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Beyond the Pandemic: State Policy Options for Supporting Families

November 2020

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Child & Family Research Partnership
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Beyond the Pandemic: State Policy Options for Supporting Families

RESEARCH BRIEF

B.002.1120 | November 2020

SUMMARY

The temporary changes that state and federal governments have made in response to COVID-19 provide opportunities to learn more about the positive impacts state policy changes can have on young children and their families.

- States have made **access to public health insurance easier and more affordable** through changes to Medicaid policy.
- Recent **expansions to telehealth access and coverage can make it easier for families to access needed health care**, but it will be important to address inequities in technology, especially in rural communities.
- Temporary paid sick leave mandates at the state and federal level can **ensure equitable access to paid sick leave, job protections, and improved public health**.
- Federal emergency paid family leave has supported parents in caring for children during the pandemic, and **states can implement their own paid family leave programs to positively impact child and family outcomes**.
- States have made it easier for families to access and keep their SNAP benefits during the pandemic, and **reductions in administrative burden can boost SNAP participation and reduce family food insecurity**.
- Federal funding allowed states flexibility to modify child care subsidy policies to offer additional assistance to families and providers, and **ongoing flexibility and state funding can support child care providers and families facing uncertainty and challenges post-pandemic**.

Introduction

The COVID-19 pandemic has created numerous challenges for families, particularly those with young children and families of color. Loss of employment has led to the loss of employer-sponsored health insurance, economic insecurity, and food insecurity. Working parents have had to juggle child care, schooling, and care for themselves and their families. In an effort to support families through the crisis, state and federal governments have implemented changes to existing programs to ensure access to needed services; however, many of these temporary changes are slated to expire in the coming months.

Rigorous research conducted prior to the pandemic has shown that many of the policy changes spurred by COVID-19 can positively impact child and family wellbeing, and this brief highlights several examples of COVID-19 policy responses that have created more flexibility and support for existing evidence-based state policies and strategies. States may consider maintaining these changes beyond the pandemic to improve outcomes for infants, toddlers, and their parents.

Medicaid

COVID-19 Highlights the Responsiveness of Medicaid

The public health emergency of COVID-19 and the subsequent economic downturn has revealed the possibilities and strength of Medicaid. Prior to the pandemic, the federal Patient Protection and Affordable Care Act (also known as the ACA) provided subsidies to purchase health insurance in the online marketplace and expanded Medicaid eligibility for most adults with incomes up to 138 percent of the federal poverty level (FPL). To date, 37 states[i,ii] have expanded Medicaid coverage to most adults with incomes up to 138 percent of the FPL.[1]

Job loss and individuals leaving the labor force have resulted in some workers losing employer-based health coverage. Fortunately, health insurance coverage seemed to not drop off dramatically as a result of the dual crises of COVID-19 and unemployment. Recent research shows an 8.0 percentage point reduction in employer-sponsored health insurance between March/April and September of this year. Approximately 3 million individuals lost job-based insurance in those six months.[2] However, this reduction appears to be offset by a 4.0 percentage point increase in Medicaid and Children's Health Insurance Program (CHIP) enrollment and a 3.2 percentage point increase in private nongroup

[i] Nebraska passed a ballot initiative in 2018 to expand Medicaid. Enrollment began in August 2020 and coverage began in October 2020. Oklahoma and Missouri have enacted but not yet implemented Medicaid expansion.

[ii] State counts in this brief include the District of Columbia, unless otherwise noted.

coverage through the ACA marketplace. Importantly, the estimated rate of those without insurance was not significantly statistically different between March/April and September 2020.[3]

States Have Varied Medicaid Approaches to Respond to COVID-19

The robust response of Medicaid in 2020 is likely attributable to a blend of state and federal Medicaid policy actions to react to COVID-19. Due to the public health emergency declaration[4] and the Stafford Act Emergency Declaration[5] issued by President Trump, the federal Health and Human Services (HHS) department has permitted several pathways for states to implement new Medicaid policies.[6] To address the increase in individuals relying on Medicaid due to the economic downturn, states can take advantage of disaster-related state plan amendments (SPAs) as well as administrative actions separately from the federal government.[7,8]

