February 10, 2022 – Minnesota House of Representatives

PRENATAL-TO-3 POLICY IMPACT CENTER

Research for Action and Outcomes

CYNTHIA OSBORNE, PH.D.

Executive Director, Prenatal-to-3 Policy Impact Center
Professor of Early Childhood Education and Policy
Vanderbilt University, Peabody College of Education and Human Development

Our Earliest Experiences Shape Our Lives

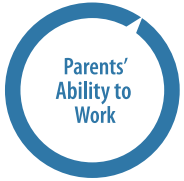
- All children deserve to be born healthy and raised in nurturing environments, with limited exposure to adversity
- Nurturing relationships in the earliest years lead to healthier brains and bodies, which influence health and wellbeing over the life course
- Chronic adversity harms children's neurological, biological, and social development, and can have lifelong consequences
- Millions of children lack the opportunities to the 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.

MINNESOTA

State Prenatal-to-3 Outcome Measures

Policy Goal	Outcome Measure	Worst State		Best State	Rank
Access to Needed Services	% Low-Income Women Uninsured	47.8%	13.3% MN	3.8%	14
	% Births to Women Not Receiving Adequate Prenatal Care	24.9%	10.1% MN	5.1%	8
	% Eligible Families with Children < 18 Not Receiving SNAP	26.7%	13.1% MN	2.0%	44
	% Children < 3 Not Receiving Developmental Screening	73.5%	40.0% MN	40.0%	1
Parents' Ability to Work	% Children < 3 Without Any Full-Time Working Parent	39.0%	20.4% MN	14.8%	11
Sufficient Household Resources	% Children < 3 in Poverty	33.1%	12.8% MN	8.6%	12
	% Children < 3 Living in Crowded Households	35.8%	14.9% MN	8.6%	25
	% Households Reporting Child Food Insecurity	12.1%	5.1% MN	1.2%	19
Healthy and Equitable Births	% Babies Born Preterm (< 37 Weeks)	14.6%	9.3% MN	8.2%	10
	# of Infant Deaths per 1,000 Births	9.1	4.5 MN	3.1	9

MINNESOTA

State Prenatal-to-3 Outcome Measures

Policy Goal	Outcome Measure	Worst State		Best State	Rank
Parental Health and Emotional Wellbeing	% Children < 3 Whose Mother Reports Fair/Poor Mental Health	10.9%	4.6% MN	1.0%	27
	% Children < 3 Whose Parent Lacks Parenting Support	24.0%	9.4% MN	6.4%	9
Nurturing and Responsive Child-Parent Relationships	% Children < 3 Not Read to Daily	75.9%	57.0% MN	45.4%	14
	% Children < 3 Not Nurtured Daily	52.7%	38.5% MN	28.1%	13
	% Children < 3 Whose Parent Reports Not Coping Very Well	46.1%	25.9% MN	20.1%	12
Nurturing and Responsive Child Care in Safe Settings	% Providers Not in QRIS	Updated Data Not Available			
	% Children Without Access to EHS	96.2%	88.8% MN	69.0%	16
Optimal Child Health and Development	% Children Whose Mother Reported Never Breastfeeding	33.0%	7.8% MN	7.5%	3
	% Children < 3 Not Up to Date on Immunizations	38.4%	15.6% MN	15.6%	1
	Maltreatment Rate per 1,000 Children < 3	39.5	9.1 MN	2.1	13

Prenatal-to-3 State Policy Roadmap

- **Core Principles**
  - Grounded in the science of the developing child
  - Committed to promoting equity
  - Guided by the most rigorous evidence, to date
- **Purpose**
  - A guide for state policy leaders to develop and implement the most effective investments that states can make to empower parents and ensure all children thrive from the start
- **Approach**
  - Identified 5 effective policies and 6 effective strategies that positively impact PN-3 outcomes
  - Tracking annual state progress toward policy adoption and implementation of the 11 solutions
  - Monitoring the wellbeing of infants and toddlers in each state, and progress toward reducing disparities in opportunities and outcomes

Summary

POLICIES

Expanded Income Eligibility for Health Insurance

Reduced Administrative Burden for SNAP

Paid Family Leave

State Minimum Wage

State Earned Income Tax Credit

STRATEGIES

Comprehensive Screening and Connection Programs

Child Care Subsidies

Group Prenatal Care

Evidence-Based Home Visiting Programs

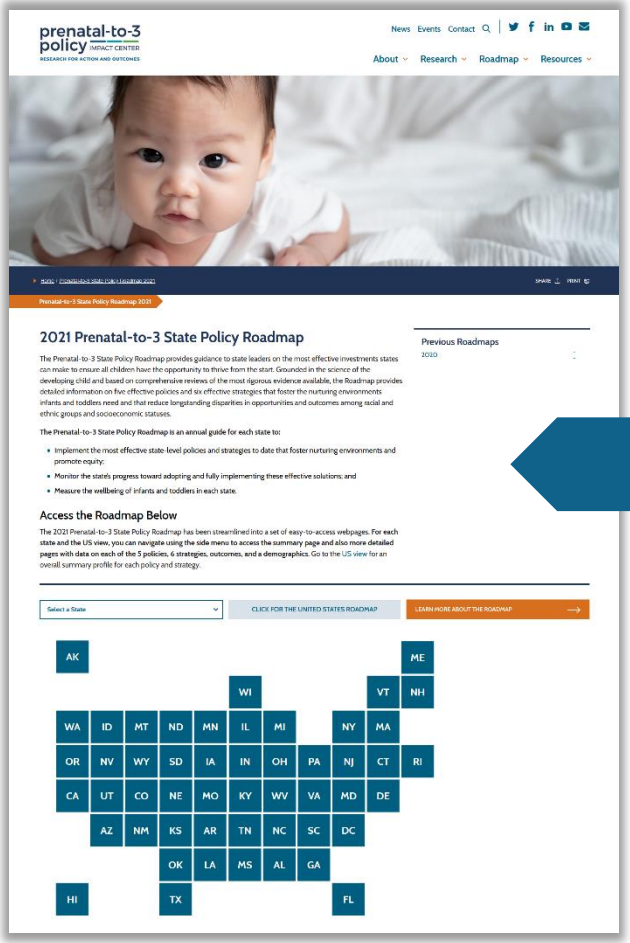
Early Head Start

Early Intervention Services

DATA

Outcomes

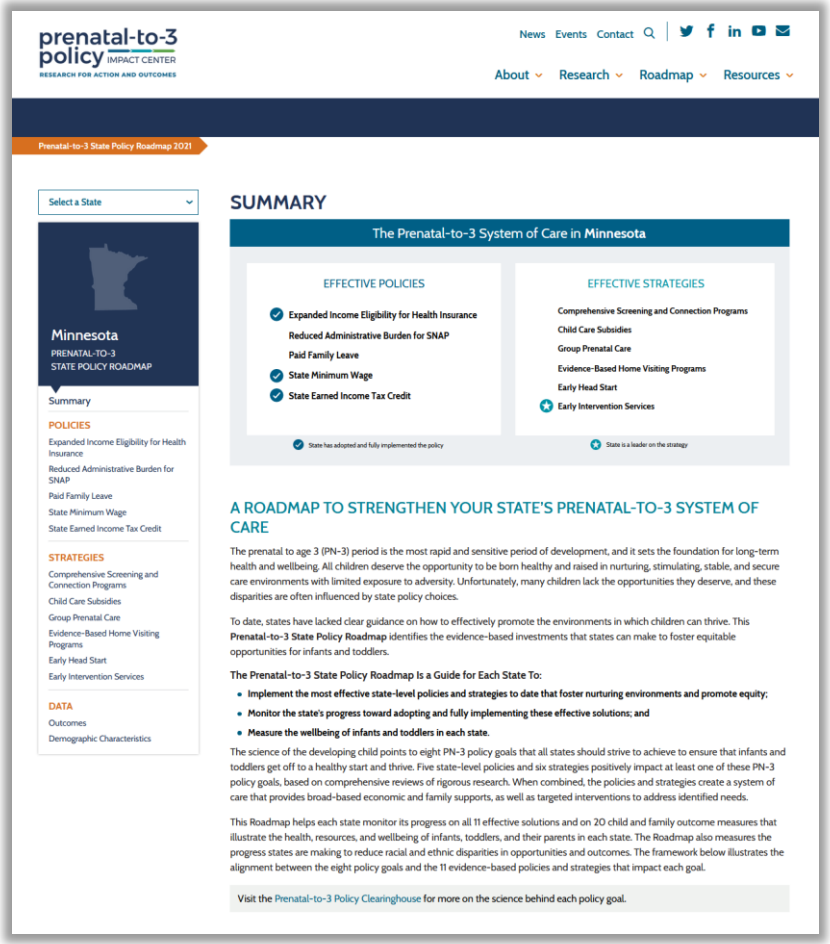
Demographic Characteristics



2021 Prenatal-to-3 State Policy Roadmap

pn3policy.org/roadmap

2021 Prenatal-to-3 State Policy Roadmap: State Summary for Minnesota



prenatal-to-3 policy IMPACT CENTER
RESEARCH FOR ACTION AND OUTCOMES

News Events Contact

About Research Roadmap Resources

Prenatal-to-3 State Policy Roadmap 2021

Select a State

Minnesota
PRENATAL-TO-3
STATE POLICY ROADMAP

Summary

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

STRATEGIES
Comprehensive Screening and Connection Programs
Child Care Subsidies
Group Prenatal Care
Evidence-Based Home Visiting Programs
Early Head Start
Early Intervention Services

DATA
Outcomes
Demographic Characteristics

SUMMARY

The Prenatal-to-3 System of Care in **Minnesota**

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

EFFECTIVE STRATEGIES
- Comprehensive Screening and Connection Programs
- Child Care Subsidies
- Group Prenatal Care
- Evidence-Based Home Visiting Programs
- Early Head Start
- Early Intervention Services

State has adopted and fully implemented the policy
State is a leader on the strategy

A ROADMAP TO STRENGTHEN YOUR STATE'S PRENATAL-TO-3 SYSTEM OF CARE

The prenatal to age 3 (PN-3) period is the most rapid and sensitive period of development, and it sets the foundation for long-term health and wellbeing. All children deserve the opportunity to be born healthy and raised in nurturing, stimulating, stable, and secure care environments with limited exposure to adversity. Unfortunately, many children lack the opportunities they deserve, and these disparities are often influenced by state policy choices.

To date, states have lacked clear guidance on how to effectively promote the environments in which children can thrive. This **Prenatal-to-3 State Policy Roadmap** identifies the evidence-based investments that states can make to foster equitable opportunities for infants and toddlers.

The Prenatal-to-3 State Policy Roadmap Is a Guide for Each State To:

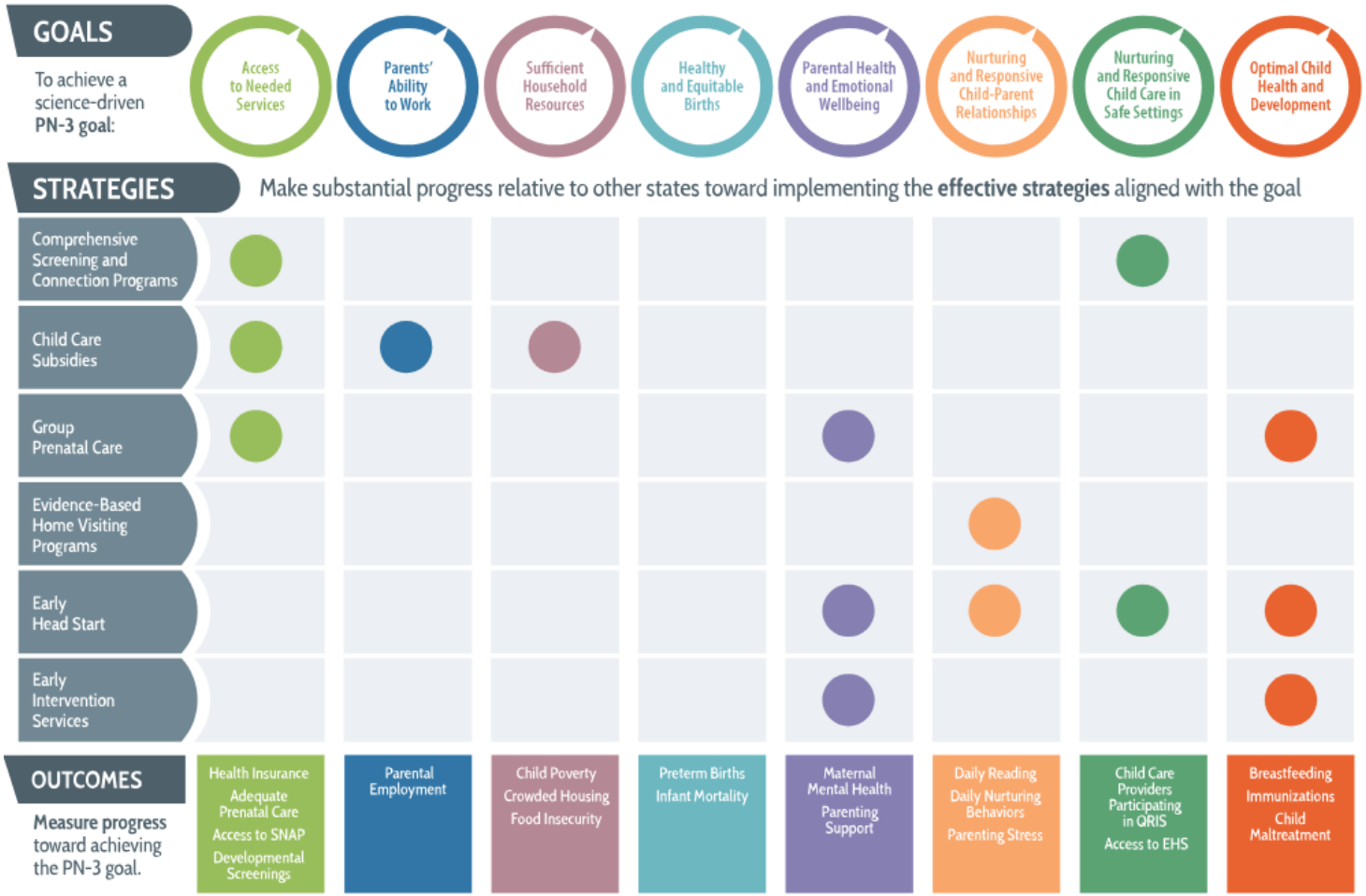
- **Implement the most effective state-level policies and strategies to date that foster nurturing environments and promote equity;**
- **Monitor the state's progress toward adopting and fully implementing these effective solutions; and**
- **Measure the wellbeing of infants and toddlers in each state.**

The science of the developing child points to eight PN-3 policy goals that all states should strive to achieve to ensure that infants and toddlers get off to a healthy start and thrive. Five state-level policies and six strategies positively impact at least one of these PN-3 policy goals, based on comprehensive reviews of rigorous research. When combined, the policies and strategies create a system of care that provides broad-based economic and family supports, as well as targeted interventions to address identified needs.

