Child Care Bureau

State Child Care Subsidies: Trends in Rate Ceilings and Family Fees

A CCDF Issue Brief

May 2005

State CCDF Plans

This **Child Care and Development Fund Issue Brief** *examines State child care provider reimbursement rate ceilings and family fees as detailed in the* **Child Care and Development Fund (CCDF) Plans for FY 2004-2005** *of the 50 States, the District of Columbia, and Puerto Rico. The State CCDF Plans for FY 2004-2005 became effective October 1, 2003, and may be amended as policies or initiatives change.*

A Shared Responsibility: Subsidy Reimbursements and Family Fees

The Child Care and Development Fund (CCDF) provides $4.8 billion in formula grants to States, Territories, and Tribes to subsidize the cost of child care for low-income families. As authorized in the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, eligible families must meet certain income requirements and must need child care so they can work or participate in approved training or education. CCDF Lead Agencies issue vouchers to families who may select any legally operating provider participating in the subsidy program to care for their children. States establish a maximum rate up to which they will reimburse providers for the cost of authorized child care. CCDF subsidizes the cost of care up to this reimbursement rate ceiling; and families typically share the responsibility for child care costs by paying a copayment fee (or "copay") directly to their provider according to a sliding fee scale established by the State. States may waive copays for some families. In Fiscal Year 2003, the median family copay nationally was $38 per month. Reimbursement rates and family copays are among the policy levers States have at their disposal in determining how many families they can serve with available funds.

FY 2002–FY 2004 FAST FACTS...

- Twenty-three States showed no increase in parent copayment levels for a typical family, but in 17 States, copays rose by a median increase of 20 percent.
- Two-thirds of States examined showed no change in reimbursement rate ceilings for centers in the largest urban areas.
- Between 20 and 25 percent of States increased rate ceilings for infant, toddler, and preschool care.

Copayments: The Family's Share

PRWORA and accompanying Federal rules require States to establish a sliding fee scale, which is used to determine each family's contribution to the cost of child care purchased through the child care subsidy program.[1] The sliding fee or copay must vary based on income and the size of the family. States balance parent copays, income eligibility levels,[2] and provider reimbursement rates against available funding and the number of families to be served.

How States Determine Copayment Levels

States determine copays differently, but all base copayment levels on family income and family size. As indicated in CCDF Plans for FY 2004-2005, 43 States (83 percent) established copay levels primarily based on a percentage of family income, slightly more than in State CCDF Plans for FY 2002-2003 (39 States or 78 percent). Nine States express copays as a percentage of the price of care or of the State's child care reimbursement rate ceiling, a slight drop from 11 States in the CCDF Plans for FY 2002-2003.

Half of the States (25) reported using other factors in addition to family size and family income to determine family copay levels in FY 2004-2005. Eighteen States reported charging an additional copay when more than one child from a family is receiving subsidized child care, and 13 States reported assessing lower copays for part-time care.

Changes in State Copayment Levels

The variety of factors States use when establishing copay schedules presents a challenge for any comparative analysis of change in copay levels. To determine the extent to which State policies changed, copays required of a typical working family of three, with income at 125 percent of the Federal Poverty Level (FPL), were determined using sliding fee schedules submitted with the States' FY 2002-2003 and FY 2004-2005 CCDF Plans. Using this approach, the authors were able to identify copay amounts in 46 States for both periods.[3]

In 23 States—half of the States examined—the copay amounts showed essentially no change from FY 2002-2003 to FY 2004-2005, either staying at the same amount or at the same percentage of income or price.[4] This analysis revealed another 23 States did make changes to copayment policies that affected the amounts families owed. In 17 of those States (37 percent of the 46 States examined), the sample family faced higher copays, with a median increase of 20 percent; however, in six States (13 percent of all those examined), lower copays were assessed in FY 2004-2005 than in FY 2002-2003, and the median decrease was 32 percent.