The Families First Coronavirus Response Act (FFCRA) also made critical changes to assist states with the increase in Medicaid enrollment. The law provided states with a temporary 6.2 percentage point increase in the regular federal matching rate for the emergency period or the Federal Medical Assistance Percentage (FMAP).[iii,9] States can receive this FMAP increase by complying with Maintenance of Effort (MOE) requirements that include: States cannot make eligibility standards more restrictive, cannot adopt new or increased premiums on any beneficiary, cannot disenroll any individuals unless the individual is no longer a resident of the state or requests termination, and must cover cost-sharing, testing services, and treatment for COVID-19.[10,11]

Many Medicaid emergency authorities have been enacted to address the COVID-19 pandemic. For example, 8 states have implemented less restrictive income and resource requirements for benefit eligibility and/or have increased benefits for enrollees. Other policy provisions include eliminating copays (20 states), eliminating or waiving premiums (20 states), and adjusting or increasing existing benefits (22 states).[12]

Additional authorities would make it easier for individuals to enroll in Medicaid. For instance, 18 states have adopted self-attestation (proclaiming one's eligibility category on certain income and non-income documentation to prove eligibility), and 3 states adopted simplified applications. Finally, 6 states have opted to provide continuous eligibility for children for up to 12 months.[13,14]

Although temporary and outside of the scope of the Prenatal-to-3 Policy Impact Center's previous research review, these COVID-19 related Medicaid changes are important to ensure coverage of uninsured individuals. Most immediately, the public health emergency

[iii] The FMAP is the rate at which the federal government matches state spending on services for Medicaid beneficiaries.

provided necessary money to state Medicaid programs. The additional revenue and flexibility could be an opportunity for states to experiment with more accessible and affordable health insurance options through Medicaid.[15]

For states to continue providing health insurance for residents, renewed federal funding would offset the growth in Medicaid enrollment, particularly as states face budgetary constraints due the economic recession. If the public health emergency is terminated, the Medicaid SPA flexibilities would end on January 20, 2021, the continuous coverage requirement would end on January 31, 2021, and the MOE provisions would end on March 31, 2021.[16]

Rigorous Research Links State Medicaid Expansion to Better Health and Financial Outcomes

The termination of some Medicaid benefits following the end of the public health emergency will reduce access and coverage for individuals; however, the gaps in health insurance will likely be most pronounced in states that have not expanded Medicaid. Expansion and nonexpansion states differ in myriad ways, including different income thresholds, benefit comprehensiveness, and inclusion or exclusion of noncitizens. Recent research found that both expansion and nonexpansion states can expand their Medicaid programs by revisiting eligibility, enrollment, and benefit levels.[17]

Rigorous research has identified the expansion of Medicaid eligibility as a key strategy to increase health care coverage[18] and found a positive correlation between health insurance enrollment and health care use.[19] Much attention has been focused on studying the impact of state Medicaid expansion before and after implementation. State Medicaid expansion is associated with fewer issues paying medical bills and in delaying health care due to cost, as well as increases in credit scores, less debt sent to collections, fewer evictions, and a reduction in the number of payday loans.[20]

The impact of expanded income eligibility for health insurance extends beyond economic security. Rigorous research findings point to Medicaid expansion reducing maternal deaths among Black and Hispanic mothers, indicating the potential of the policy to reduce racial disparities in adverse birth outcomes. Other findings show fewer Hispanic infant deaths in states that have expanded Medicaid compared to nonexpansion states.[21]

Pre-pandemic estimates projected that 4 million uninsured Americans would receive health insurance if Medicaid expansion were enacted across the country.[22] The evidence shows that state expansions of Medicaid, in addition to increasing access to affordable health insurance, positively impacts economic security, access to needed health services during the perinatal period and material wellbeing outcomes, and birth outcomes for some groups.[23]

Perinatal Telehealth Services

COVID-19 Has Ushered in a Shift Toward Telehealth; Four Times More Patients Are Now Using Telehealth to Access Some of Their Care Than Before the Pandemic