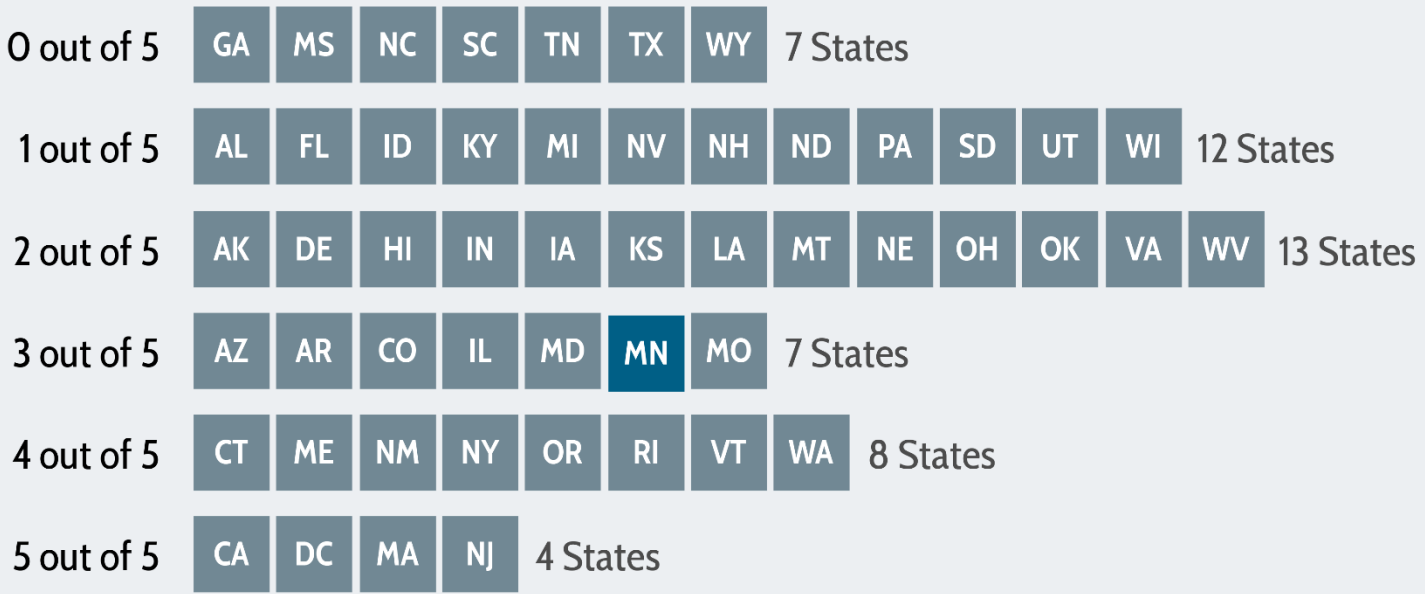
This Roadmap helps each state monitor its progress on all 11 effective solutions and on 20 child and family outcome measures that illustrate the health, resources, and wellbeing of infants, toddlers, and their parents in each state. The Roadmap also measures the progress states are making to reduce racial and ethnic disparities in opportunities and outcomes. The framework below illustrates the alignment between the eight policy goals and the 11 evidence-based policies and strategies that impact each goal.

Visit the Prenatal-to-3 Policy Clearinghouse for more on the science behind each policy goal.

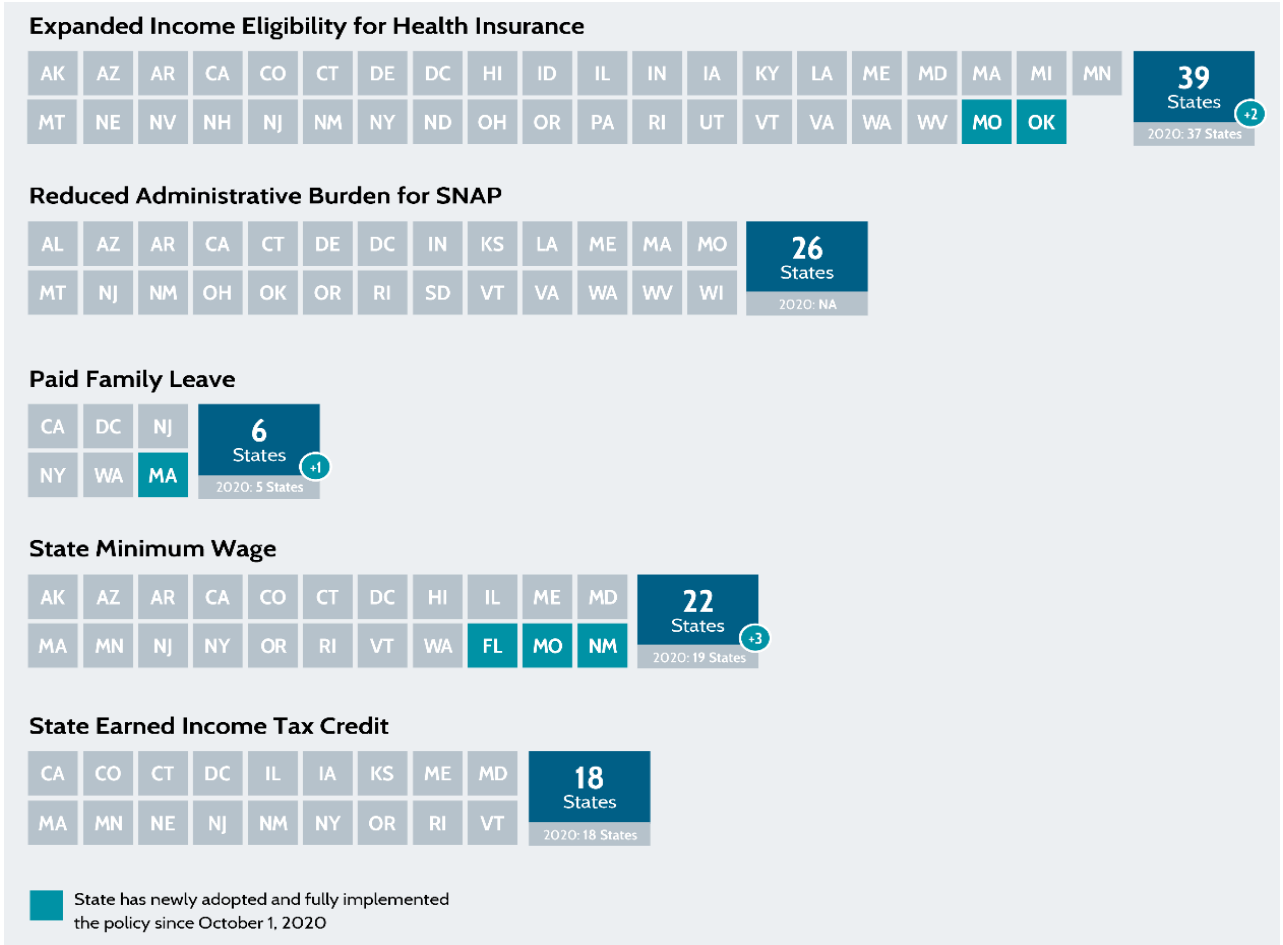

GOALS
To achieve a science-driven PN-3 goal:
Access to Needed Services
Parents' Ability to Work
Sufficient Household Resources
Healthy and Equitable Births
Parental Health and Emotional Wellbeing
Nurturing and Responsive Child-Parent Relationships
Nurturing and Responsive Child Care in Safe Settings
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
Comprehensive Screening and Connection Programs
Child Care Subsidies
Group Prenatal Care
Evidence-Based Home Visiting Programs
Early Head Start
Early Intervention Services
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

Minnesota Has Adopted and Fully Implemented 3 Policies



5 Additional States Fully Implemented a Roadmap Policy This Past Year
(MO implemented 2!)



Note: Due to additional evidence on how states can effectively reduce administrative burden for SNAP, 2021 is a new baseline year, and we do not show changes in the past year.

MINNESOTA

State Action

The Prenatal-to-3 System of Care in Minnesota

POLICIES

Effective policies impact PN-3 goals and research provides clear state legislative or regulatory action.

	Policy Definition		State Implementation
Expanded Income Eligibility for Health Insurance	State has adopted and fully implemented the Medicaid expansion under the ACA that includes coverage for most adults with incomes up to 138% of the federal poverty level.	✓	In 2010, Minnesota was one of the first six states to sign up for the early Medicaid expansion option. Legislators proposed no bills in the last year to modify eligibility requirements.
Reduced Administrative Burden for SNAP	State assigns 12-month recertification and simplified reporting to all eligible families with children, and offers online services, including at minimum, an online application.		Minnesota assigns 12-month recertification intervals to all eligible families with children, but only assigns simplified reporting to some families with children. Minnesota has an online application and offers renewal services online, but it does not offer change reporting online.
Paid Family Leave	State has 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.		Minnesota does not have a paid family leave program. Legislators proposed companion bills in the last year to enact a paid family leave program with up to 12 weeks of benefits. One of the companion bills had 35 sponsors and moved out of committee, but did not pass this session.
State Minimum Wage	State has adopted and fully implemented a minimum wage of $10 or greater.	✓	The current state minimum wage in Minnesota is $10.08, with annual adjustments for inflation. In the last year, legislators proposed five bills to increase the state minimum wage to $15.00 for small employers and $17.00 for large employers, but all of the bills failed.
State Earned Income Tax Credit	State has 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.	✓	Minnesota has a refundable EITC that has a unique structure distinct from the federal credit. The average state EITC in Minnesota equals 39% of the federal credit. In the last year, legislators proposed legislation to increase the value and expand eligibility of the credit, but no bills passed.

✓ Adopted and fully implemented as of October 1, 2021

MINNESOTA

State Action

The Prenatal-to-3 System of Care in Minnesota

STRATEGIES

Effective strategies impact PN-3 goals, but the research does not yet provide precise guidance for state legislative or regulatory action.

	Characteristics of Leading States		State Implementation
Comprehensive Screening and Connection Programs	Leading states 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.		Families in Minnesota have access to two of the three evidence-based comprehensive screening and connection programs, Family Connects and HealthySteps, but not DULCE.
Child Care Subsidies	Leading states provide high reimbursement rates that meet the providers' true cost of care, require low family copays, and have a low family share of the total cost of child care.		In Minnesota, low-income families with a child care subsidy may pay up to 28.1% of the total market rate price of care, and the state's base reimbursement rates cover only 79.7% of the true cost of providing base-quality care.
Group Prenatal Care	Leading states provide financial support for group prenatal care, provide enhanced reimbursement rates for group prenatal care through Medicaid, and serve a substantial percentage of pregnant people.		In Minnesota, 1.2% of the state's pregnant people participated in group prenatal care through the CenteringPregnancy model in 2019. The state passed legislation in 2018 to establish a grant program for initiatives that aim to improve maternal health outcomes, which included group prenatal care. The state distributed the first awards in 2019.
Evidence-Based Home Visiting Programs	Leading states serve a substantial percentage of low-income families with young children and use state dollars or Medicaid to support home visiting services.		Relative to other states, Minnesota serves a higher percentage of its low-income children under age 3 in the state's home visiting programs. The state takes advantage of Medicaid funding as part of the financing strategy for its home visiting programs.
Early Head Start	Leading states have a state-specific program, provide state financial support for EHS, and serve a substantial percentage of low-income children.		Minnesota contributes to its Early Head Start programs by supplementing federal Early Head Start funding at the state level. Approximately 11.2% of eligible infants and toddlers in Minnesota have access to EHS.
Early Intervention Services	Leading states serve a substantial percentage of children under age 3, increase eligibility for children, and maximize the use of Medicaid to pay for EI services.	★	Minnesota serves 6.5% of its 0-to-3 population in EI over the course of a year, ranking 30th among all states on this indicator. The state is a leader in advancing equity for children in EI; it is one of 10 states with the smallest gaps in the percentage of children served across racial/ethnic groups. Minnesota is a birth mandate state, so EI services are guaranteed at no cost to all eligible children under age 3.