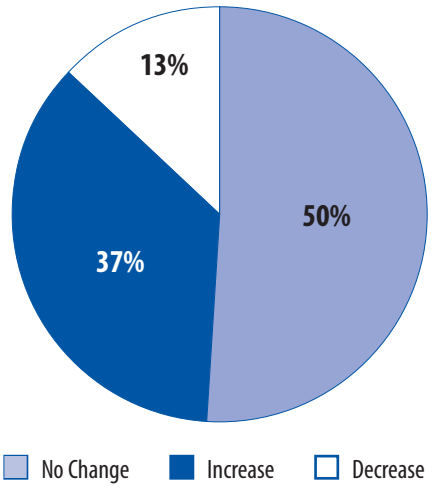
State Policies for Waiving Copays

Increasingly States are waiving copays, usually for targeted populations such as families receiving Temporary Assistance for Needy Families (TANF) assistance or families receiving protective or preventive services.[5] In FY 2004-2005, 39 States (75 percent) reported waiving copays for some families with incomes at or below the poverty level, up from 33 (66 percent) reporting in FY 2002-2003 CCDF Plans. A significantly higher number of States waived fees for families with open TANF cases, increasing from 14 in FY 2002-2003 to 24 in FY 2004-2005. Similarly, many more States waived fees for families receiving protective services, up from four States in FY 2002-2003 to 16 States in FY 2004-2005. Despite these changes, State use of copay waivers for *all* families with incomes at or below poverty dropped only slightly from 12 States to 11 States. The number of States requiring all families to pay a fee dropped from five in FY 2002-2003 to two in FY 2004-2005.

State Policies Prohibiting Providers from Charging Families Additional Fees

States have the flexibility to decide whether providers receiving subsidy payments are prohibited from charging fees, in addition to the copays set by the State, for any unsubsidized portion of the provider's normal fees. Such a prohibition helps protect families from facing additional costs for care; however, if State reimbursement rates—plus family copayment fees—do not cover providers' costs, a prohibition on additional fees can have a financial impact on providers, potentially discouraging them from accepting families funded through CCDF subsidies. In FY 2004-2005 CCDF Plans, 17 States reported that they prohibit child care providers from charging families for any unsubsidized portion of the providers' normal fees, up slightly from 14 States reporting in FY 2002-2003 CCDF Plans.

Change in Copayment Levels for Families of Three with Incomes at 125% of Federal Poverty Level, FY 2002–FY 2004



Source: State Child Care and Development Fund Plans for FY 2002-2003 and FY 2004-2005

Subsidy Reimbursement Rate Ceilings

How much a provider receives in reimbursement for authorized child care services provided through CCDF is based in large part on the rate schedule set by each State. Typically, these rate schedules outline the maximum reimbursement rate, which varies by age of child and type of care setting. CCDF rules require that subsidy rates must be sufficient "to ensure equal access" to child care services comparable to those available to families not eligible to receive child care assistance.[6] CCDF funds typically cannot be used to pay more for services than providers charge the general public. States may set higher differential rates for care that is higher in quality, harder to find, and/or more expensive to provide. In such circumstances, States may pay providers more than their usual and customary charges as an incentive for quality or hard-to-find care.

How States Establish Reimbursement Ceilings: Market Rate Surveys and Available Resources

A Market Rate Survey (MRS) is a tool States use to help set rate ceilings that ensure equal access. States must conduct a local MRS every two years and must use its results to inform the rate structures they establish.[7] States establish maximum rates in the context of policy choices involving eligibility and family copayments, as well as amid competition for finite public resources.

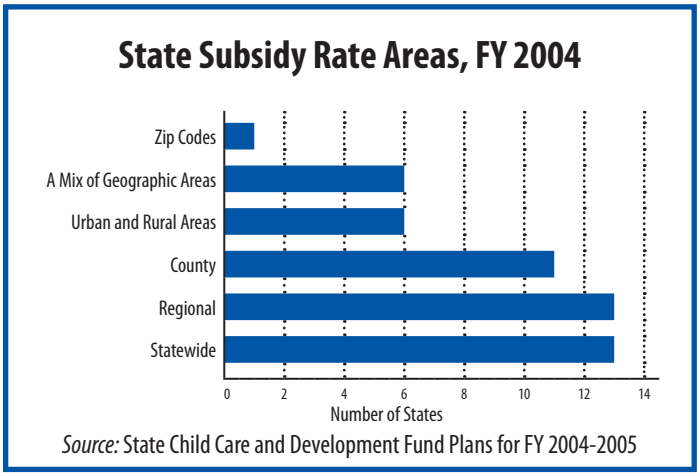
In most States, the MRS is conducted every two years as required, but two States reported doing so annually. Usually, there is a brief lag between the date of the MRS and the implementation of revised rate ceilings; however, in some States implementation of revised reimbursement rate ceilings, a process that may involve legislative action, can take more than a year to complete. In FY 2004-2005 CCDF Plans, 23 States submitted rate schedules that

predated the State's most recent MRS, up from 13 States in FY 2002-2003. Of course, if resources are not sufficient or if survey results do not suggest change is needed, States may leave in place the existing rate structure, which then would predate the MRS. In the FY 2004-2005 CCDF Plans, several States explained that fiscal pressures and other policy options such as closing intake or increasing copays, weighed against increasing rates; however, in other cases, States determined the MRS results did not warrant adjusting rate ceilings.