One of the biggest changes to occur in the health care field in the wake of COVID-19 has been a significant shift from in-person care to telehealth — the remote or virtual delivery of patient services. The need to stay home to prevent the spread of the coronavirus has meant that many families have opted to see their doctors, dentists, and mental health providers through a screen or consult via telephone instead of in the office, when offered these alternatives. A May 2020 report by McKinsey & Company noted that telehealth use jumped from reaching 11 percent of US consumers before COVID-19 to 46 percent of consumers in the first few months of the pandemic.[24]

Federal and State Policies Have Broadened Medicare and Medicaid Coverage of Telehealth

Given the constraints preventing travel and in-person care, federal and state telehealth policies have adapted quickly to allow for greater flexibility to bring telehealth access to more people who need it.[25] In addition to federal measures broadening telehealth eligibility and coverage for the Medicare program, which generally serves individuals ages 65 and older, changes to the Medicaid program have impacted low-income families with children, including in the prenatal-to-3 period. For example, according to a June 2020 report by Mathematica,[26] 44 states[iv] responded to the crisis by expanding the kinds of health care services eligible for telehealth delivery in the Medicaid program, and 49 states/territories newly allowed for audio-only or text-based delivery of services in addition to video. A total of 32 states also allowed new kinds of providers to deliver telehealth services covered by Medicaid (for example, behavioral health and dental providers).

A recent scan by the Urban Institute identified a number of innovative telehealth practices that individual states have put in place to increase access during the pandemic.[27] For example, New Jersey newly allowed telehealth to provide doula support, home visiting, and Early Intervention services, and the Massachusetts Medicaid program contracted with a digital health provider, Maven, to provide maternity services and other health care to women and children during the pandemic. In addition, the University of Pennsylvania developed a tool called “Pregnancy Watch” which sends text messages to pregnant and newly postpartum women who may have symptoms of COVID-19 to ensure they receive proper care.

[iv] The Mathematica report cited here also included the Virgin Islands and Puerto Rico in its review.

Evidence Suggests That Telehealth Is Effective for Delivering Positive Clinical Outcomes, Including in the Perinatal Period

Surveys indicate that satisfaction with telehealth services during the COVID-19 era has been high, and many patients hope to continue virtual medical visits in the future and find them convenient.[28] Importantly, evidence from rigorous studies supports the use of telehealth as a mode of delivering health care to patients during the perinatal period, with multiple studies showing clinical outcomes equivalent to, and sometimes better than, in-person care — especially for low-risk pregnancies.

For example, a randomized trial of a reduced-visit prenatal care model ("OB Nest") that substituted phone and online contact for some of the usual office visits found that patients were more satisfied and less stressed than participants in the control group, and the groups experienced no differences in the perceived quality of care, the likelihood of receiving all necessary screenings and vaccines, or in clinical outcomes (preterm births and low birthweight).[29] In another study, a nursing intervention delivered via telephone to pregnant women at risk for preterm and low birthweight (in addition to regular prenatal care) was found to be beneficial for Black women: The participants saw a 26 percent reduction in low birthweight and a 27 percent reduction in preterm births when compared to the control group, who did not receive the additional nursing contact.[30]

These studies show that for low-risk pregnancies, telehealth contact may safely substitute for some in-person visits, and in cases of higher-risk pregnancies, telehealth *enhancements* to traditional care may improve clinical outcomes for mothers and infants without requiring mothers to travel to additional in-person visits.

For infants and toddlers, the American Academy of Pediatrics (AAP) supports telehealth as a means to assess young children's health and development when in-person visits are not feasible for health or safety reasons, but the AAP advises that "well-child care should occur in person whenever possible" given the importance of early screenings and vaccinations in ensuring healthy development.[31]

States and the Federal Government Can Support Families by Maintaining Recent Expansions to Telehealth Access, but Will Need to Address Inequities in Technology