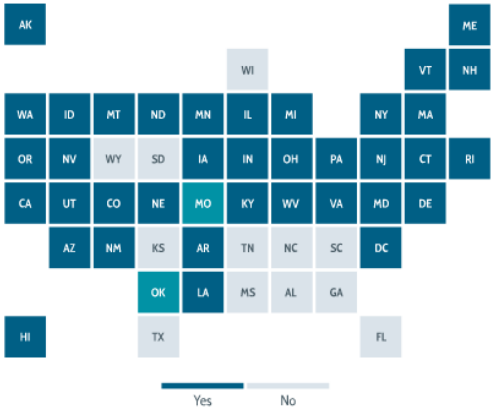
★ Leading state on effective strategy

MINNESOTA

POLICY: Medicaid Expansion

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.



2020: 37 states

State has newly adopted and implemented the policy since October 1, 2020

Minnesota

In 2010, Minnesota was one of the first six states to sign up for the early Medicaid expansion option. Legislators proposed no bills in the last year to modify eligibility requirements.

2020 Status:

How Does Medicaid Expansion Impact PN-3 Outcomes?

- 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)

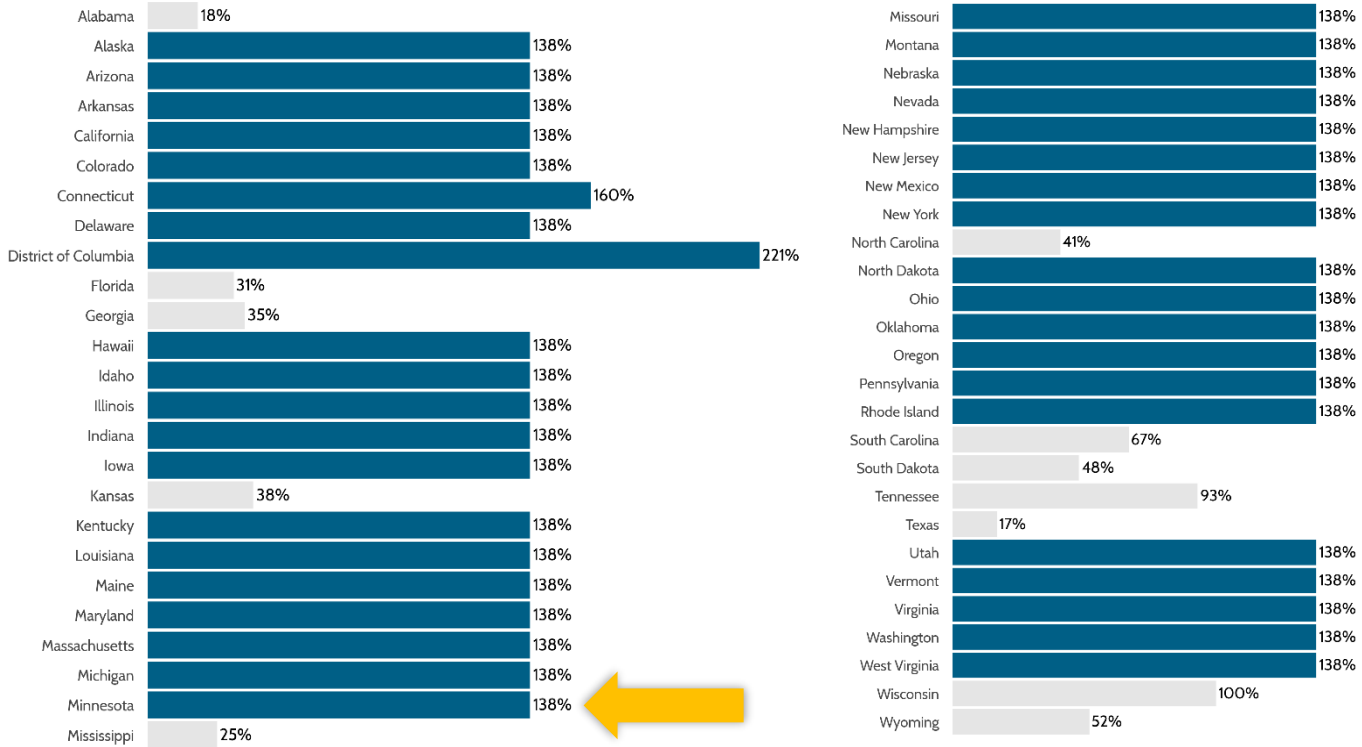
- A 4.7 percentage point decrease in the likelihood of experiencing a catastrophic financial burden (KK)
- A decrease in financial difficulty and care avoidance because of cost (C, K, & II)
- A reduction in the poverty rate (Supplemental Poverty Measure) of up to 1.4 percentage points, corresponding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

- 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 (7.01 per 100,000 live births in the overall population) (J)

MINNESOTA

POLICY: Medicaid Expansion

Variation Across States in Parents' Medicaid Income Eligibility Limits as a Percentage of the Federal Poverty Level

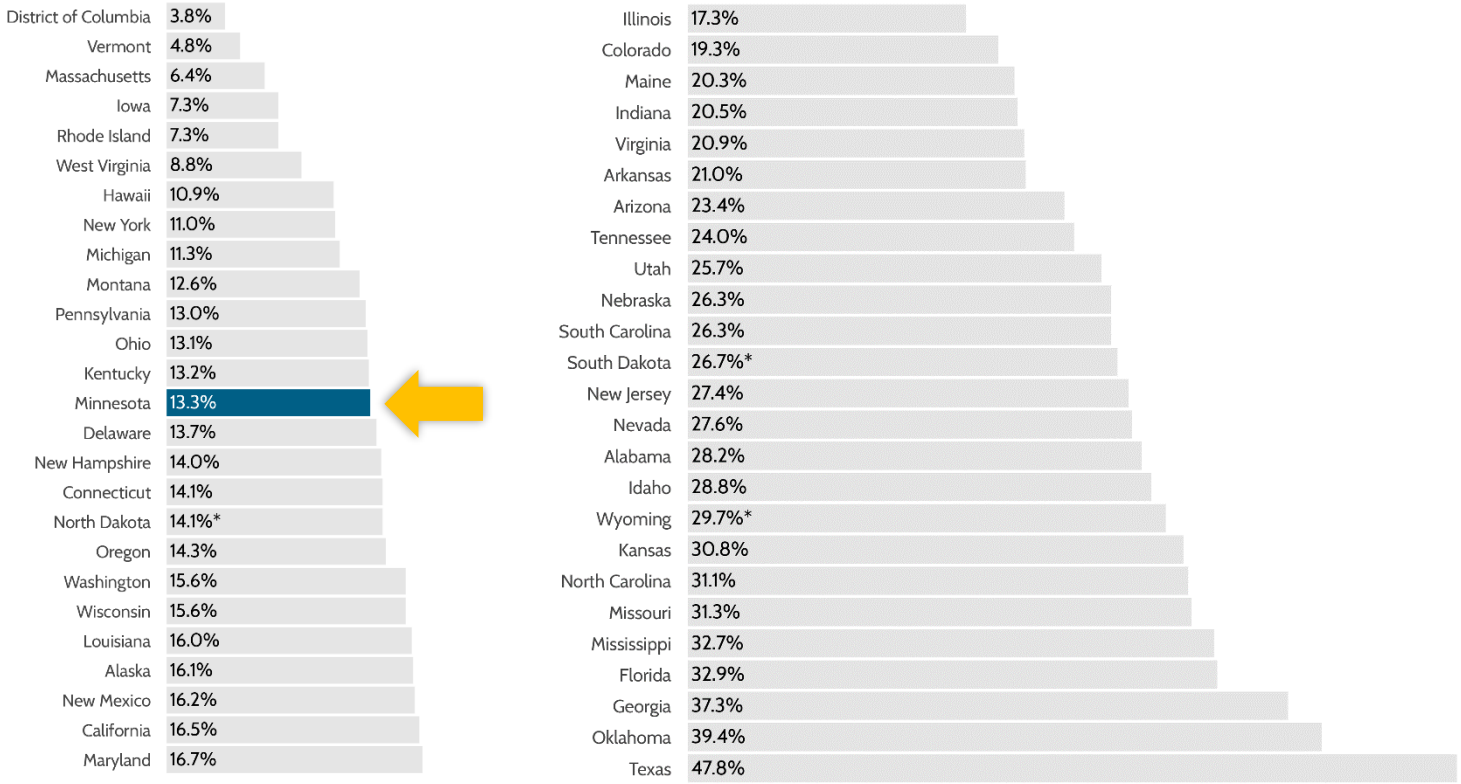


As of January 1, 2021. Kaiser Family Foundation and Medicaid state plan amendments (SPAs). Blue bar indicates that the state has expanded Medicaid.

MINNESOTA

POLICY: Medicaid Expansion

% Low-Income Women of Childbearing Age Without Health Insurance



Low income = <= 138% Federal Poverty Level

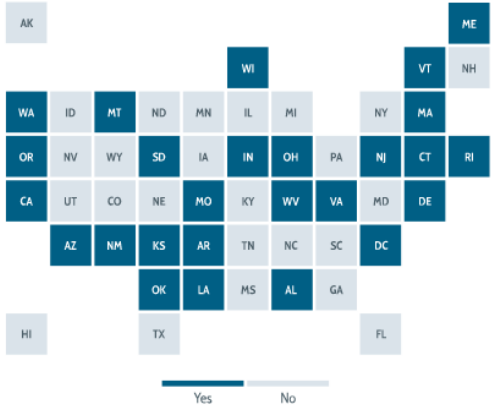
2019 American Community Survey (ACS) 1-Year Public Use Microdata Sample (PUMS).

MINNESOTA

POLICY:
Reduced Administrative Burden for SNAP

Reduced administrative burden for SNAP is an effective state policy to impact:

26 states assign 12-month recertification and simplified reporting to all eligible families with children, and offer online services, including at minimum, an online application.



Note. 2020 data are N/A. 2021 is the first year to track the number of states with a "Yes" for SNAP using updated methodology.

Minnesota

Minnesota assigns 12-month recertification intervals to all eligible families with children, but only assigns simplified reporting to some families with children. Minnesota has an online application and offers renewal services online, but it does not offer change reporting online.

As of July 1, 2021. Individual states' SNAP manuals, states' SNAP websites, and personal communications.

How Does Reduced Administrative Burden for SNAP Impact PN-3 Outcomes?

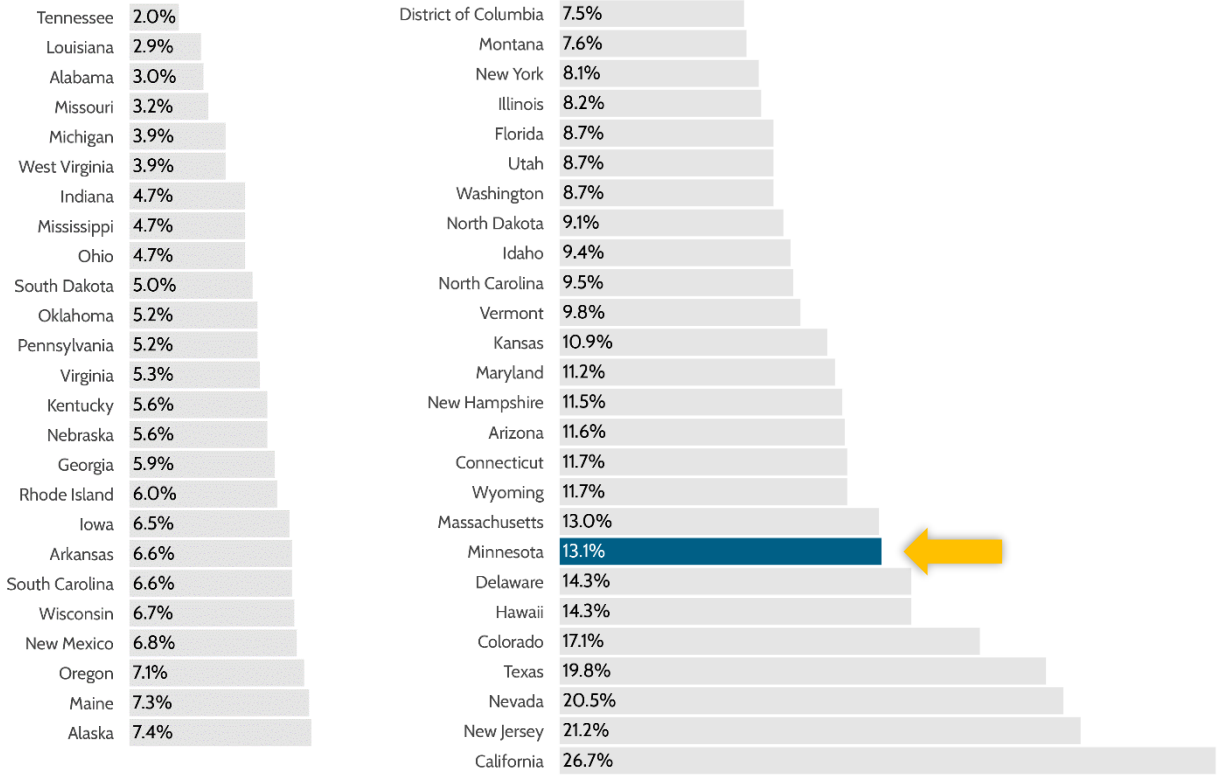
- Recertification intervals longer than 12 months led to an 11.4 percentage point increase in SNAP participation among households with children (E)
- The elimination of policies that added transaction costs and stigma to SNAP participation explained 14.2% of the SNAP caseload increase from 2000 to 2016 (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)

MINNESOTA

POLICY:
Reduced Administrative Burden for SNAP

% Eligible Families With Children Under Age 18 Not Receiving SNAP



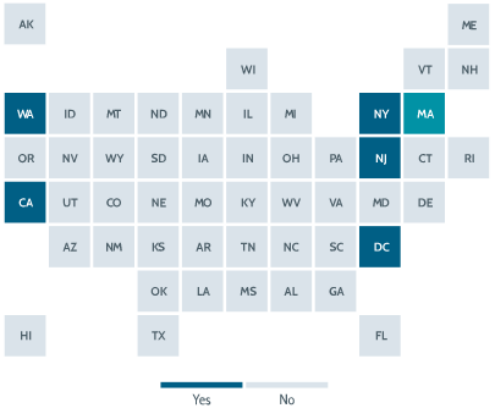
As of 2015-2017 (CPS-ASEC 2016-2018). Urban Institute's TRIM3 project.

