>
<tr>
<td>Sufficient Household</td>
<td>% Children &lt; 3 Living in Crowded Households</td>
<td>35.8%</td>
<td>8.6%</td>
</tr>
<tr>
<td>Resources</td>
<td>% Households Reporting Child Food Insecurity</td>
<td>16.7%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Healthy and</td>
<td>% Babies Born Preterm (&lt; 37 Weeks)</td>
<td>14.2%</td>
<td>7.6%</td>
</tr>
<tr>
<td>Equitable Births</td>
<td># of Infant Deaths per 1,000 Births</td>
<td>8.3</td>
<td>3.7</td>
</tr>
<tr>
<td>Policy Goal</td>
<td>Outcome Measure</td>
<td>Worst State</td>
<td>Best State</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
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</tr>
<tr>
<td>Parental Health and Emotional Wellbeing</td>
<td>% Children &lt; 3 Whose Mother Reports Fair/Poor Mental Health</td>
<td>12.6%</td>
<td>2.3%</td>
</tr>
<tr>
<td></td>
<td>% Children &lt; 3 Whose Parent Lacks Parenting Support</td>
<td>23.5%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Nurturing and Responsive Child-Parent Relationships</td>
<td>% Children &lt; 3 Not Read to Daily</td>
<td>75.4%</td>
<td>47.7%</td>
</tr>
<tr>
<td></td>
<td>% Children &lt; 3 Not Nurtured Daily</td>
<td>51.7%</td>
<td>27.6%</td>
</tr>
<tr>
<td></td>
<td>% Children &lt; 3 Whose Parent Reports Not Coping Very Well</td>
<td>45.0%</td>
<td>20.8%</td>
</tr>
<tr>
<td>Nurturing and Responsive Child Care in Safe Settings</td>
<td>% Providers Not Participating in QRIS^</td>
<td>97.6%</td>
<td>0.0%</td>
</tr>
<tr>
<td></td>
<td>% Children Without Access to EHS</td>
<td>96.2%</td>
<td>69.0%</td>
</tr>
<tr>
<td>Optimal Child Health and Development</td>
<td>% Children Whose Mother Reported Never Breastfeeding</td>
<td>34.0%</td>
<td>6.0%</td>
</tr>
<tr>
<td></td>
<td>% Children &lt; 3 Not Up to Date on Immunizations</td>
<td>36.0%</td>
<td>14.2%</td>
</tr>
<tr>
<td></td>
<td>Maltreatment Rate per 1,000 Children &lt; 3</td>
<td>34.7</td>
<td>1.9</td>
</tr>
</tbody>
</table>
2022 Prenatal-to-3 State Policy Roadmap

The Prenatal-to-3 State Policy Roadmap provides guidance to state leaders on the most effective investments states can make to ensure all children thrive from the start. Grounded in the science of the developing child and based on comprehensive reviews of the most rigorous evidence available, the Roadmap provides detailed information on five effective policies and six effective strategies that foster the nurturing environments infants and toddlers need, and that reduce longstanding disparities in access and outcomes among racial and ethnic groups and socioeconomic statuses.

The Prenatal-to-3 State Policy Roadmap is an annual guide for each state to:

- Assess the wellbeing of its infants and toddlers and prioritize state PN-3 policy goals;
- Identify the evidence-based policy solutions proven to impact PN-3 policy goals;
- Monitor states’ adoption and implementation of the 11 effective Roadmap policies and strategies;
- Track the impact that policy changes have on improving the wellbeing of children and families and reducing disparities between racial and ethnic groups.

In this Roadmap, we provide a summary of the progress that states have made over the last year toward full and equitable implementation of the 11 effective policies and strategies. The Roadmap also includes demographic characteristics of infants and toddlers across the U.S., and for each state, as well as a set of 20 outcome measures that illustrate how the wellbeing of children and families varies across states.

Additional details, including extensive information on the impact that each solution has on the eight PN-3 policy goals, the choices that states can make to effectively implement them, the progress states have made in the past year toward implementation, and how states compare to each other in their generosity and reach of the policies and strategies is provided in a profile for each policy and strategy.
GOALS
To achieve a science-driven PN-3 goal:

Access to Needed Services
Parents’ Ability to Work
Sufficient Household Resources
Healthy and Equitable Births
Parental Health and Emotional Wellbeing
Nurturing and Responsive Child-Parent Relationships
Nurturing and Responsive Child Care in Safe Settings
Optimal Child Health and Development

POLICIES
Adopt and fully implement the effective policies aligned with the goal

Expanded Income Eligibility for Health Insurance
Reduced Administrative Burden for SNAP
Paid Family Leave
State Minimum Wage
State Earned Income Tax Credit

OUTCOMES
Measure progress toward achieving the PN-3 goal.

Health Insurance Adequate Prenatal Care Access to SNAP Developmental Screenings
Parental Employment
Child Poverty Crowded Housing Food Insecurity
Preterm Births Infant Mortality
Maternal Mental Health Parenting Support
Daily Reading Daily Nurturing Behaviors Parenting Stress
Child Care Providers Participating in QRIS Access to EHS
Breastfeeding Immunizations Child Maltreatment
### GOALS

To achieve a science-driven PN-3 goal:

- Access to Needed Services
- Parents’ Ability to Work
- Sufficient Household Resources
- Healthy and Equitable Births
- Parental Health and Emotional Wellbeing
- Nurturing and Responsive Child-Parent Relationships
- Nurturing and Responsive Child Care in Safe Settings
- Optimal Child Health and Development

### STRATEGIES

Make substantial progress relative to other states toward implementing the **effective strategies** aligned with the goal:

<table>
<thead>
<tr>
<th>Strategies</th>
<th>Access to Needed Services</th>
<th>Parents’ Ability to Work</th>
<th>Sufficient Household Resources</th>
<th>Healthy and Equitable Births</th>
<th>Parental Health and Emotional Wellbeing</th>
<th>Nurturing and Responsive Child-Parent Relationships</th>
<th>Nurturing and Responsive Child Care in Safe Settings</th>
<th>Optimal Child Health and Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Screening and Connection Programs</td>
<td>🟢</td>
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<tr>
<td>Child Care Subsidies</td>
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<tr>
<td>Group Prenatal Care</td>
<td>🟢</td>
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<tr>
<td>Evidence-Based Home Visiting Programs</td>
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<td>Early Head Start</td>
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<tr>
<td>Early Intervention Services</td>
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</tbody>
</table>

### OUTCOMES

Measure progress toward achieving the PN-3 goal:

- Health Insurance
  - Adequate Prenatal Care
  - Access to SNAP Developmental Screenings
- Parental Employment
- Child Poverty
  - Crowded Housing
  - Food Insecurity
- Preterm Births
  - Infant Mortality
- Maternal Mental Health
  - Parenting Support
- Maternal Mental Health
  - Parenting Stress
- Daily Reading
  - Daily Nurturing Behaviors
- Parenting Stress
  - Parenting Stress
- Child Care Providers Participating in QRTS
  - Access to EHS
- Breastfeeding
  - Immunizations
  - Child Maltreatment
<table>
<thead>
<tr>
<th>Count of Policies Adopted</th>
<th>States</th>
<th>Total States</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 out of 5</td>
<td>GA MS NC SC TX WY</td>
<td>6</td>
</tr>
<tr>
<td>1 out of 5</td>
<td>AL FL ID NH ND SD TN UT WI</td>
<td>9</td>
</tr>
<tr>
<td>2 out of 5</td>
<td>AK HI IA KS KY LA MI MT NE NV OH OK PA WV</td>
<td>14</td>
</tr>
<tr>
<td>3 out of 5</td>
<td>AZ AR CO DE IN MO</td>
<td>6</td>
</tr>
<tr>
<td>4 out of 5</td>
<td>IL ME MD MN NM NY OR RI VT VA</td>
<td>10</td>
</tr>
<tr>
<td>5 out of 5</td>
<td>CA CT DC MA NJ WA</td>
<td>6</td>
</tr>
</tbody>
</table>
## THE PRENATAL-TO-3 SYSTEM OF CARE IN THE UNITED STATES

<table>
<thead>
<tr>
<th>Effective Roadmap Policy</th>
<th>Total number of states that have adopted and fully implemented each policy</th>
<th>2022 Progress Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expanded Income Eligibility for Health Insurance</td>
<td>39</td>
<td>No new states adopted and fully implemented Medicaid expansion this past year, but 11 of the 12 remaining non-expansion states introduced legislation to do so. Two states are still considering expansion. Negotiations within the North Carolina legislature are ongoing, and South Dakota will vote on a ballot measure to expand Medicaid in November 2022.</td>
</tr>
<tr>
<td>Reduced Administrative Burden for SNAP</td>
<td>33</td>
<td>Two states, Kentucky and Maryland, increased their recertification intervals for SNAP from 6 to 12 months this past year. Two other states that have already implemented policies to reduce administrative burden, Minnesota and New Jersey, introduced legislation to make access to SNAP easier for more groups, but the legislation did not pass in either state.</td>
</tr>
<tr>
<td>Paid Family Leave Program of at Least 6 Weeks</td>
<td>7</td>
<td>Connecticut fully implemented its paid family leave program of 12 weeks in January 2022, joining six other states that currently provide at least 6 weeks of paid leave to families. Two states, Delaware and Maryland, enacted 12-week paid family leave programs that will be fully implemented in 2026 and 2025, respectively. Oregon and Rhode Island will fully implement their paid family leave programs in 2023.</td>
</tr>
<tr>
<td>State Minimum Wage of $10.00 or Greater</td>
<td>25</td>
<td>This past year, three states - Delaware, Nevada, and Virginia - increased their minimum wages to more than $10.00, due to previously scheduled increases. Michigan, Ohio, and South Dakota are scheduled to increase their minimum wages to greater than $10.00 in January 2023.</td>
</tr>
<tr>
<td>Refundable State Earned Income Tax Credit of at Least 10% the Federal Credit</td>
<td>21</td>
<td>This past year, Virginia adopted and fully implemented a refundable EITC of at least 10% of the federal credit effective tax year 2022. Indiana and Washington also began offering a refundable EITC of at least 10% of the federal credit this year, due to previously enacted legislation. Hawaii enacted legislation to offer a 20% refundable credit beginning in tax year 2023.</td>
</tr>
</tbody>
</table>
# The Prenatal-to-3 System of Care in the United States

<table>
<thead>
<tr>
<th>Service Type</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Screening and Connection Programs</td>
<td>CA, CO, CT, NJ, OR</td>
</tr>
<tr>
<td>Child Care Subsidies</td>
<td>CA, LA, MI, NM, OR</td>
</tr>
<tr>
<td>Group Prenatal Care</td>
<td>CA, MD, MT, OH, SC</td>
</tr>
<tr>
<td>Evidence-Based Home Visiting Programs</td>
<td>IL, IA, KS, ME, NY</td>
</tr>
<tr>
<td>Early Head Start</td>
<td>DC, ME, MA, NE, OR</td>
</tr>
<tr>
<td>Early Intervention Services</td>
<td>CT, IL, MA, NM, RI</td>
</tr>
</tbody>
</table>

For additional information on the choices states can make to be a leader in an effective strategy, visit the [policy and strategy profiles](#).
Eight States Have Newly Implemented At Least One Effective Policy

(Virginia implemented two!)