Many states' new telehealth policies implemented as a response to COVID-19 are intended to be temporary and are facing impending expiration dates. However, given the evidence that telehealth can be just as effective as in-person care for certain populations, states may consider making some of the more flexible policies permanent measures. These changes may be especially beneficial for communities in rural areas, who often have less access to specialized health care. The federal government currently considers 80 percent of rural areas in the US to be "medically underserved" because of a dearth of providers relative to

need, and the number of providers in rural areas is expected to decline further as rural doctors, who are on average older than urban doctors, retire.[32] In 2019, for example, 121 out of 254 counties in Texas had no medical specialists, and 35 counties had no physicians at all.[33] According to a report by the US Centers for Medicare and Medicaid Services, less than 50 percent of women living in rural areas can reach perinatal care within a 30-mile drive from home.[34]

Patients can only benefit from telehealth, however, if they have the necessary equipment and Internet access at home; according to the Federal Communications Commission, over 24 million Americans and 31 percent of rural households[35] may lack access to the Internet at home — and other surveys put the figure as high as 42 million Americans.[36] Increasing Medicaid coverage for telehealth services in the prenatal-to-3 period may be one way to boost access to needed care and improve outcomes for these populations even after the COVID-19 crisis has become less acute. To have the greatest impact, these policies should be implemented alongside efforts to increase Internet access to ensure equity between rural and urban communities.

Paid Sick Leave

Temporary Paid Sick Leave Mandates Enacted at the State and Federal Level Allow Workers to Quarantine and Care for Their Children While Preventing the Spread of COVID-19

The recent effects of COVID-19 highlight the importance of staying home when sick to prevent the transmission of illnesses. However, approximately 24 percent of workers in the United States lacked access to paid sick leave in 2019, according to the Bureau of Labor Statistics.[37] A few states have enacted temporary emergency paid sick leave policies to improve public health and stop the spread of the virus.[38] The state policies vary from 4 to 14 paid days to allow employees to quarantine or to take care of a dependent child.

New York's policy applies to workers in all industries, and it is set to become a permanent policy in January 2021.[39] California and Colorado have passed temporary policies that focus on workers in industries most at risk for spreading the virus, such as grocery store workers, food delivery workers, and those in child care and home health care.[40] Additionally, the federal FFCRA temporarily mandates up to 2 weeks paid time off at the employee's regular rate of pay for workers who must quarantine due to COVID-19. The FFCRA gives a tax credit to employers to offset the costs of providing paid sick leave. This act is set to expire December 31, 2020.[41]

Current Statewide Legislation Improves Access to Paid Sick Leave for Workers in Certain Industries and for Hispanic Workers, Who Have the Least Access

Currently, 14 states have enacted permanent legislation to require employers to provide paid sick leave to ensure more equitable access to leave-taking.[42] The rate of accrual varies,

but most states require a minimum of 1 hour of sick leave earned per 30 hours worked – approximately 1 hour per week. Most state mandates cover all employees working in the state, though many have exemptions for small businesses or specific industries such as nonprofit organizations.

Some groups of workers are less likely to have paid sick leave access. Workers in the occupations of production, retail, construction, farming, and service[v] are the least likely to have access to paid sick leave.[43] Hispanic workers are overrepresented in these occupations, and are the ethnic group least likely to have paid sick leave – only 46 percent.[44,45] Among other racial and ethnic groups, the gaps are smaller. For example, 62 percent of Black workers and 53 percent of American Indian or Alaskan Native workers have access to paid sick leave, compared with 63 percent of White workers.[46] Workers in the lower end of the wage distribution are the least likely to have access, and low-income households have less of a financial buffer when they must take unpaid time off work for well-visits or illness.[47]

Rigorous Research Shows Paid Sick Leave Policies Produce Positive Health and Work Outcomes for Workers, but Further Data Are Needed on the Outcomes for Younger Children Whose Parents Have Paid Sick Leave Access

Workers and their families are better off overall when employees have access to paid sick leave. State mandates have been found to increase access to leaving-taking without affecting workers' hours or wages.[48] Workers without paid sick leave may avoid taking time off even when sick if it means going without pay. Additionally, workers may fear job loss or negative performance reviews by employers for taking unpaid sick leave.