MINNESOTA

POLICY: Paid Family Leave

A paid family leave program of a minimum of 6 weeks is an effective state policy to impact:

6 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.



2020: 5 states

State has newly adopted and implemented the policy since October 1, 2020

Minnesota

Minnesota does not have a paid family leave program. Legislators proposed companion bills in the last year to enact a paid family leave program with up to 12 weeks of benefits. One of the companion bills had 35 sponsors and moved out of committee, but did not pass this session.

2020 Status:

How Does Paid Family Leave Impact PN-3 Outcomes?

- An increase in leave-taking in the first year after birth of 5 weeks for mothers and 2 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 (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 less-educated, low-income, and single mothers (M)

How Does Paid Family Leave Impact PN-3 Outcomes?

- A 5.3 percentage point increase in the number of parents who reported coping well with the day-to-day demands of parenting (C)
- An 8.2 percentage point decrease in parental risk of being overweight (P)
- A 12 percentage point decrease in parental consumption of any alcohol (P)

- 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)

- 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 low-income families (E)
- A decrease in hospital admissions for pediatric abuse 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)

Variation Across States in Paid Family Leave Benefits and Administration

State	Implementation Timeline	Current Maximum Number of Weeks of Benefit	Current Maximum Dollar Value of Weekly Benefit	Current Benefit as Percentage of Wages	Funding and Administration Mechanisms
California	Enacted in 2002; benefits available in 2004	8	$1,357	Between 60% and 70% of the worker's average weekly wage, depending on their income. Very low-wage workers receive a fixed benefit amount set by statute, which may result in higher wage replacement rates.	Workers cover the full cost through a payroll deduction currently set at 1.2% of wages (does not apply to wages over $128,298/year). The program is administered through an existing state government department.
Colorado	Enacted in 2020; premiums effective in 2023; benefits available in 2024	12	$1,100	90% of the worker's average weekly wage for the portion of their wages equal to or less than 50% of the state average weekly wage; and then 50% of the portion of their wages above 50% of the state average weekly wage.	Workers and employers share the cost. Up to 50% of the premium can be withheld from workers' wages; employers (with more than 10 employees) contribute at least 50% of the premium. Initially, the total premium will be 0.9% of wages. Premiums do not apply to wages above the Social Security contribution base. The program is administered through a new state government division.
Connecticut	Enacted in 2019; premiums effective in 2021; benefits available in 2022	12	$780	95% of the worker's average weekly wage for the portion of their wages equal to or less than 40 times the state minimum wage; and then 60% of the portion of their wages above 40 times the state minimum wage.	Workers cover the full cost, currently set at 0.5% of wages. Contributions do not apply to wages above the Social Security contribution base. The program is administered through a new quasi-public agency.
District of Columbia	Enacted in 2017; benefits available in 2020	8	$1,000	90% of the worker's average weekly wage for the portion of their wages equal to or less than 60 times the DC minimum wage; and then 50% of the portion of their wages above 60 times the DC minimum wage.	Employers cover the full cost and contribute 0.62% of the wages of covered workers. The program is administered through a new state government office.
Massachusetts	Enacted in 2018; premiums effective in 2019; benefits available in 2021	12	$850	80% of the worker's average weekly wage for the portion of their wages equal to or less than 50% of the statewide average weekly wage; and then 50% of the portion of their wages above 50% of the statewide average weekly wage.	Workers cover the full cost, currently set at 0.75% of wages. Premiums do not apply to wages above the Social Security contribution base. The program is administered through a new state government department.

As of July 28, 2021. State paid family leave laws and A Better Balance.

Variation Across States in Paid Family Leave Benefits and Administration

State	Implementation Timeline	Current Maximum Number of Weeks of Benefit	Current Maximum Dollar Value of Weekly Benefit	Current Benefit as Percentage of Wages	Funding and Administration Mechanisms
New Jersey	Enacted in 2008; premiums effective & benefits available in 2009	12	$903	85% of the worker's average weekly wage.	Workers cover the full cost through a payroll deduction, currently set at 0.28% of wages. This deduction does not apply to wages above $138,200/year. The program is administered through an existing state government department.
New York	Enacted in 2016; benefits available in 2018 (maximum benefit of 12 weeks available in 2021)	12	$972	67% of the worker's average weekly wage.	Workers cover the full cost through a payroll deduction, currently set at 0.511% of wages. This deduction does not apply to wages above $1,450.17/ week. The program is administered through an existing state government department.
Oregon	Enacted in 2019; premiums effective & benefits available in 2023	12	$1,497	100% of the worker's average weekly wage for the portion of their wages equal to or less than 65% of the statewide average weekly wage; and then 50% of the portion of their wages above 65% of the statewide average weekly wage.	Workers and employers share the cost. Up to 60% of the premium can be withheld from workers' wages; employers (with more than 25 employees) contribute at least 40% of the premium. The total premium will not exceed 1% of wages. Premiums do not apply to wages above $132,900/year. The program is administered through an existing state government department.
Rhode Island	Enacted in 2013; benefits available in 2014 (benefits increase to 6 weeks in 2022, with maximum benefit of 8 weeks available in 2023)	4	$978	60% of the worker's average weekly wage.	Workers cover the full cost through a payroll deduction, currently set at 1.3% of wages. This deduction does not apply to wages above $74,000/year. The program is administered through an existing state government department.
Washington	Enacted in 2017; premiums effective in 2019; benefits available in 2020	12	$1,206	90% of the worker's average weekly wage for the portion of their wages equal to or less than 50% of the statewide average weekly wage; and then 50% of the portion of their wages above 50% of the statewide average weekly wage.	Workers cover the full cost, currently set at 0.13% of wages. Premiums do not apply to wages above the Social Security contribution base. The program is administered through an existing state government department.

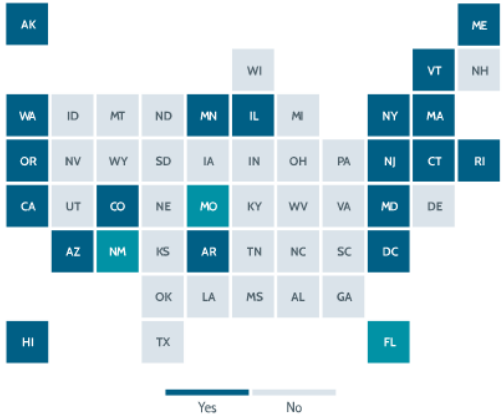
As of July 28, 2021. State paid family leave laws and A Better Balance.

MINNESOTA

POLICY: State Minimum Wage

A state minimum wage of $10.00 or greater is an effective state policy to impact:

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



2020: 19 states

State has newly adopted and implemented the policy since October 1, 2020

Minnesota

The current state minimum wage in Minnesota is $10.08, with annual adjustments for inflation. In the last year, legislators proposed five bills to increase the state minimum wage to $15.00 for small employers and $17.00 for large employers, but all of the bills failed.

2020 Status:

How Does a Higher State Minimum Wage Impact PN-3 Outcomes?

- 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 low-income families and produced a 4.9% reduction in poverty for children under age 18 (B)

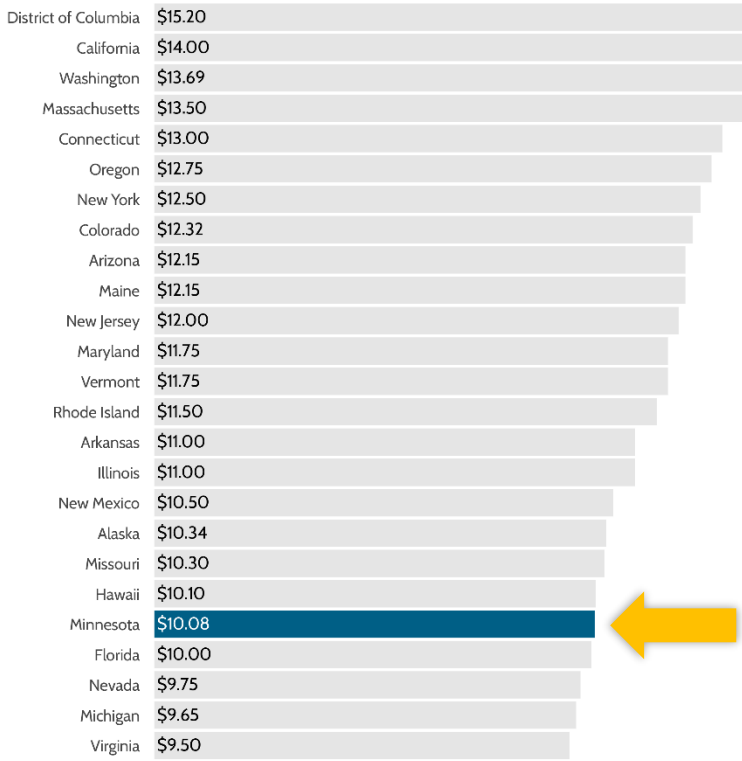
- A $1.00 minimum wage increase above the federal level led to approximately a 2% decrease in low birthweight and a 4% decrease in postneonatal mortality (E)
- For pregnant women, setting the tipped minimum wage at the full federal minimum wage level led to overall healthier birthweights for gestational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

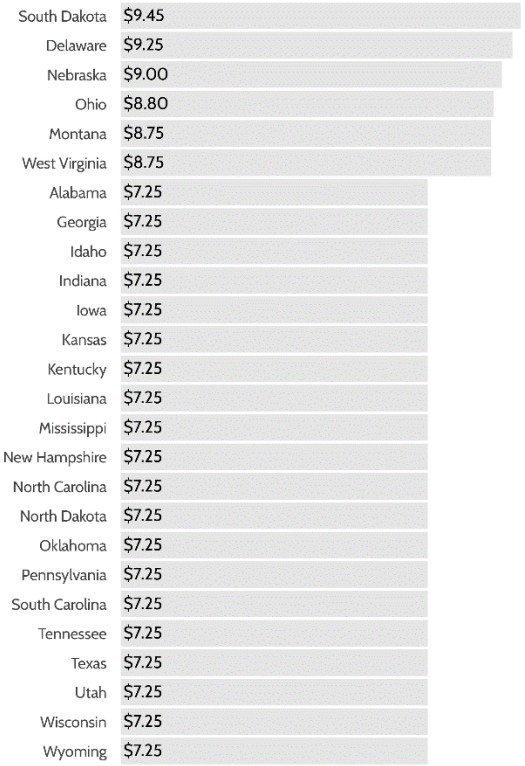
- A $1.00 increase in the minimum wage reduced child neglect reports by 9.6% overall and by 10.8% for children ages 0 to 5 (G)
- Children affected by a $1.00 increase in the minimum wage from birth through age 5 saw an 8.7% higher likelihood of excellent or very good health and missed 15.6% fewer school days due to illness or injury from ages 6 through 12 (I)

MINNESOTA

POLICY: State Minimum Wage

Current State Minimum Wages





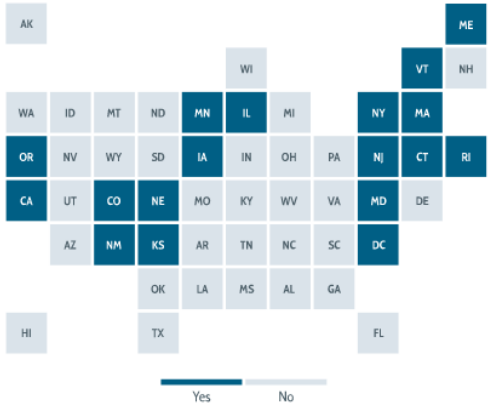
As of October 1, 2021. State labor statutes.

MINNESOTA

POLICY: State Earned Income Tax Credit

A refundable state EITC of at least 10% of the federal EITC is an effective state policy to impact:

18 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.



2020: 18 states

Minnesota

Minnesota has a refundable EITC that has a unique structure distinct from the federal credit. The average state EITC in Minnesota equals 39% of the federal credit. In the last year, legislators proposed legislation to increase the value and expand eligibility of the credit, but no bills passed.

2020 Status: ✓

As of Tax Year 2021. State income tax statutes.

How Does a State EITC Impact PN-3 Outcomes?