### Changes in Policy Adoption and Implementation in the Last Year

<table>
<thead>
<tr>
<th>Policy Type</th>
<th>States Implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expanded Income Eligibility for Health Insurance</td>
<td>39 States</td>
</tr>
<tr>
<td>Reduced Administrative Burden for SNAP</td>
<td>33 States</td>
</tr>
<tr>
<td>Paid Family Leave of at Least 6 Weeks</td>
<td>7 States</td>
</tr>
<tr>
<td>State Minimum Wage of $10.00 or Greater</td>
<td>25 States</td>
</tr>
<tr>
<td>Refundable State Earned Income Tax Credit of at Least 10%</td>
<td>21 States</td>
</tr>
</tbody>
</table>

State has newly adopted and fully implemented the policy since October 1, 2021
Expanded income eligibility for health insurance is an effective state policy to impact:

39 states have adopted and fully implemented the Medicaid expansion under the Affordable Care Act that includes coverage for most adults with incomes up to 138% of the federal poverty level.

2022 Progress Summary

No new states adopted and fully implemented Medicaid expansion this past year, but 11 of the 12 remaining non-expansion states introduced legislation to do so.

Two states are still considering expansion. Negotiations within the North Carolina legislature are ongoing, and South Dakota will vote on a ballot measure to expand Medicaid in November 2022.
How Does Medicaid Expansion Impact PN-3 Outcomes?

**Access to Needed Services**
- An 8.6 percentage point increase in preconception Medicaid coverage (B)
- An increase of 0.9 months of Medicaid coverage postpartum (I)
- An increase in receiving adequate prenatal care by 3.6 percentage points for Hispanic women and 2.6 percentage points for non-Hispanic women (EE)

**Sufficient Household Resources**
- A 4.7 percentage point decrease in the likelihood of experiencing a catastrophic financial burden (KK)
- A decrease in financial difficulty and care avoidance because of cost (C, K, & II)
- A reduction in the poverty rate (Supplemental Poverty Measure) of up to 1.4 percentage points, corresponding to lifting more than 690,000 people out of poverty (CC)

**Healthy and Equitable Births**
- 0.53 fewer infant deaths per 1,000 live births among Hispanic infants (V)
- 16.3 fewer Black maternal deaths per 100,000 live births (7.0 per 100,000 live births in the overall population) (I)

**Optimal Child Health and Development**
- 422 fewer cases of neglect per 100,000 children under age 6 (U)
- 17.3% reduction in first-time neglect reports for children under age 5 (NN)
Variation Across States in Parents’ Medicaid Income Eligibility Limits as a Percentage of the Federal Poverty Level

As of January 1, 2021. Kaiser Family Foundation and Medicaid state plan amendments (SPAs). Blue bar indicates that the state has expanded Medicaid.
% Low-Income Women of Childbearing Age Without Health Insurance

Low income = <= 138% Federal Poverty Level
2019 American Community Survey (ACS) 1-Year Public Use Microdata Sample (PUMS).
Reduced administrative burden for SNAP is an effective state policy to impact:

33 states have implemented a combination of policies to reduce the administrative burden for SNAP.

2022 Progress Summary

Two states, Kentucky and Maryland, increased their recertification intervals for SNAP from 6 to 12 months this past year.

Two other states that have already implemented policies to reduce administrative burden, Minnesota and New Jersey, introduced legislation to make access to SNAP easier for more groups, but the legislation did not pass in either state.
How Does Reduced Administrative Burden for SNAP Impact PN-3 Outcomes?

- Recertification intervals longer than 12 months led to an 11.4 percentage point increase in SNAP participation among households with children (E)
- The elimination of policies that added transaction costs and stigma to SNAP participation explained 14.2% of the SNAP caseload increase from 2000 to 2016 (A)
- Policies lengthening recertification intervals to longer than 3 months were associated with a 5.8% increase in SNAP participation from 2000 to 2009 (K)

- Participation in SNAP reduced household food insecurity by up to 36% in households with children (2)
% Eligible Families With Children Under Age 18 Not Receiving SNAP

- Tennessee: 2.0%
- Louisiana: 2.9%
- Alabama: 3.0%
- Missouri: 3.2%
- Michigan: 3.9%
- West Virginia: 3.9%
- Indiana: 4.7%
- Mississippi: 4.7%
- Ohio: 4.7%
- South Dakota: 5.0%
- Oklahoma: 5.2%
- Pennsylvania: 5.2%
- Virginia: 5.3%
- Kentucky: 5.6%
- Nebraska: 5.6%
- Georgia: 5.9%
- Rhode Island: 6.0%
- Iowa: 6.5%
- Arkansas: 6.6%
- South Carolina: 6.6%
- Wisconsin: 6.7%
- New Mexico: 6.8%
- Oregon: 7.1%
- Maine: 7.3%
- Alaska: 7.4%
- District of Columbia: 7.5%
- Montana: 7.6%
- New York: 8.1%
- Illinois: 8.2%
- Florida: 8.7%
- Utah: 8.7%
- Washington: 8.7%
- North Dakota: 9.1%
- Idaho: 9.4%
- North Carolina: 9.5%
- Vermont: 9.8%
- Kansas: 10.9%
- Maryland: 11.2%
- New Hampshire: 11.5%
- Arizona: 11.6%
- Connecticut: 11.7%
- Wyoming: 11.7%
- Massachusetts: 13.0%
- Minnesota: 13.1%
- Delaware: 14.3%
- Hawaii: 14.3%
- Colorado: 17.1%
- Texas: 19.8%
- Nevada: 20.5%
- New Jersey: 21.2%
- California: 26.7%
A paid family leave program of a minimum of 6 weeks is an effective state policy to impact:

- Access to Needed Services
- Parents' Ability to Work
- Sufficient Household Resources
- Healthy and Equitable Births
- Parental Health and Emotional Wellbeing
- Nurturing and Responsive Child-Parent Relationships
- Nurturing and Responsive Child Care in Safe Settings
- Optimal Child Health and Development

7 states have adopted and fully implemented a paid family leave program of a minimum of 6 weeks following the birth, adoption, or the placement of a child into foster care.