In the preamble to the CCDF Final Rule, the Child Care Bureau, Administration for Children and Families, U.S. Department of Health and Human Services suggested that payment rates set at or above the 75th percentile of the MRS would be one way States could demonstrate equal access for subsidized families.[8] At the 75th percentile, the rate cap would equal or exceed the rates charged for 75 percent of the care in the market.[9] In FY 2004-2005 CCDF Plans, 23 States—down from 27 in FY 2002-2003 CCDF Plans—indicated that they cap reimbursement rates at the 75th percentile of an MRS or higher. Eight of these States noted that rates were established at the 75th percentile of a prior year MRS.

Rate Units and Rate Areas

States reimburse providers using different units of service—hourly, daily, weekly, and/or monthly. Nearly two-thirds of States (31) use part-time as well as full-time units of service, whether accounting for service delivery on an hourly, daily, weekly, or monthly basis. Seventeen States use a combination of hourly, daily, weekly, and/or monthly units of service, while 12 States reported rate ceilings in daily service units. Fewer than 10 States reported rate ceilings in weekly or monthly service units.



Source: State Child Care and Development Fund Plans for FY 2004-2005

When establishing reimbursement rate ceilings, States are permitted to define the geographical outlines of the market within which rates are grouped and for which the rate ceiling is established. About one-quarter of the States (13) establish Statewide rate structures, and another quarter (13) use regional rates. Other rate areas used include county-level and rural/urban. In determining whether rates will apply uniformly Statewide or vary by county, region, or other area, States balance multiple factors (demographic, economic, and fiscal).

Rates for Informal Care

Many Lead Agencies reported that it is difficult to conduct an accurate Market Rate Survey among informal, unregulated child care providers. Instead, 13 States indicated they index informal care rate ceilings to their regulated family child care rates—at between 50 percent and 100 percent of the family child care rate—or index them to minimum wage standards.

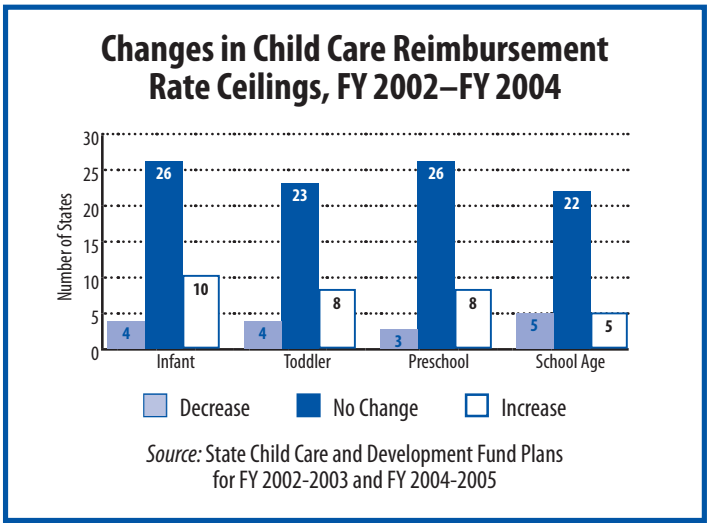
Differential Rates

Thirty States reported setting higher rate ceilings for care that is more difficult to find or more expensive to provide. Typically, such "differential rates" apply for care for children with special needs (18 States); care provided during nontraditional hours or on weekends (9 States); and care that meets higher standards of quality than those included in basic licensing requirements (19 States).

Changes in State Reimbursement Rate Ceilings

Reimbursement rate ceilings vary depending on the age of the child, the care-setting, county or other rate region, as well as tier level in a Statewide tiered reimbursement system. As a result, States typically do not have a single rate, but may have hundreds of separate rate caps. In this analysis, reimbursement ceilings for center-based child care in the largest urban area in each State were compared as submitted with FY 2002-2003 and FY 2004-2005 CCDF Plans. For States with tiered reimbursement schedules, which pay a higher rate for higher quality care, the base rate was used.[10]

For most States, reimbursement rate ceilings remained constant from FY 2002-2003 to FY 2004-2005. In each age range, about two-thirds of the States examined showed no change in the maximum rate. Between 20 percent and 25 percent of States increased rate ceilings for infant (10 States), toddler (8), and preschool (8) care. Fewer than 15 percent of States decreased rate ceilings for infant (4), toddler (4), and preschool (3) care. Maximum rates for school-age child care rose and fell in an equal number of States (5). Among those States for which comparisons could be made, more States—nearly twice as many—raised rate ceilings than lowered them for infant, toddler, and preschool care.[11]