- Unmarried mothers with children under age 3 were 9 percentage points more likely to work with each additional $1,000 in average EITC benefits (federal plus state) (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 boosted the likelihood of mothers' employment (for at least one week per year) by 19% (B)

- State EITCs boosted 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 grams 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)

MINNESOTA

STRATEGY:
Comprehensive Screenings and Connection Programs

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

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: CT MA NJ NC OR

Families in Minnesota have access to two of the three evidence-based comprehensive screening and connection programs, Family Connects and HealthySteps, but not DULCE.

How Do Comprehensive Screenings 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)

- 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)

MINNESOTA

STRATEGY: Group Prenatal Care

Group prenatal care is an effective state strategy to impact:

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 serve a substantial percentage of pregnant people.

State leaders: MD MT NJ OH SC

In Minnesota, 1.2% of the state's pregnant people participated in group prenatal care through the CenteringPregnancy model in 2019. The state passed legislation in 2018 to establish a grant program for initiatives that aim to improve maternal health outcomes, which included group prenatal care. The state distributed the first awards in 2019.

How Does Group Prenatal Care Impact PN-3 Outcomes?

- A 6.4 percentage point decrease in the likelihood of receiving inadequate prenatal care (C)
- Approximately 2 more prenatal visits among participating Black women with high-risk pregnancies (H)

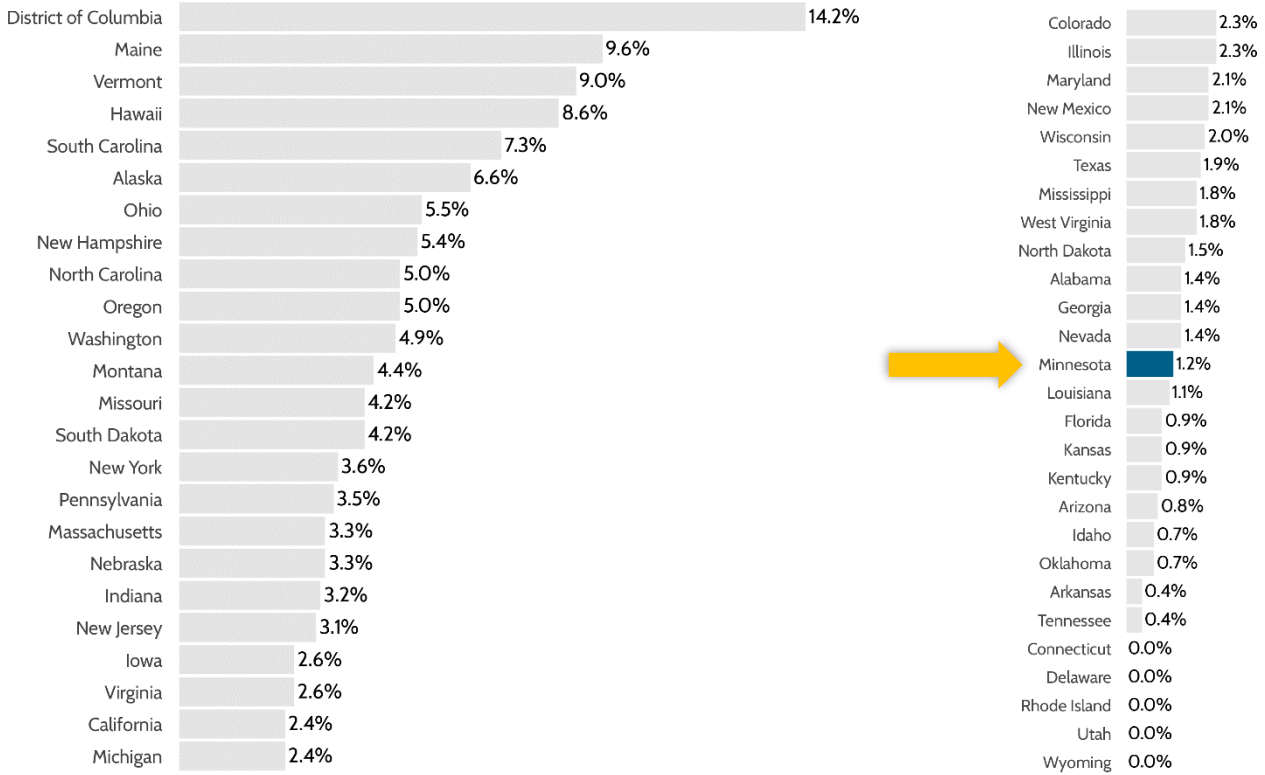
- Cases of probable depression decreased by 31% for women in group prenatal care compared to 15% for women in individual prenatal care from the second trimester to 1 year postpartum (A)
- High-stress women in group prenatal care were more likely to experience a decrease in depressive symptoms postpartum (D)

- The rate of breastfeeding initiation increased by approximately 12 percentage points (C)

MINNESOTA

STRATEGY: Group Prenatal Care

Estimated % of Births to People Participating in CenteringPregnancy



As of 2019. Centering Healthcare Institute Inc.

MINNESOTA

STRATEGY: Evidence-Based Home Visiting Programs

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

EVIDENCE-BASED HOME VISITING PROGRAMS

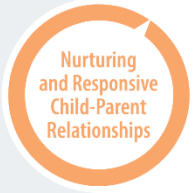
provide support and education to parents in the home through a trained professional or paraprofessional.

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

State leaders: IL IA KS ME NY

Minnesota, relative to other states, serves a higher percentage of its low-income children under age 3 in the state's home visiting programs. The state takes advantage of Medicaid funding as part of the financing strategy for its home visiting programs.

How Do Evidence-Based Home Visiting Programs 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)

MINNESOTA

STRATEGY: Evidence-Based Home Visiting Programs

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	12.8%
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%
Florida	7.9%
West Virginia	7.9%
New Hampshire	7.2%
Washington	7.2%
Massachusetts	6.7%
New York	6.6%
Virginia	6.3%
Hawaii	6.1%
North Carolina	6.1%
Maryland	5.9%
Idaho	5.8%
New Mexico	5.7%
South Dakota	5.5%
Nebraska	4.7%
South Carolina	4.6%
Utah	4.1%
Louisiana	3.9%
California	2.9%
Arkansas	2.5%
Tennessee	2.5%
Alabama	2.2%
Texas	2.2%
Georgia	1.7%
Mississippi	1.2%
Nevada	0.8%
Vermont	NR

2020 National Home Visiting Resource Center Yearbook. 2018 & 2019 American Community Survey (ACS) 1-Year Public Use Microdata Sample (PUMS).

MINNESOTA

STRATEGY: Early Head Start

Early Head Start is an effective state strategy to impact:

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 serve a substantial percentage of low-income children.

State leaders: AK DC IL ME NE OR WA

Minnesota contributes to its Early Head Start programs by supplementing federal Early Head Start funding at the state level. Approximately 11.2% of eligible infants and toddlers in Minnesota have access to EHS.

How Does Early Head Start Impact PN-3 Outcomes?

- Parents participating in EHS reported lower distress associated with parenting 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)

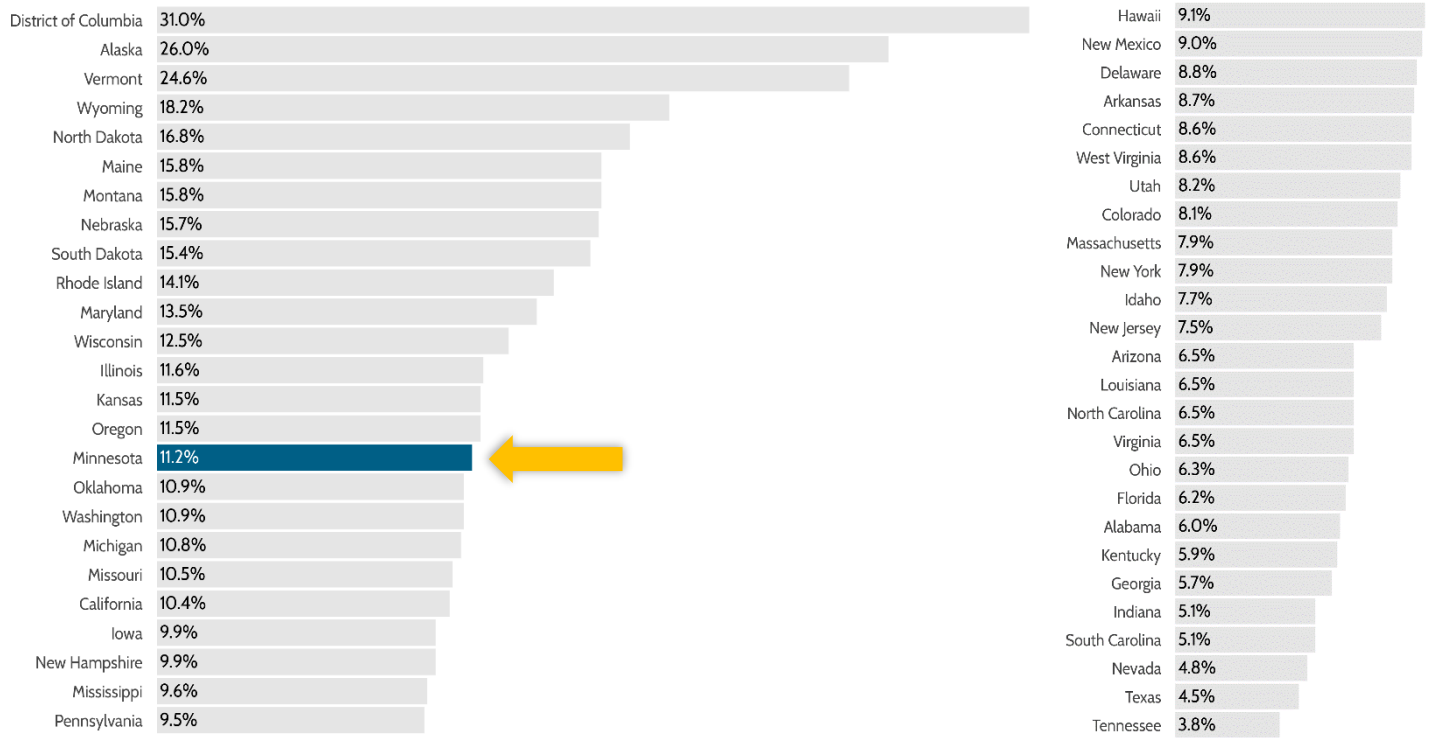
- The share of children participating in good-quality center-based care was 3 times greater among children in EHS at age 2 (K)
- In center-based care, caregiver-child interactions were better among EHS participants than among nonparticipants (K)

- Children in EHS were more engaged with a 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)

MINNESOTA

STRATEGY: Early Head Start

Estimated % of Income-Eligible Children With Access to Early Head Start



2019 Early Head Start (EHS) Program Information Report (PIR) and 2018 & 2019 American Community Survey (ACS) Public-Use Microdata Sample (PUMS).

MINNESOTA

STRATEGY: 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 maximize the use of Medicaid to pay for EI services.

State leaders: CO CT IL MA MN NM RI

Minnesota serves 6.5% of its 0-to-3 population in EI over the course of a year, ranking 30th among all states on this indicator. The state is a leader in advancing equity for children in EI; it is one of 10 states with the smallest gaps in the percentage of children served across racial/ethnic groups. Minnesota is a birth mandate state, so EI services are guaranteed at no cost to all eligible children under age 3.

How Do Early Intervention Services Impact PN-3 Outcomes?

- 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)

- 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)

MINNESOTA

STRATEGY: Early Intervention Services

Cumulative % Children Under Age 3 Receiving EI Services

New Mexico	21.9%
Massachusetts	20.1%
Rhode Island	14.6%
West Virginia	13.8%
New Hampshire	12.9%
Vermont	12.5%
Pennsylvania	10.9%
Connecticut	10.7%
Indiana	10.7%
New Jersey	10.2%
Wyoming	10.2%
Illinois	10.1%
Kansas	9.9%
North Dakota	9.5%
New York	9.4%
Delaware	7.7%
Maryland	7.7%
Hawaii	7.6%
District of Columbia	7.4%
Washington	7.3%
Kentucky	7.2%
Oregon	7.2%
Colorado	7.1%
Michigan	7.0%
Virginia	7.0%
South Carolina	6.9%
Utah	6.9%
Wisconsin	6.7%
Tennessee	6.6%
California	6.5%
Maine	6.5%
Minnesota	6.5%
Idaho	6.4%
Nevada	6.3%
South Dakota	6.2%
Alaska	6.1%
Ohio	5.9%
Louisiana	5.8%
Missouri	5.8%
North Carolina	5.8%
Iowa	5.7%
Florida	5.3%
Texas	5.3%
Georgia	5.0%
Arizona	4.6%
Nebraska	4.6%
Alabama	4.4%
Mississippi	3.2%
Montana	3.1%
Oklahoma	3.0%
Arkansas	2.1%

As of 2019-2020. US Department of Education, EDFacts Metadata and Process System (EMAPS) and US Census Population Estimates.

MINNESOTA

STRATEGY: Child Care Subsidies

Child care subsidies are an effective state strategy to impact:

CHILD CARE SUBSIDIES

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, and have a low family share of the total cost of child care.

State leaders: CA DC LA NM NY SD WA

In Minnesota, low-income families with a child care subsidy may pay up to 28.1% of the total market rate price of care, and the state's base reimbursement rates cover only 79.7% of the true cost of providing base-quality care.