2022 Progress Summary

Connecticut fully implemented its paid family leave program of 12 weeks in January 2022, joining six other states that currently provide at least 6 weeks of paid leave to families.

Two states, Delaware and Maryland, enacted 12-week paid family leave programs that will be fully implemented in 2026 and 2025, respectively.

Oregon and Rhode Island will fully implement their paid family leave programs in 2023.
How Does Paid Family Leave Impact PN-3 Outcomes?

- An increase in family leave-taking in the first year after birth of 5 weeks for mothers and up to 3 days for fathers (B)
- An increase in family leave-taking of 14.4 percentage points among Black mothers and 6.4 percentage points among Hispanic mothers (no significant increase was found among White mothers) (N)
- An increase in the receipt of postpartum care of 1.5 percentage points for White women and 3.4 percentage points for women of other racial groups (Z)

- Up to an 8 percentage point increase in maternal labor force participation in the months surrounding birth (D)
- An increase in time worked by mothers of 7.1 weeks in the second year of a child's life (B)
- A 13% increase in the likelihood of mothers returning to their prebirth employer in the year following birth (B)
- An 18.3 percentage point increase in the probability of mothers working 1 year following birth (B)

- An average increase of $3,400 in household income among mothers of 1-year-olds (M)
- A 2 percentage point reduction in the poverty rate, with the greatest effects among single mothers with low levels of education and income (M)
### How Does Paid Family Leave Impact PN-3 Outcomes?

#### Parental Health and Emotional Wellbeing
- A 5.3 percentage point increase in the number of parents who reported coping well with the day-to-day demands of parenting (C)
- A 12 percentage point decrease in parental consumption of any alcohol (P)

#### Nurturing and Responsive Child-Parent Relationships
- An increase in mothers' time spent with children, including reading to their children 2.1 more times per week, having breakfast with children 0.7 more times per week, and going on outings with children 1.8 more times per month (A)

#### Optimal Child Health and Development
- A 1.3 percentage point increase in exclusive breastfeeding at age 6 months (G)
- A 7.5 percentage point increase in the likelihood of breastfeeding initiation among Black mothers (K)
- Up to a 7 percentage point decrease in the likelihood of infants receiving late vaccinations among families with low incomes (E)
- A decrease in hospital admissions for pediatric abusive head trauma of 2.8 admissions per 100,000 children under age 2 and 5.1 admissions per 100,000 children under age 1 (I)
### POLICY

#### Paid Family Leave

#### Variation Across States in Paid Family Leave

#### Benefits, Funding Mechanisms, and Eligibility

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**Source:** As of October 1, 2022. State paid family leave laws and A Better Balance.

<table>
<thead>
<tr>
<th><strong>Adopted a Statewide Paid Family Leave Program</strong></th>
<th><strong>Fully Implemented a Paid Family Leave Program of at least 6 Weeks</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>CA</td>
<td>CA</td>
</tr>
<tr>
<td>CO</td>
<td>CT</td>
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<td>CT</td>
<td>DE</td>
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<td>MA</td>
<td>NJ</td>
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<tr>
<td>NJ</td>
<td>NY</td>
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<tr>
<td><strong>12 States</strong></td>
<td><strong>7 States</strong></td>
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</tbody>
</table>

**Number of Weeks of Benefit**

- **5 Weeks**
  - RI
- **8 Weeks**
  - CA
- **12 Weeks**
  - CO
  - CT
  - DE
  - DC
  - MA
  - NJ
  - NY
  - OR
  - WA

**Benefit as a Percentage of Worker’s Average Weekly Wages**

- **60% to 85%**

**Maximum Dollar Value of Weekly Benefit**

- **$840 to $1,590**

**Funding Mechanism (Who Covers the Cost)**

- **Workers**
  - CA
  - CT
  - MA
  - NJ
  - NY
  - RI
  - WA
- **Shared between Workers and Employers**
  - CO
  - DE
  - MA
  - MD
  - OR
  - DC
- **Employers**
  - DC

**Eligibility**

- Automatic or opt-in coverage for public, private, or domestic workers; opt-in coverage for self-employed employees; Employer size
A state minimum wage of $10.00 or greater is an effective state policy to impact:

25 states have adopted and fully implemented a minimum wage of $10.00 or greater.

2022 Progress Summary

This past year, three states - Delaware, Nevada, and Virginia - increased their minimum wages to more than $10.00, due to previously scheduled increases.

Michigan, Ohio, and South Dakota are scheduled to increase their minimum wages to greater than $10.00 in January 2023.
## How Does a Higher State Minimum Wage Impact PN-3 Outcomes?

### Sufficient Household Resources
- For mothers with no college degree with children under age 6, a 10% increase in the minimum wage reduced poverty by 9.7% (J)
- A 10% increase in the minimum wage led to a 3.5% increase in earnings for families with low incomes and produced a 4.9% reduction in poverty for children under age 18 (B)

### Healthy and Equitable Births
- A $1.00 minimum wage increase above the federal level led to an approximately 2% decrease in low birthweight and 4% decrease in postneonatal mortality (E)
- For pregnant women, setting the tipped minimum wage at the full federal minimum wage level led to overall healthier birthweights for gestational age (O)

### Optimal Child Health and Development
- A $1.00 increase in the minimum wage reduced child neglect reports by 9.6% overall and 10.8% for children ages 0 to 5 (G)
- Children affected by a $1.00 increase in the minimum wage from birth through age 5 saw an 8.7% higher likelihood of excellent or very good health and missed 15.6% fewer school days due to illness or injury from ages 6 through 12 (I)
A refundable state EITC of at least 10% of the federal EITC is an effective state policy to impact:

21 states have adopted and fully implemented a refundable EITC of at least 10% of the federal EITC for all eligible families with any children under age 3.