Several studies on state- and city-level sick leave policies found decreased rates of illness for workers after enactment of paid sick leave laws.[49] One 2020 study focusing on positive health externalities found that state paid sick leave mandates decreased influenza-like illness by 28 percent in the year after enactment.[50] A 2020 study on the effect of the emergency sick leave provision of the FFCRA found that states where workers newly gained access to paid sick leave saw a 56 percent decrease in COVID-19 cases post-FFCRA compared with states that already had access to paid sick leave.[51] Although more causal studies are needed on the impact on infant and toddler health given parental access to paid sick leave, the ability of working parents to take care of their children's health depends on workplace factors such as paid sick leave.

[v] "Service Occupations" includes workers in Food and Beverage Preparation (e.g., hostesses, bartenders, cooks), Health Service (e.g., home health aides, dental assistants), Cleaning and Building Service, and Personal Service (e.g., hairdressers, recreation attendants, child care workers)

Maintaining Paid Sick Leave Mandates During and After COVID-19 Will Help to Ensure Equitable Access and Improve Public Health

As evidenced by many states, employer-required paid sick leave policies are proven to decrease the rates of influenza-like illness.[52] In the age of COVID-19, a large sector of the working population is without access to paid sick leave. With the federal FFCRA protections set to expire in December, states may consider mandated paid sick leave as an avenue to create more equitable access and improve public health during and after the COVID-19 pandemic.

Paid Family Leave

The Federal Government Offered Emergency Paid Family Leave During the Crisis to Support Parents in Caring for Children

Momentum for passing paid family leave policies has strengthened as a result of the COVID-19 pandemic, which has put into sharp relief the difficulty many families face when trying to balance work and the care of children or other family members. In response to the crisis, the federal government passed the FFCRA in March 2020, which included provisions supporting emergency paid leave for many employees.[53] For example, the act provided "up to an additional 10 weeks of paid expanded family and medical leave at two-thirds the employee's regular rate of pay" for employees who had been with their employer for at least 30 days and had a child care need due to COVID-19 closures. This benefit was expanded to 12 weeks in the subsequent Coronavirus Aid, Relief, and Economic Security (CARES) Act.[54] The federal government will reimburse employers through payroll tax credits for each dollar spent on these benefits.

Access to Paid Family Leave Remains Unequal Across the Country; a Minority of States Have Policies Requiring Employers to Offer Paid Leave

Currently, only 10 states have passed statewide paid family leave programs, including California, Colorado, Connecticut, the District of Columbia, Massachusetts, New Jersey, New York, Oregon, Rhode Island, and Washington, and the leave ranges from 4 to 12 weeks.[55] Only 6 states, however, have begun implementing their programs and paying benefits.[vi] According to the most recent available data from the Leave Module of the American Time Use Survey, 50.5 percent of workers who are not self-employed reported that they had access to any paid family leave, regardless of state policy, whether through a formal family or medical leave benefit, or through other forms of paid time off, such as

[vi] California, DC, New Jersey, New York, Rhode Island, and Washington. Rhode Island offers 4 weeks, whereas the others offer 6 or more weeks. Evidence suggests a minimum of 6 weeks of paid leave can improve outcomes for children and families.

vacation days.[vii] In contrast, a minority of Americans in 2019 (19 percent) reported access to a paid family leave benefit specifically designed for the purpose of caring for a child or family member, and 89 percent reported access to *unpaid* family leave.[56]

Access to Paid Family Leave Positively Impacts a Variety of Family and Child Outcomes

A growing body of evidence demonstrates positive economic and health benefits for both parents and children when paid leave is available after a birth, adoption, or foster placement. Paid family leave policies, specifically those offering 6 weeks or more, have been shown in comprehensive evidence reviews[57] to increase women's labor force attachment, lower the risk of poverty, improve mothers' mental health, and increase the amount of time parents spend with children in their youngest years. In addition, children's health also benefits from paid family leave: Studies show that infants and toddlers are more likely to receive timely vaccinations, be breastfed for longer, and are less likely to suffer from a variety of health problems when they reach elementary school.

The research shows that when states support families' ability to take the time they need to care for new children, they are also investing in lasting economic, health, and social benefits. In the era of COVID-19, families are increasingly having to balance work, home-schooling, and caring for children and older loved ones, and paid family leave policies can promote better outcomes starting from the earliest years.