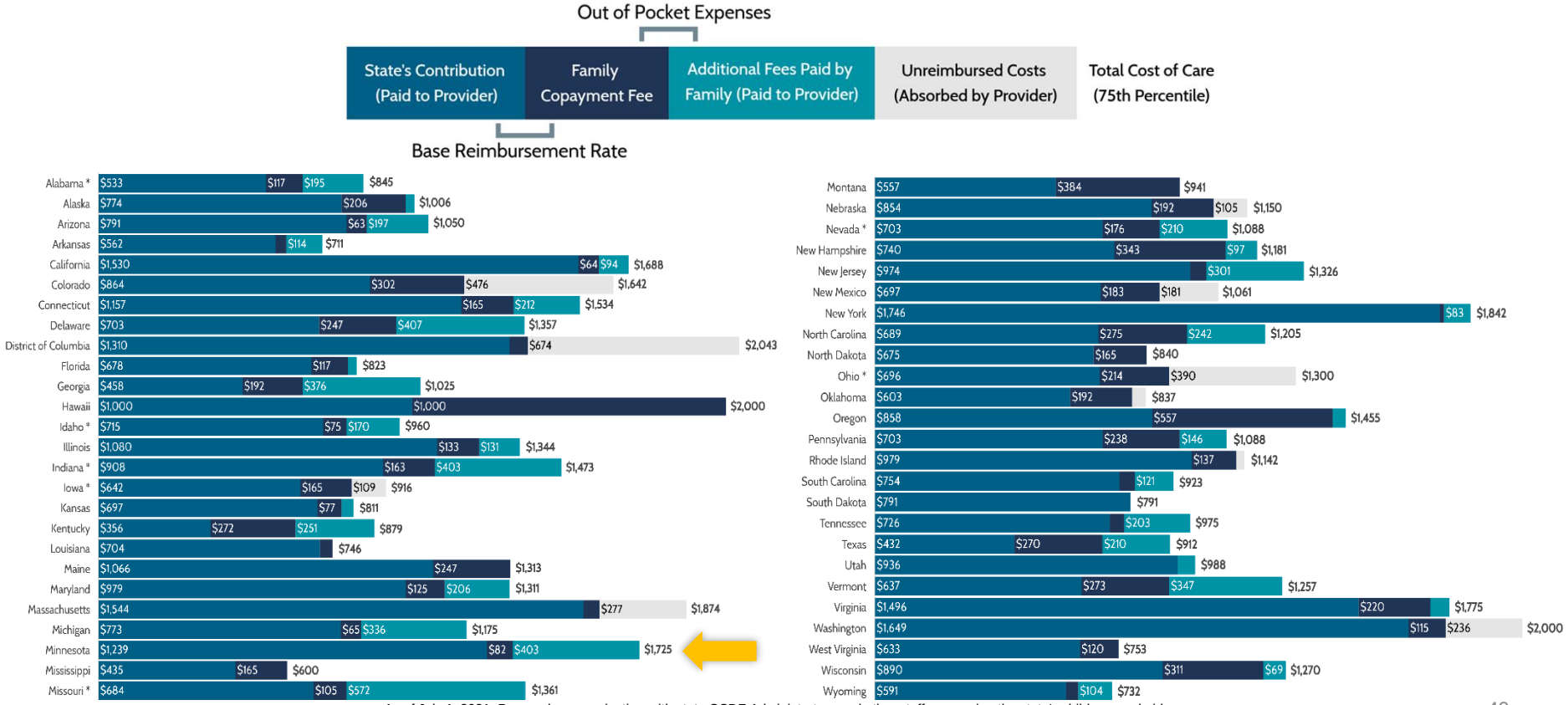
How Do Child Care Subsidies Impact PN-3 Outcomes?

- Higher state subsidy spending per low-income 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 low-income 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 the Distribution of the Total Cost of Child Care

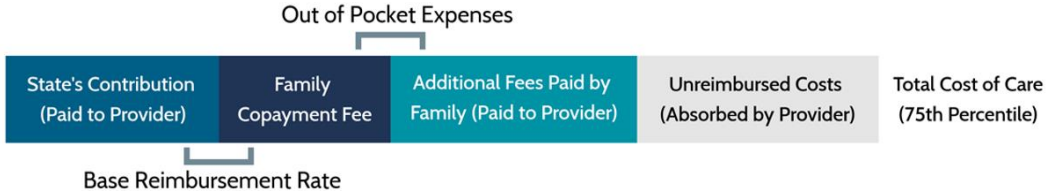


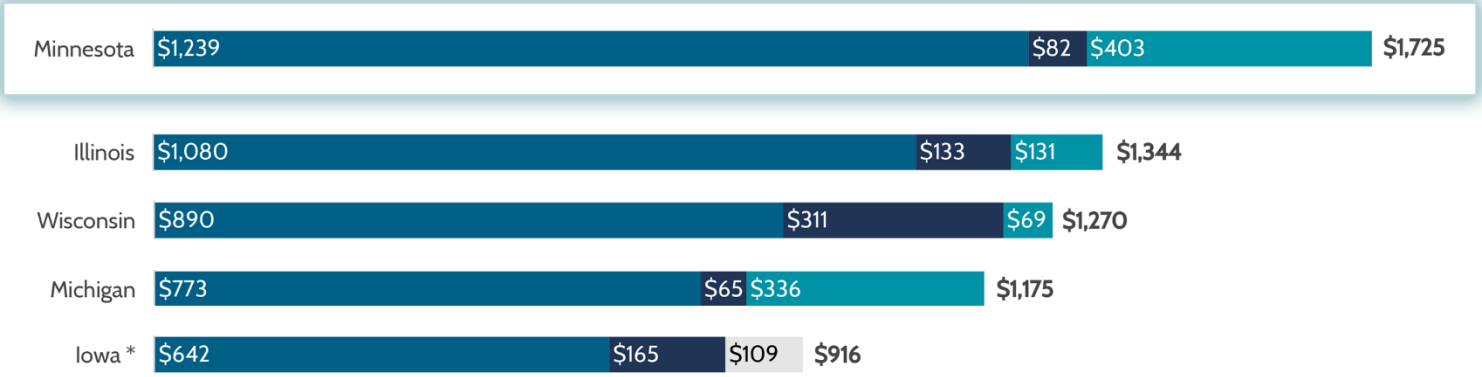
As of July 1, 2021. Personal communication with state CCDF Administrators and other staff overseeing the state's child care subsidy programs; State children and families department websites; state CCDF plans; and the State Market Rate Surveys.

MINNESOTA

STRATEGY: Child Care Subsidies

Variation Across Region in the Distribution of the Total Cost of Child Care



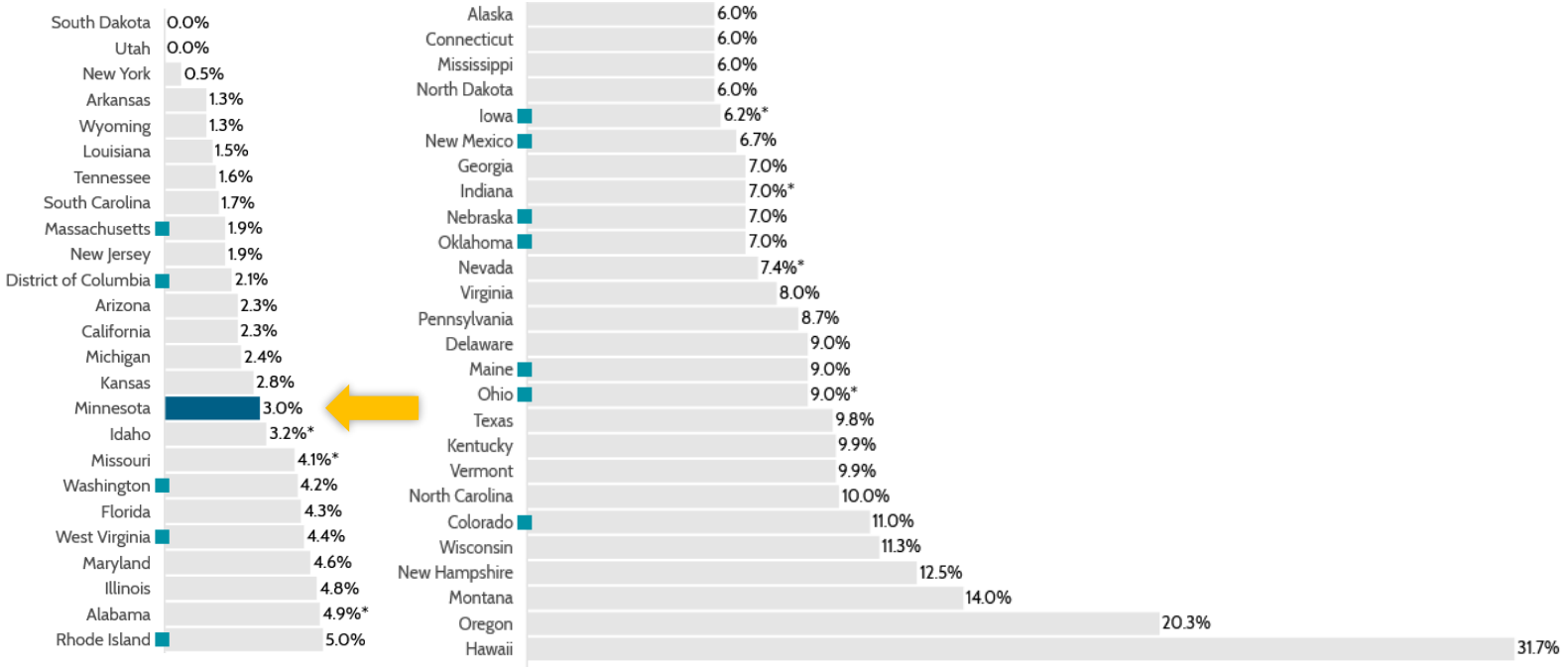


As of July 1, 2021. Personal communication with state CCDF Administrators and other staff overseeing the state's child care subsidy programs; State children and families department websites; state CCDF plans; and the State Market Rate Surveys.

MINNESOTA

STRATEGY: Child Care Subsidies

Monthly Copayment as a Percentage of Income for a Family of 3 at 150% FPL*



As of July 1, 2021. State children and families department websites and state CCDF plans.

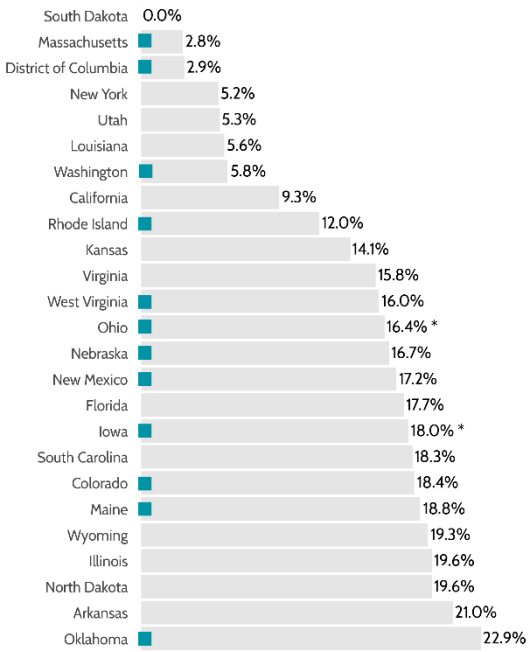
State does not allow providers to charge parents the difference between the reimbursement rate and provider rate