2022 Progress Summary

This past year, Virginia adopted and fully implemented a refundable EITC of at least 10% of the federal credit effective tax year 2022.

Indiana and Washington also began offering a refundable EITC of at least 10% of the federal credit this year, due to previously enacted legislation.

Hawaii enacted legislation to offer a 20% refundable credit beginning in tax year 2023.
How Does a Higher State EITC Impact PN-3 Outcomes?

- With each additional $1,000 in average EITC benefits (federal plus state), unmarried mothers with children under age 3 were 9 percentage points more likely to work (C).
- A state EITC set at 10% of the federal credit increased employment among single mothers by 2.1 percentage points compared to single women with no children (GG).
- Living in a state with an EITC increased the likelihood of mothers’ employment (for at least one week per year) by 19% (B).

- State EITCs increased mothers’ annual wages by 32% (B).
- A $1,000 increase in average federal and state EITC benefits led to an increase of $2,400 in the pre-tax earnings of households with infants and toddlers, and poverty was reduced by 5 percentage points (C).
- A rigorous simulation found that if all states adopted the policy of the most generous EITC state, then child poverty would be reduced by 1.2 percentage points (KK).

- The state EITC led to increases in birthweight of between 16 and 104 grams, depending on the credit’s generosity level (B, CC).
- In states with refundable EITCs of at least 10% of the federal credit, Black mothers with a high school education or less saw greater reductions in low birthweight rates for their infants (1.4 percentage points) compared to White mothers with a high school education or less (0.7 percentage points) (II).
### Federal EITC by EITC Status

<table>
<thead>
<tr>
<th>State</th>
<th>Policy Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>AK</td>
<td></td>
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<tr>
<td>WA</td>
<td></td>
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<tr>
<td>ID</td>
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<td>MT</td>
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<tr>
<td>ND</td>
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<tr>
<td>MN</td>
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<tr>
<td>IL</td>
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<tr>
<td>MI</td>
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<tr>
<td>NY</td>
<td></td>
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<tr>
<td>ME</td>
<td></td>
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<tr>
<td>OR</td>
<td></td>
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<tr>
<td>NV</td>
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<tr>
<td>WY</td>
<td></td>
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<tr>
<td>SD</td>
<td></td>
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<tr>
<td>IA</td>
<td></td>
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<tr>
<td>IN</td>
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<tr>
<td>OH</td>
<td></td>
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<tr>
<td>PA</td>
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<tr>
<td>NJ</td>
<td></td>
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<tr>
<td>CT</td>
<td></td>
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<tr>
<td>RI</td>
<td></td>
</tr>
<tr>
<td>CA</td>
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<tr>
<td>UT</td>
<td></td>
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<tr>
<td>CO</td>
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<tr>
<td>NE</td>
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<tr>
<td>MO</td>
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<td>KY</td>
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<td>WV</td>
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<td>VA</td>
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<td>MD</td>
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<td>AZ</td>
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<tr>
<td>AR</td>
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<td>TN</td>
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<tr>
<td>NC</td>
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<td>DC</td>
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<tr>
<td>GA</td>
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<tr>
<td>HI</td>
<td></td>
</tr>
<tr>
<td>TX</td>
<td></td>
</tr>
<tr>
<td>FL</td>
<td></td>
</tr>
</tbody>
</table>

**Legend:**
- **Refundable EITC of at Least 10%**
- **Refundable EITC < 10%**
- **Nonrefundable EITC**
- **No EITC**
- **No EITC and No Income Tax**

Roll over each state to view a state’s EITC value as a % of the federal EITC.

As of Tax Year 2021. State income tax statutes, the Center on Budget and Policy Priorities, and the Urban Institute.
COMPREHENSIVE SCREENING AND CONNECTION PROGRAMS

Comprehensive screening and connection programs are an effective state strategy to impact:

- Access to Needed Services
- Parents’ Ability to Work
- Sufficient Household Resources
- Healthy and Equitable Births
- Parental Health and Emotional Wellbeing
- Nurturing and Responsive Child-Parent Relationships
- Nurturing and Responsive Child Care in Safe Settings
- Optimal Child Health and Development

COMPREHENSIVE SCREENING AND CONNECTION PROGRAMS use screening tools to identify the needs of children and families and connect them to targeted programs and services.

**State leaders in this strategy** have a high percentage of families who access the programs, enact legislation to reach families across the state, and invest deeply in evidence-based programs.

**State leaders:**

- CA
- CO
- CT
- NJ
- OR
How Do Comprehensive Screening and Connection Programs Impact PN-3 Outcomes?

- DULCE families received an average of 0.5 more community resources at the 6 and 12 month follow up (J)
- Family Connects families accessed between 0.7 (D) and 0.9 (B) more community resources
- HealthySteps families had 3.5 times higher odds of being informed about community resources (F)
- DULCE families had an 11 percentage point increase in the likelihood of attending at least 5 routine health care visits by 12 months (J) and HealthySteps families had 1.7 times greater odds of attending the 12 month well-child visit (F)

- Among those parents in Family Connects using nonparental care, out-of-home care quality was rated higher (0.66 points on a 5 point scale) compared to control families (B)

- By child age 12 months, Family Connects families reduced emergency department visits by 50% (B)
- DULCE families were 15 percentage points more likely to have received immunizations on time at child age 6 months (J)
- HealthySteps families were 3 percentage points less likely to put their infants in the wrong sleep position (E)
### Number of Sites and Percent of Children/Families Served through the Family Connects Program