Source: State Child Care and Development Fund Plans for FY 2002-2003 and FY 2004-2005

Conclusion

Changes in child care copayment levels and rate ceilings suggest a mixed response to the competing fiscal demands facing many States in recent years. Most States showed no change in their sliding fee scales, but those States that did change copays tended to increase the portion of costs borne by families. Most States also did not show a change in reimbursement rate ceilings; however, nearly twice as many States examined *increased* center-based maximum rates for all ages (except school-age care). Rate ceilings decreased in approximately 10 percent of States, reducing the share of costs reimbursed by those States.

Endnotes

[1] The statute at Section 658E(c)(5) specifies that families are required to share in the cost of subsidized child care. The CCDF Final Rule, 45 CFR Parts 98 and 99, was promulgated in the *Federal Register*, July 24, 1998; §98.42 addresses the sliding fee scale requirement.

[2] Additional information concerning income eligibility limits is in the tandem *CCDF Issue Brief,* "Trends in State Eligibility Policies" (July 2004), by NCCIC for the Child Care Bureau, Administration for Children and Families, U.S. Department of Health and Human Services, which is available online at *http://nccic.org/pubs/issuebriefs/trendseligibility.html*. The NCCIC Web site features additional information regarding CCDF Plans at *http://nccic.org/pubs/stateplan/stateplan-intro.html.*

[3] To address specific factors in copay schedules, the authors assumed that the sample family had one 4-year-old child receiving a child care subsidy for authorized care provided in a child care center only. Federal Poverty Level for a family of three was $14,630 in 2001 and $15,260 in 2003, and slightly more in Alaska and Hawaii in both years. *The CCDF Data Summary, Child Care Assistance Family Copayment Policies, Family of Three, 2003* (July 2004), by NCCIC for the Child Care Bureau, Administration for Children and Families, U.S. Department of Health and Human Services, provides data for all 50 States, Territories, and the District of Columbia, and is available online at *http://nccic.org/pubs/datasum/ccassistcopay.html.*

[4] This analysis examined changes in the estimated amount a typical working family would pay, not changes in the copayment policy itself. States may have changed copay schedules—for example, by altering income levels for other than a family of three with an income at 125% of Federal Poverty Level (FPL)—and that change would not be reflected in this analysis. Where the percent change in copay amount for the typical family was equal to the percentage change in the income amount associated with 125% of FPL, we concluded that no substantive change in policy had occurred. In actuality, the copay amount did increase, not as a result of change in State policies, but because of the annual adjustments in FPL.

[5] The CCDF Final Rule permits States to waive fees for families with incomes at or below the poverty level (§98.42(c)) and, on a case by case basis, to waive the fee and income eligibility requirements in cases of children in or needing protective services (§98.20).

[6] CCDF Final Rule §98.43.

[7] For more information on Market Rate Surveys, see *Conducting Market Rate Surveys and Establishing Rate Policies* (July 2001), by NCCIC for the Child Care Bureau, Administration for Children and Families, U.S. Department of Health and Human Services. It is available on NCCIC's Web site at *http://nccic.org/pubs/conductmrs-erp.html.*

[8] CCDF Final Rule §98.43.

[9] Most States reported that they believe rates established at the 75th percentile of the Market Rate Survey ensure that families who receive child care assistance have equal access to comparable services provided to children or private-paying parents. Some States also pointed to the extent to which providers agree to accept payment through the subsidy voucher or certificate as an indication of reasonable access to the range of child care services available.

[10] Anomalies in the child care market mean that these rate ceilings may not always be the highest rates paid within each State; moreover, evaluating changes in rates is a complex matter that should consider changes in income eligibility limits and copayment levels.

[11] The change in rate ceilings within each age range was calculated only for those States whose rate schedules included comparable data in both the FY 2002-2003 and FY 2004-2005 State CCDF Plans. For example, if a State changed the definition of infant or added a distinct toddler rate in place of an infant/toddler rate, the State's rates for that age range were not included in our calculations. Similarly, when rate tables expressed rates in different units (e.g., days rather than weeks), those rates were excluded from our calculations for that age range. Complete data for both years were not available for all States for all age ranges.

About this Brief

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10530 Rosehaven St., Suite 400, Fairfax, VA 22030 • Voice: 800-616-2242 • TTY: 800-516-2242 • Fax: 800-716-2242
E-mail: *info@nccic.org* • Web: *http://nccic.org*

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