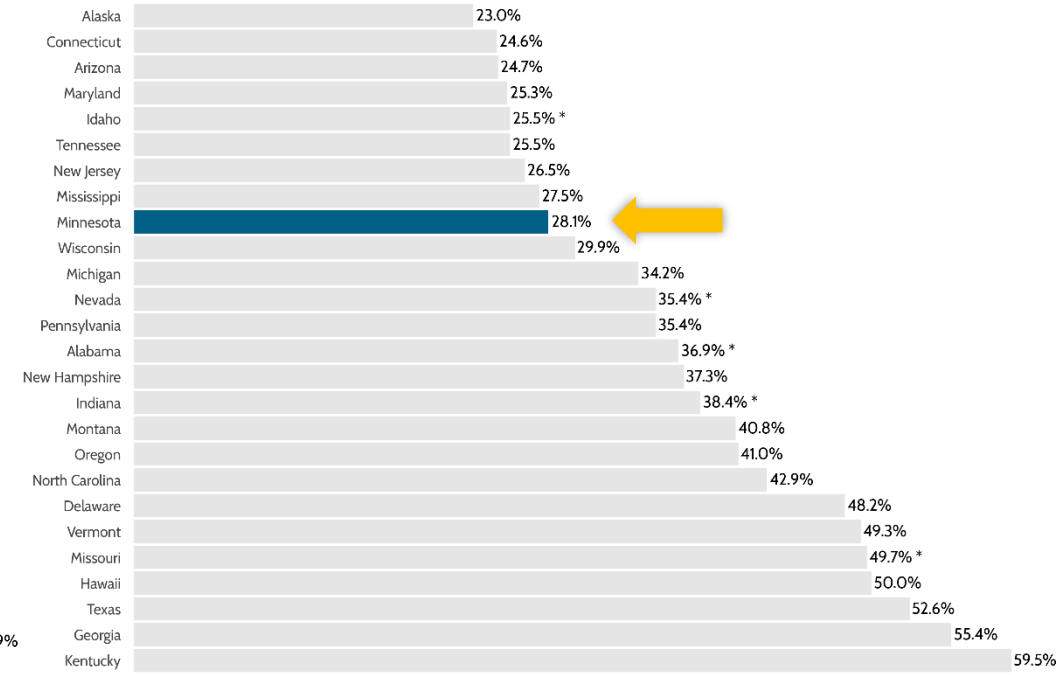
MINNESOTA

STRATEGY: Child Care Subsidies

Family Share of Child Care Costs for an Infant in Center-Based Care

Paid by a Family of 3 at 150% FPL*





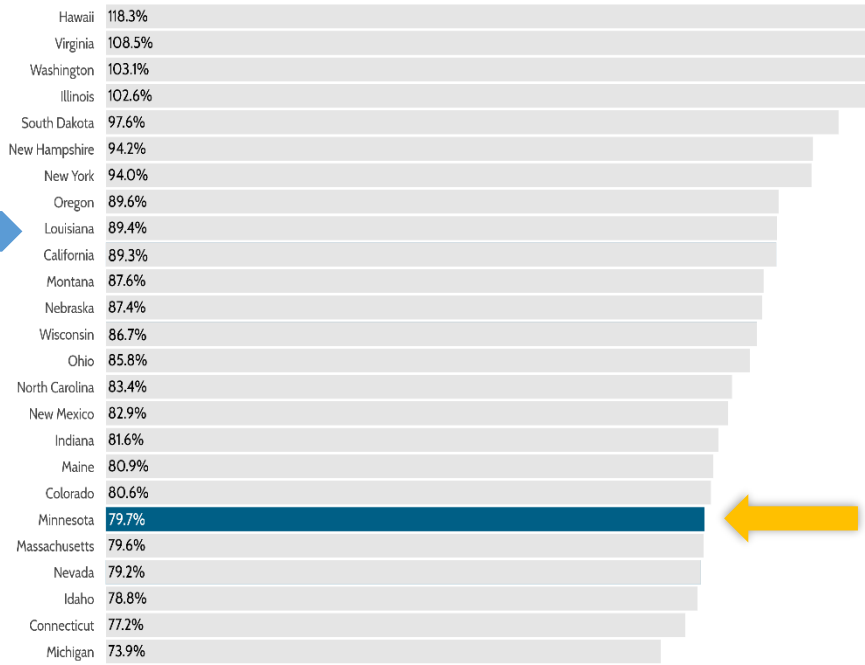
As of July 1, 2021. Personal communication with state CCDF Administrators and other staff overseeing the state's child care subsidy programs; State children and families department websites; state CCDF plans; and the State Market Rate Surveys.

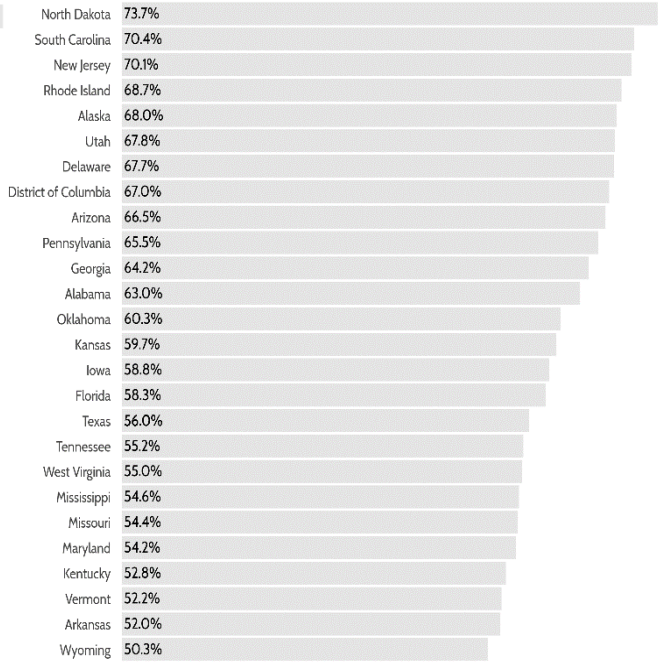
State does not allow providers to charge parents the difference between the reimbursement rate and provider rate

MINNESOTA

STRATEGY: Child Care Subsidies

Base Reimbursement Rates for Infants in Center-Based Care as a Percentage of the Estimated True Cost of Base-Quality Care





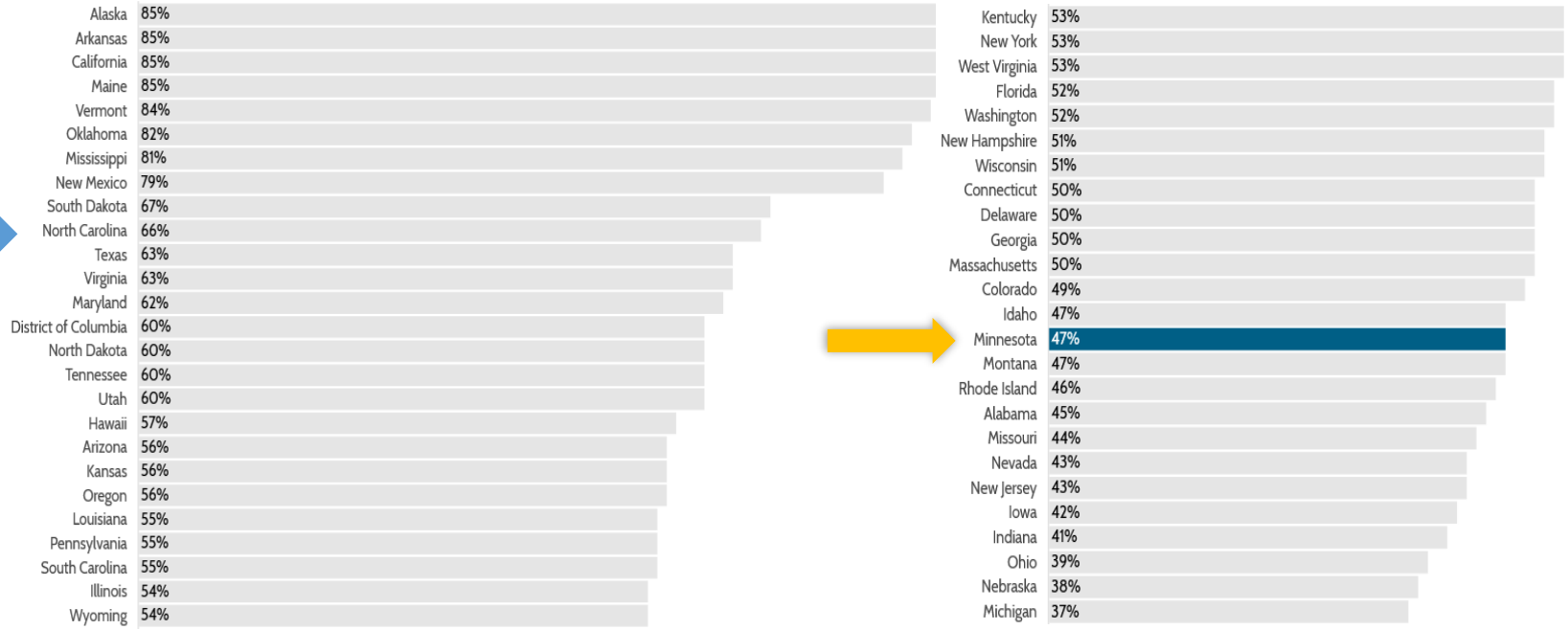
As of July 1, 2021. Personal communication with state CCDF Administrators and other staff overseeing the state's child care subsidy programs; State children and families department websites; and the Center for American Progress.

MINNESOTA

STRATEGY: Child Care Subsidies

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



Sources: As of July 2021. National Women's Law Center and state-specific legislation.

Recent Changes to Reimbursement Rates in Minnesota

- As of November 15, 2021, Minnesota increased daily reimbursement rates for providers participating in the subsidy system
  - Based on the 2021 Market Rate Survey (MRS), base reimbursement rates still fall short of the 75th percentile
  - However, providers serving infants and toddlers are now reimbursed at the 40th percentile of the 2021 MRS (prior rates were set at the 25th percentile of the 2018 MRS)
  - Base reimbursement rates also fall short of the estimated true cost of base- and high-quality care in MN
- The base reimbursement rates increased to approximately:
  - $1,586 and $1,361 per month for infants and toddlers in center care, respectively; and
  - $845 and $802 per month for infants and toddlers in family child care, respectively
- The highest quality reimbursement rates increased to approximately:
  - $1,903 and $1,633 per month for infants and toddlers in center care, respectively; and
  - $1,014 and $962 per month for infants and toddlers in family child care, respectively

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

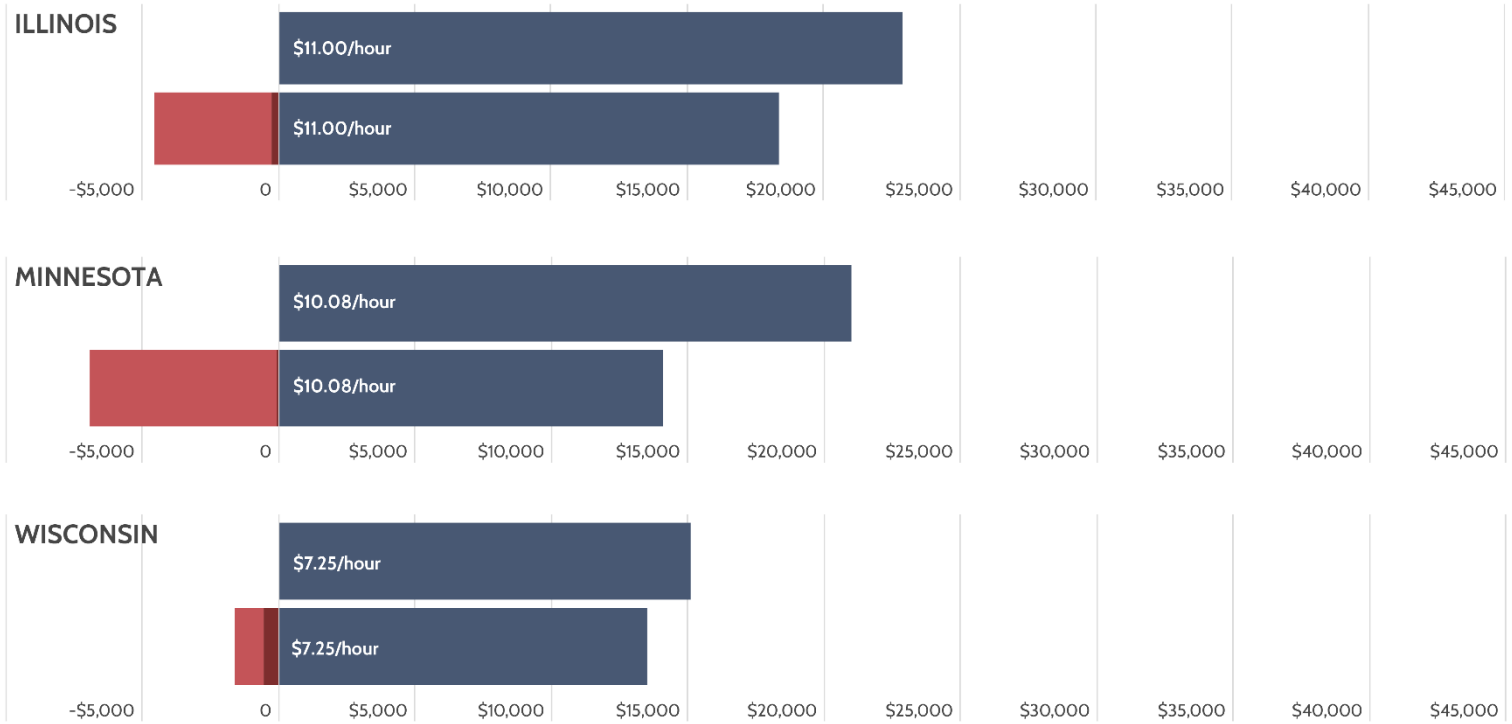
Total Resources Based on State Policy Choices

Minimum Wage Earnings

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; Bureau of Economic Analysis; 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.