<table>
<thead>
<tr>
<th>State</th>
<th>Number of Program Sites</th>
<th>% of Children/Families Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arkansas</td>
<td>1</td>
<td>0.5%</td>
</tr>
<tr>
<td>California</td>
<td>1</td>
<td>0.1%</td>
</tr>
<tr>
<td>Illinois</td>
<td>3</td>
<td>1.9%</td>
</tr>
<tr>
<td>Iowa</td>
<td>1</td>
<td>2.3%</td>
</tr>
<tr>
<td>Maryland</td>
<td>2</td>
<td>0.8%</td>
</tr>
<tr>
<td>Minnesota</td>
<td>1</td>
<td>1.1%</td>
</tr>
<tr>
<td>North Carolina</td>
<td>6</td>
<td>3.5%</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>1</td>
<td>1.9%</td>
</tr>
<tr>
<td>Oregon</td>
<td>4</td>
<td>0.7%</td>
</tr>
<tr>
<td>Texas</td>
<td>6</td>
<td>0.8%</td>
</tr>
<tr>
<td>Washington</td>
<td>1</td>
<td>0.2%</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>1</td>
<td>0.4%</td>
</tr>
</tbody>
</table>

GROUP PRENATAL CARE

Group prenatal care is an effective state strategy to impact:

- Access to Needed Services
- Parents' Ability to Work
- Sufficient Household Resources
- Healthy and Equitable Births
- Parental Health and Emotional Wellbeing
- Nurturing and Responsive Child-Parent Relationships
- Nurturing and Responsive Child Care in Safe Settings
- Optimal Child Health and Development

GROUP PRENATAL CARE

provides education, support, and obstetric care to pregnant people with similar gestational age in a group format.

State leaders in this strategy provide financial support for group prenatal care, provide enhanced reimbursement rates for group prenatal care through Medicaid, and/or serve pregnant people in a high number of group prenatal care sites across the state.

State leaders:

<table>
<thead>
<tr>
<th>CA</th>
<th>MD</th>
<th>MT</th>
<th>OH</th>
<th>SC</th>
</tr>
</thead>
</table>

[34]
### STRATEGY

#### Group Prenatal Care

<table>
<thead>
<tr>
<th>Access to Needed Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• A 6.4 percentage point decrease in the likelihood of receiving inadequate prenatal care compared to individual prenatal care participants (C)</td>
</tr>
<tr>
<td>• Approximately 2 more prenatal visits among participating Black women with high-risk pregnancies compared to women in individual care (H)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Parental Health and Emotional Wellbeing</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Cases of probable depression decreased by 31% for women in group prenatal care compared to 15% for women in individual prenatal care from the second trimester to 1 year postpartum (A)</td>
</tr>
<tr>
<td>• High-stress women in group prenatal care were more likely than women in individual prenatal care to experience a decrease in depressive symptoms postpartum (D)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Optimal Child Health and Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The rate of breastfeeding initiation increased by approximately 12 percentage points for women in group prenatal care compared to women in individual prenatal care (C)</td>
</tr>
</tbody>
</table>

---

How Does Group Prenatal Care Impact PN-3 Outcomes?

35
Number of Centering Pregnancy Sites Across States

California 56
Ohio 49
North Carolina 29
South Carolina 26
Pennsylvania 25
New Jersey 24
Washington 21
Illinois 20
New York 20
Indiana 14
Michigan 14
Maryland 12
Colorado 9
Massachusetts 9
Missouri 6
Oregon 6
District of Columbia 6
Oklahoma 6
Florida 5
Maine 5
Hawaii 4
Alabama 3
Georgia 3
Minnesota 3
Nebraska 3
Nevada 3
Virginia 3
Wisconsin 3
Alaska 2
Arizona 2
Kentucky 2
Montana 2
New Hampshire 2
Arkansas 1
Iowa 1
Kansas 1
Louisiana 1
Mississippi 1
New Mexico 1
North Dakota 1
Tennessee 1
Vermont 1
West Virginia 1
Connecticut 0
Delaware 0
Idaho 0
Rhode Island 0
South Dakota 0
Utah 0
Wyoming 0

Source: As of 2021. Centering Healthcare Institute Inc
EVIDENCE-BASED HOME VISITING

Evidence-based home visiting programs are an effective state strategy to impact:

- Access to Needed Services
- Parents’ Ability to Work
- Sufficient Household Resources
- Healthy and Equitable Births
- Parental Health and Emotional Wellbeing
- Nurturing and Responsive Child-Parent Relationships
- Nurturing and Responsive Child Care in Safe Settings
- Optimal Child Health and Development

EVIDENCE-BASED HOME VISITING PROGRAMS

provide support and education to parents in the home through a trained professional or paraprofessional.

State leaders in this strategy serve a substantial percentage of low-income families with young children and/or use state dollars or Medicaid to support home visiting services.

State leaders:

- IL
- IA
- KS
- ME
- NY
How Does Evidence-Based Home Visiting Impact Parenting Outcomes?

- Home visiting led to small but significant effects for improving parenting behaviors (overall effect sizes on parenting outcomes from meta-analyses range from 0.09 to 0.37) (A, C, D, E)
- Significant effects emerge within the context of many more null findings (B, E)
Estimated % of Eligible Children Under Age 3 Served in Evidence-Based Home Visiting Programs

- Iowa: 35.1%
- Kansas: 23.8%
- Maine: 23.8%
- Rhode Island: 22.7%
- Michigan: 21.4%
- Indiana: 19.5%
- Missouri: 17.3%
- Wyoming: 13.2%
- Colorado: 12.6%
- Montana: 12.1%
- Oregon: 11.7%
- Minnesota: 11.6%
- Kentucky: 11.2%
- Connecticut: 10.7%
- Illinois: 10.1%
- Pennsylvania: 10.1%
- Delaware: 9.5%
- New Jersey: 9.1%
- North Dakota: 8.9%
- Arizona: 8.8%
- Ohio: 8.6%
- Wisconsin: 8.6%
- Oklahoma: 8.2%
- Alaska: 8.1%
- District of Columbia: 7.9%

EARLY HEAD START

Early Head Start is an effective state strategy to support:

Access to Needed Services  Parents’ Ability to Work  Sufficient Household Resources  Healthy and Equitable Births  Parental Health and Emotional Wellbeing  Nurturing and Responsive Child-Parent Relationships  Nurturing and Responsive Child Care in Safe Settings  Optimal Child Health and Development

EARLY HEAD START

serves low-income pregnant women, infants, toddlers, and their families through comprehensive child development and family services delivered in a variety of formats.