Reducing the Administrative Burden for SNAP

The Pandemic and Its Economic Effects Have Increased Food Insecurity, Especially for Families with Young Children

As the pandemic first swept the US in spring 2020, long lines formed not just at grocery stores, with consumers eager to stock up, but at food banks and pantries as well. The crisis and associated rise in unemployment have exacerbated food insecurity, especially among households with children. An April 2020 survey by the Brookings Institution's Hamilton Project found that over 20 percent of all households reported experiencing food insecurity, and among households with children under age 18, the figure was close to 35 percent (these families reported that at least once, "The food that we bought just didn't last, and we didn't have enough money to get more" or "The children in my household were not eating enough because we just couldn't afford more").[58] Among families with children under age 12, food insecurity was at 40.9 percent, showing just how dire the crisis has been for younger children.

[vii] Calculations were done by the Prenatal-to-3 Policy Impact Center.

Expansions to SNAP Benefits Have Been an Important Lifeline for Many Families During the Crisis

In response, the federal government provided some emergency relief through the Supplemental Nutrition Assistance Program (SNAP), previously known as "food stamps." Although the federal government pays 100 percent of SNAP benefits, the states and federal government share administrative costs, and states have the flexibility to administer their programs differently based on options that the federal government provides.[59] For example, the FFCRA allowed states to provide emergency supplemental benefits to households receiving less than the maximum benefit (which is about 60 percent of households on SNAP), and all states chose to implement this option.[60] As of October 5, 2020, 42 states were still providing these emergency benefits. In addition, the relief law provided meal replacement benefits (called "pandemic-EBT") for students whose schools closed and who typically receive free or reduced-price meals through school. This option has been extended through September 2021 and is now available to children whose schools are offering hybrid learning (distance and in-person), as well as children in child care settings.

Many States Have Made It Easier for Families to Access and Keep Their Nutrition Benefits

In addition to expanding benefits, states have also taken steps to make it easier for families to keep their benefits and remain enrolled in the program throughout the crisis, through reducing what is known as the "administrative burden" of SNAP participation – the time and paperwork associated with enrolling and staying in the program. Typically, families receiving SNAP have to recertify their eligibility for the program by submitting documentation and/or completing an interview every 3 to 12 months, depending on the state.[61] In response to the crisis, states were able to extend the deadlines for renewal and waive some of the usual application recertification requirements, including interviews and physical signatures.[62]

These Changes Can Boost Participation in the SNAP Program and Reduce Family Food Insecurity

Evidence from rigorous studies suggests that reducing the administrative burden associated with SNAP participation can significantly increase eligible families' participation in the program and contribute to lessening childhood food insecurity. For example, comprehensive reviews of the evidence[63] have shown that providing eligible families with longer intervals of time before they have to renew their eligibility increases participation, and combining longer intervals with other low-burden policies, such as simpler income reporting and allowing for online applications, can boost participation even further.

Given that SNAP receipt has been associated with a 36 percent reduction in childhood food insecurity,[64] as well as better birth outcomes and improved long-term child health, states aiming to support children's health after the pandemic would be wise to maintain or extend many of the SNAP protections that have been newly put in place in 2020.

Child Care Subsidies

The Pandemic Caused Considerable Challenges Related to Child Care for Families and Providers

The onset of the pandemic created immediate and substantial challenges for the child care sector and families with young children who rely on child care. Many child care providers had to close and remained closed for an extended period of time due to state regulations and/or concerns for the safety and wellbeing of children and child care staff. Early in the pandemic, a survey of child care providers found that 63 percent of providers said they would be unable to survive a closure of longer than one month without significant financial support from public entities.[65] One analysis suggested that up to half of the child care capacity in the US was "at risk of disappearing" without adequate financial support.[66]

In the months since the pandemic began, providers who were not already serving children of essential workers have started to reopen, often with significant changes to regulations to ensure the safety of staff and children.[67,68] These regulations often include lower child-to-staff ratios, guidance to avoid mixing groups of children and teachers, and additional requirements on sanitization and personal protective equipment. Each of these regulations increased costs for providers, many of whom already operate on small profit margins. Additionally, many child care providers continue to see low enrollment,[69] even after accounting for reduced capacity due to state and federal guidance on safe operations during the pandemic.