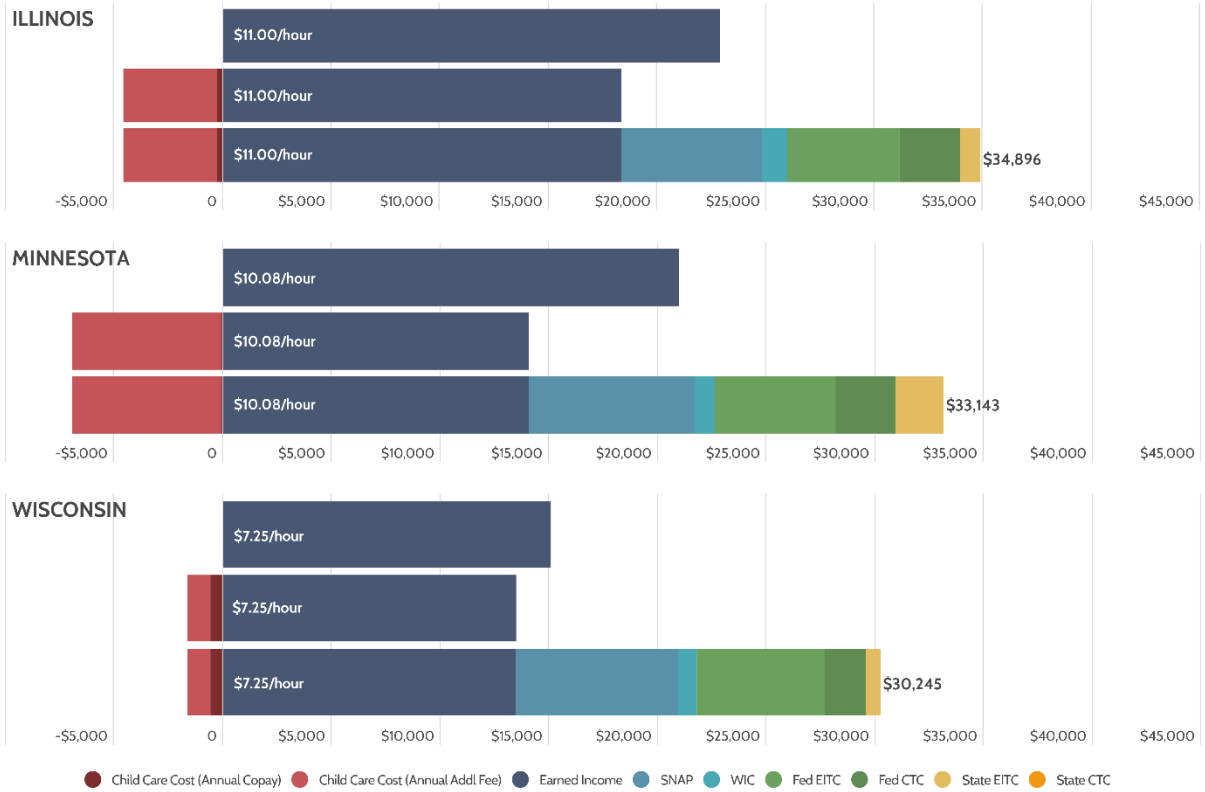
Total Resources Based on State Policy Choices

Minimum Wage Earnings (Less Out of Pocket Child Care Expenses)



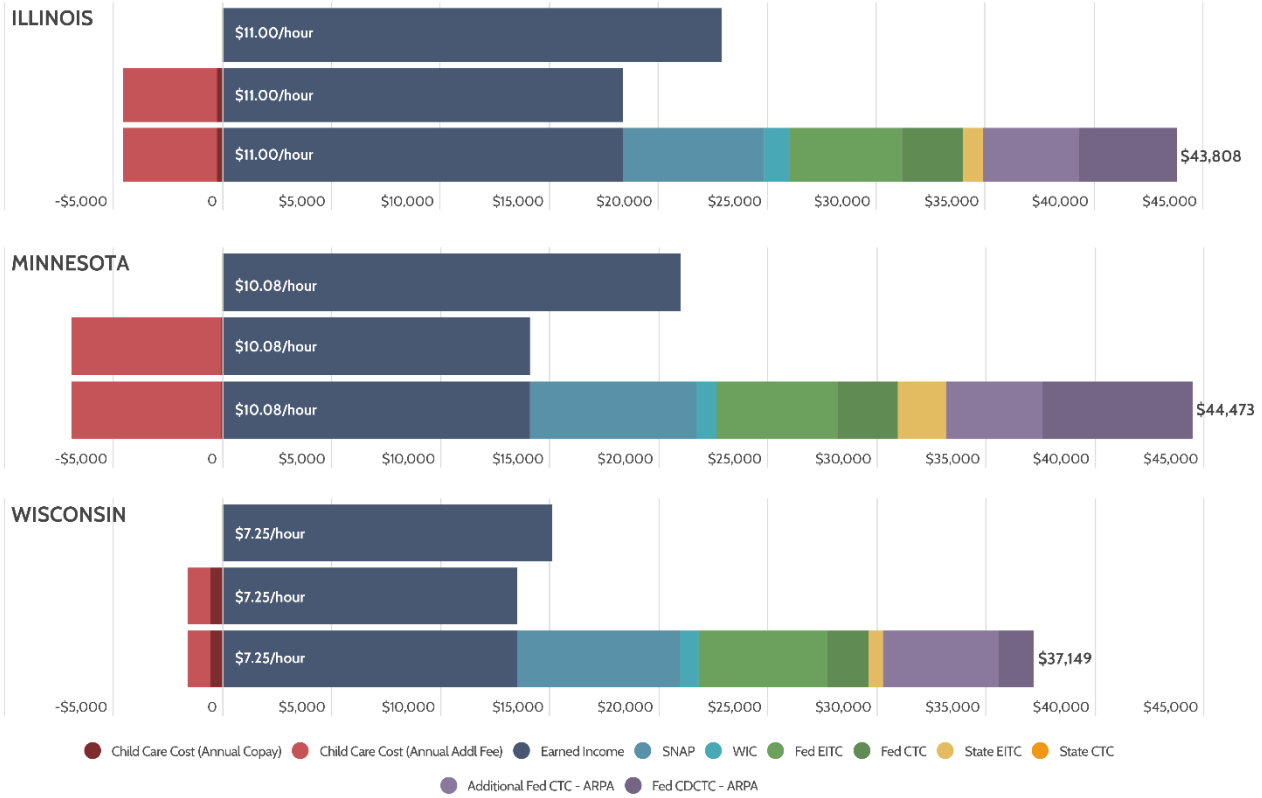
Total Resources Based on State Policy Choices

Minimum Wage Earnings (Less Out of Pocket Child Care Expenses) Plus Federal and State Benefits



Total Resources Based on State Policy Choices

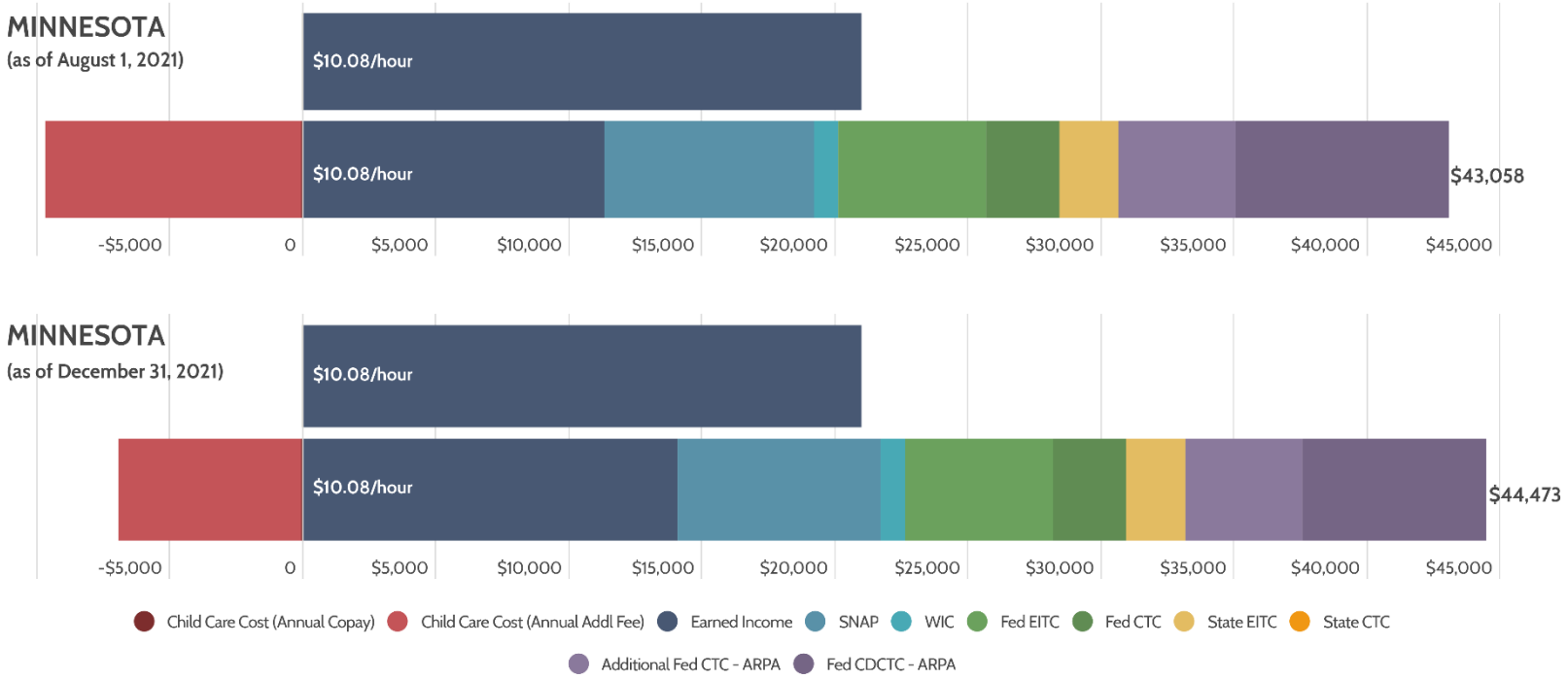
Minimum Wage Earnings (Less Out of Pocket Child Care Expenses) Plus Federal and State Benefits



Total Resources Based on State Policy Choices

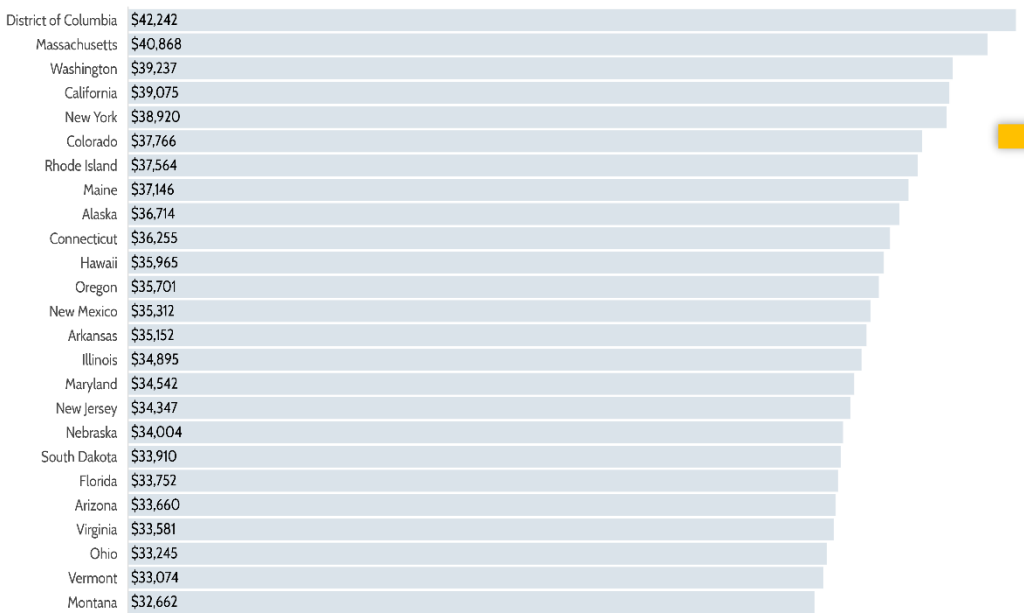
Minimum Wage Earnings (Less Out of Pocket Child Care Expenses) Plus Federal and State Benefits

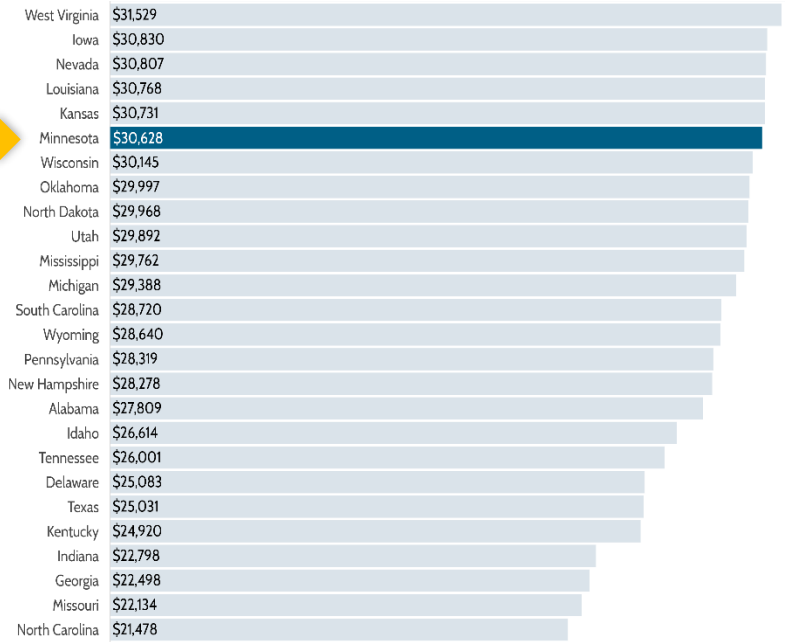
Before and after child care reimbursement rate changes



Total Available Resources for a Family of 3 Across States

Annual earned income and benefits (less out-of-pocket child care expenses) for a family with two children and one full-time state minimum wage earning adult





Notes: The federal poverty level for a family of three in 2021 is $21,960 (in the 48 contiguous states and DC), $27,450 (in AK), and $25,260 (in HI).
Sources: 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.

Moving Forward

- Offering ourselves as a resource to state policy leaders
- Identifying innovative practices in states to share widely
- Building the evidence base to identify additional effective policies
- Measuring progress toward policy implementation
- Monitoring changes in outcomes (difficult with COVID)
- Analyzing cost, funding, and return on investment of policies
- Determining whether the policy is equitable and closes gaps in outcomes

Connect

pn3policy.org

@pn3policy and **#pn3policy**

Subscribe: **http://bit.ly/email_pn3**