State leaders in this strategy have a state-specific program, provide state financial support for EHS, and/or serve a substantial percentage of low-income children.

State leaders:

DC  ME  MA  NE  OR
How Does Early Head Start Impact PN-3 Outcomes?

- Parents participating in EHS reported lower parenting distress as compared to the control group at child age 2 (I, S: effect size -0.11)

- EHS participation led to more supportive home environments for language and literacy (I, S: effect size 0.12), particularly for Black families (N: effect size 0.19) and families with moderate-level risk factors (N: effect size 0.18)
- Fewer parents participating in EHS reported spanking their child at age 3 (J, S: effect size -0.13)
- Black parents participating in EHS were more involved in school at grade 5 (T: effect size 0.37)

- At age 2, the share of children participating in good-quality center-based care was 3 times greater among children participating in EHS as compared to the control group (K)
- In center-based care, caregiver-child interactions were better among EHS participants than among nonparticipants (K)

- Children in EHS were more engaged with their parent during play at age 3 (J, S: effect size 0.18)
- Children in EHS had higher developmental functioning assessment scores at age 2 (I, S: effect size 0.14), particularly Black children in EHS (N: effect size 0.23)
- Children in EHS had higher vocabulary skills at ages 2 and 3 (I, J and S: effect sizes 0.11)
Estimated % of Income-Eligible Children With Access to Early Head Start

EARLY INTERVENTION SERVICES

Early Intervention services are an effective state strategy to impact:

EARLY INTERVENTION SERVICES are child- and family-centered services and therapies to support the healthy development of infants and toddlers with disabilities, developmental delays, or who are at risk for delays.

State leaders in this strategy serve a substantial percentage of children under age 3, increase eligibility for children, and/or maximize the use of Medicaid to pay for EI services.

State leaders:

CT  IL  MA  NM  RI
How Do Early Intervention Services Start Impact PN-3 Outcomes?

**Parental Health and Emotional Wellbeing**
- Mothers of low birthweight, premature infants who received EI services scored significantly higher on scales of maternal self-confidence (B, D) and maternal role satisfaction than control groups (D)

**Optimal Child Health and Development**
- A meta-analysis of 31 studies found that EI services had an average effect size of 0.62 on children’s cognitive skills and 0.43 on motor skills (F)
- Low birthweight, premature infants who were assigned to EI services saw better cognitive (C, D) and behavioral outcomes (C) at age 3 than infants in control groups
- EI services improved toddlers’ receptive language skills relative to a control group (0.35 effect size) (E)
Early Intervention Services

### Cumulative % Children Under Age 3 Receiving EI Services

<table>
<thead>
<tr>
<th>State</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massachusetts</td>
<td>20.7%</td>
</tr>
<tr>
<td>New Mexico</td>
<td>15.2%</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>14.2%</td>
</tr>
<tr>
<td>West Virginia</td>
<td>13.5%</td>
</tr>
<tr>
<td>Vermont</td>
<td>11.8%</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>11.0%</td>
</tr>
<tr>
<td>Indiana</td>
<td>10.6%</td>
</tr>
<tr>
<td>Connecticut</td>
<td>10.3%</td>
</tr>
<tr>
<td>New Jersey</td>
<td>9.8%</td>
</tr>
<tr>
<td>Kansas</td>
<td>9.7%</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>9.7%</td>
</tr>
<tr>
<td>Wyoming</td>
<td>9.6%</td>
</tr>
<tr>
<td>North Dakota</td>
<td>9.5%</td>
</tr>
<tr>
<td>Illinois</td>
<td>9.4%</td>
</tr>
<tr>
<td>New York</td>
<td>8.8%</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>7.6%</td>
</tr>
<tr>
<td>South Carolina</td>
<td>7.6%</td>
</tr>
<tr>
<td>Washington</td>
<td>7.5%</td>
</tr>
<tr>
<td>Oregon</td>
<td>7.1%</td>
</tr>
<tr>
<td>Tennessee</td>
<td>6.9%</td>
</tr>
<tr>
<td>Colorado</td>
<td>6.7%</td>
</tr>
<tr>
<td>Maryland</td>
<td>6.7%</td>
</tr>
<tr>
<td>Utah</td>
<td>6.7%</td>
</tr>
<tr>
<td>Hawaii</td>
<td>6.5%</td>
</tr>
<tr>
<td>Virginia</td>
<td>6.5%</td>
</tr>
</tbody>
</table>

CHILD CARE SUBSIDIES

Child care subsidies are an effective state strategy to impact:

- Access to Needed Services
- Parents’ Ability to Work
- Sufficient Household Resources
- Healthy and Equitable Births

CHILDMORES

provide financial assistance to help make child care more affordable for low-income families with parents who are working or enrolled in education or training programs.

State leaders in this strategy provide high reimbursement rates that meet the providers’ true cost of care, require low family copays, have a low family share of the total cost of child care, and/or expand income eligibility thresholds.

State leaders:

CA  LA  MI  NM  OR
How Do Child Care Subsidies Start Impact PN-3 Outcomes?