Federal Funding Allowed States Flexibility to Modify Child Care Subsidy Policy to Offer Additional Assistance to Families and Providers

The major source of financial relief for child care providers serving families using child care subsidies was the CARES Act, which included $3.5 billion in additional Child Care and Development Block Grant (CCDBG) funding.[70] This supplemental funding allowed states to continue payments to providers who have experienced closures or decreased enrollments, allowing providers serving children with subsidies to avoid permanent closure due to lost income during this time. States could also use funding to cover the costs of providing care for the children of essential workers (e.g., health care workers, emergency responders, sanitation workers, etc.) without regard to income eligibility.

States were also allowed to provide funds to Child Care and Development Fund (CCDF) eligible providers related to cleaning, sanitation, and personal protective equipment necessary to maintain safe day-to-day operations. The federal government encouraged states to make the receipt of funds conditional based on providers using a portion of funds to cover wages and salaries of staff during closures. Finally, states were allowed to use additional CARES Act funding for other purposes allowed under normal CCDF regulations.[71]

As a result of CARES Act funding, many states responded with temporary changes to child care subsidy program administration. For example, as of June 2020, 45 states continued to pay providers during times of closure or low attendance, 32 states provided funding for the care of children of essential workers, and 33 states waived or covered a portion of family copayments to providers.[72] Families benefit most directly from the reduction or waiver of their copayments, which normally range from 0 to 22 percent of family income for a family of three at 150 percent of the Federal Poverty Level depending on the state where a family resides.[73] By reducing copayments, states can help increase access to child care subsidies by lowering the financial burden on families to access subsidized care.

Paying providers for enrollment rather than attendance also allows providers to have greater stability during fluctuating or lower enrollment due to COVID-19. This policy may allow providers to remain open and serving families (or closed, but in business), benefiting families by preventing losses in child care supply. However, many of the provisions implemented by states as a result of CARES Act funding were temporary and expired over the summer or early fall.[74,75]

Rigorous Research Links Child Care Subsidies to Parents' Ability to Work

Although research has not yet identified the effectiveness of these state-level policy changes in response to COVID-19, rigorous research links child care subsidies to positive impacts on the wellbeing of families. A comprehensive review of the rigorous research on child care subsidies has shown that subsidy receipt and greater state per-child spending have positive impacts on the use of formal child care and maternal employment and education outcomes (including increased employment and labor force participation rates, work hours, and educational attainment).[76] Additional observational evidence found that lower copayments may also be associated with increased access to higher-quality care providers[77] and increased subsidy continuity.[78]

As child care providers across the country continue to face uncertainty and ongoing challenges as a result of the pandemic, and given the essential nature of child care to our economy and children's wellbeing, states can consider continuing COVID-related modifications to the subsidy program as a way to continue to support families and child care providers both during and after the pandemic. This investment in the wellbeing of families and support for child care providers will require additional state funding for child care subsidy programs to avoid using funds already allocated to other important aspects of the child care subsidy program.

Conclusion

The COVID-19 pandemic has highlighted the need for a strong, supportive system of care, particularly for families with young children, and the potential for program flexibility and policy changes to respond to families' needs. This brief provides examples of state and

federal policy responses to the pandemic that have created more flexibility and support for state Medicaid programs, telehealth services, paid sick leave, paid family leave, reduced administrative burden for SNAP, and child care subsidies. For more information on the pre-pandemic evidence of impacts for these and other policy solutions, see our comprehensive evidence reviews in the Prenatal-to-3 Policy Clearinghouse (pn3policy.org/clearinghouse).

MORE > > > Find guidance on the most effective policies and strategies in the Prenatal-to-3 State Policy Roadmap (pn3policy.org/roadmap).

Recommended Citation
Prenatal-to-3 Policy Impact Center. (2020). *Beyond the pandemic: State policy options for supporting families* (B.002.1120). Child and Family Research Partnership. Lyndon B. Johnson School of Public Affairs, University of Texas at Austin. https://pn3policy.org/resources/beyond-the-pandemic-state-policy-options-for-supporting-families.

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