- Higher state subsidy spending per child (of $1,000) led to 86% higher odds of enrollment in a single center-based care arrangement, rather than multiple care arrangements (B)

- A 10% increase in Child Care Development Fund subsidy expenditures led to a 0.7% increase in mothers’ employment rate (A)

- $1,000 higher annual state subsidy spending per child led to a 3.5 percentage point increase in the likelihood of maternal employment (D)

- Subsidy receipt led to an increase in monthly earnings by 250% (E)
Variation Across States in Household Income Eligibility for Child Care Subsidies as a Percentage of State Median Income

Federal Maximum Income Limit for Eligibility is 85% SMI

<table>
<thead>
<tr>
<th>State</th>
<th>Income Eligibility Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Mexico</td>
<td>140%</td>
</tr>
<tr>
<td>South Carolina</td>
<td>102%</td>
</tr>
<tr>
<td>California</td>
<td>99%</td>
</tr>
<tr>
<td>Tennessee</td>
<td>90%</td>
</tr>
<tr>
<td>Nevada</td>
<td>89%</td>
</tr>
<tr>
<td>Mississippi</td>
<td>88%</td>
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<tr>
<td>Oklahoma</td>
<td>88%</td>
</tr>
<tr>
<td>Utah</td>
<td>88%</td>
</tr>
<tr>
<td>Arkansas</td>
<td>85%</td>
</tr>
<tr>
<td>Maine</td>
<td>85%</td>
</tr>
<tr>
<td>Alaska</td>
<td>82%</td>
</tr>
<tr>
<td>Vermont</td>
<td>82%</td>
</tr>
<tr>
<td>Hawaii</td>
<td>80%</td>
</tr>
<tr>
<td>Kansas</td>
<td>75%</td>
</tr>
<tr>
<td>Kentucky</td>
<td>67%</td>
</tr>
<tr>
<td>South Dakota</td>
<td>66%</td>
</tr>
<tr>
<td>Louisiana</td>
<td>65%</td>
</tr>
<tr>
<td>North Carolina</td>
<td>65%</td>
</tr>
<tr>
<td>Texas</td>
<td>64%</td>
</tr>
<tr>
<td>Connecticut</td>
<td>62%</td>
</tr>
<tr>
<td>North Dakota</td>
<td>62%</td>
</tr>
<tr>
<td>Virginia</td>
<td>62%</td>
</tr>
<tr>
<td>Colorado</td>
<td>61%</td>
</tr>
<tr>
<td>Maryland</td>
<td>60%</td>
</tr>
<tr>
<td>Washington</td>
<td>60%</td>
</tr>
</tbody>
</table>

# Variation Across States in the Distribution of the Total Cost of Child Care

## Out of Pocket Expenses

<table>
<thead>
<tr>
<th>State's Contribution (Paid to Provider)</th>
<th>Family Copayment Fee</th>
<th>Additional Fees Paid by Family (Paid to Provider)</th>
<th>Unreimbursed Costs (Absorbed by Provider)</th>
<th>Total Cost of Care (75th Percentile)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Base Reimbursement Rate</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alabama</td>
<td>$502</td>
<td>$180</td>
<td>$1,240</td>
<td>$4,845</td>
</tr>
<tr>
<td>Alaska</td>
<td>$1,165</td>
<td>$375</td>
<td>$350</td>
<td>$3,584</td>
</tr>
<tr>
<td>Arizona</td>
<td>$1,197</td>
<td>$392</td>
<td>$1,342</td>
<td>$4,931</td>
</tr>
<tr>
<td>Arkansas</td>
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Sources: As of September 6, 2022. Personal communication with state CCDF administrators and other staff overseeing the state's child care subsidy programs, state agency websites, state CCDF plans, and state market rate surveys. When additional fee data could not be verified, data were pulled from the National Women's Law Center (as of February 2019).
How do the effective policies interact to determine the level of household resources families have available to provide for their children?

• Assumptions for the simulation
  • Single mother family, with an infant and toddler
  • She works full time, full year at the state’s minimum wage
  • She leaves her children in center-based child care, that charges the 75th percentile of the market rate
As of December 31, 2021. State labor statutes; US Department of Health and Human Services; US Department of Housing and Urban Development; Kaiser Family Foundation; Urban Institute; National Women's Law Center; USDA Food and Nutrition Service; Center on Budget and Policy Priorities; Internal Revenue Service; State income tax statutes and websites; Tax Credits for Workers and Families; Personal communication with state CCDF Administrators and other staff overseeing the state's child care subsidy programs; State children and families department websites; state CCDF plans; and the State Market Rate Surveys. Federal benefits do not include the temporary federal Child Tax Credit or Child and Dependent Care Tax Credit.
Total Resources Based on State Policy Choices
Minimum Wage Earnings (Less Out of Pocket Child Care Expenses)

DISTRICT OF COLUMBIA
- $10,000

MARYLAND
- $10,000

VIRGINIA
- $10,000

Child Care Cost (Annual Copay) | Child Care Cost (Annual Addl Fee) | Earned Income
Total Resources Based on State Policy Choices
Minimum Wage Earnings (Less Out of Pocket Child Care Expenses) Plus Federal and State Benefits

DISTRICT OF COLUMBIA

- $10,000

MARYLAND

- $10,000

VIRGINIA

- $10,000
To the extent possible, data reflect state policies as of October 1, 2022. All earnings, benefits (both federal and state), and child care costs are based on a family of three comprised of a single parent working a full-time, minimum wage job with two children in full-time, center-based child care (an infant and a toddler).
To the extent possible, data reflect state policies as of October 1, 2022. All earnings, benefits (both federal and state), and child care costs are based on a family of three comprised of a single parent working a full-time, minimum wage job with two children in full-time, center-based child care (an infant and a toddler).

State has expanded Medicaid and implemented a 6-week+ paid family leave (PFL) program

State has expanded Medicaid, but not adopted a 6-week+ PFL program

Nonexpansion state + no 6-week+ PFL program
Summary

• The prenatal-to-3 period of development sets the stage for lifelong health and wellbeing

• Many children lack the opportunities and rights they deserve for a healthy start, and these children are disproportionately children of color

• State policy choices can reduce family stressors and increase capacities, which have substantial impacts on health and wellbeing over the life course