Mitigating the Effects of Adverse Childhood Experiences (ACEs) by Strengthening Income Support for Families

Position Statement of the American Heart Association

Introduction

Poverty is an important public health issue facing the United States, as approximately 21 percent of children under 18 years (15 million) live in families with incomes below the federal poverty threshold.[1] Research demonstrates that, on average, families need an income at least twice the federal poverty level to cover basic expenses such as food, housing, and transportation.[2] Using this standard, close to 43 percent of children live in low-income families.[3]

The correlation between adverse childhood experiences (ACEs) linked to poverty and negative health outcomes in adulthood is well established.[4,5,6] The American Heart Association (AHA) believes that due to the inextricable link between children's economic circumstances and health, policy investments promoting family financial health are imperative in mitigating the effects of childhood adversities. Numerous states have adopted policies such as minimum wage and sick leave or expanded antipoverty and safety net programs to lessen the effects of low earnings and poor job quality on individuals and their families. Several of these programs, particularly those that are important for children's health and well-being, are discussed in this position paper.

Background

ACEs are potentially traumatic events, either single, acute events or sustained over time, that have a direct and synergistic impact on health and well-being throughout the life course, contributing to many of the leading causes of morbidity and mortality in the U.S.[7,8,9,10,11,12] These experiences include but are not limited to: emotional, physical, or sexual abuse; exposure to environmental hazards; and household dysfunction.[13,14] In addition, poverty, which is often described as an ACE itself, is shown as a strong reinforcing factor in the accumulation of ACEs.[15,16] While a majority of children living in poverty are not affected by multiple ACEs, there is a significant proportion of families with multiple ACEs who experience poverty.[17]

The timing, duration, and community context of poverty appear to influence life course outcomes, with earlier experiences, longer duration, and higher concentrations of poverty in the community leading to poorer outcomes.[18,19,20] According to one study, exposure to economic hardship in early life has negative consequences for health both among individuals who begin life in poverty or are chronically poor, as well as among those who moved into poverty during their childhood years.[21] Because poverty may have cumulative impacts on health, early interventions may be optimal for long-term protection.[22]

Studies have also demonstrated that long-term income instability (repeated changes in family income that are unpredictable or unintentional and that do not lead to improved economic circumstances)[23,24] increases the likelihood of falling into poverty, which has detrimental effects on child development and later adult outcomes.[25] For example, fluctuations in family income are associated with changes in the quality of the home learning environment, which is associated with children's cognitive and language skills.[26] Even a short-term sustainable drop in income may adversely affect these families due to the attendant stress and loss of resources associated with such sudden declines.[27]

Over the past few decades, income instability has increased substantially for all Americans, but particularly for low-income families.[28] In a study of 235 low- and medium- income households, researchers reported that almost all households with an annual income that lifted them above the federal poverty level—between 100 and 150 percent of it—fell back into poverty for at least one month of the year; a third of households earning twice the poverty level also experienced at least one month of poverty.[29]

Further, a growing body of evidence suggests income instability is directly linked to instability in other family domains, including parental job loss (an involuntary one, in particular) and parental separation.[30] As such, income instability's relation to changes in other aspects of family life is likely to be complex and multidirectional and these precipitating events could bias estimates of the effect of income instability on children.[31]

AHA Position Statement on Income Support for Families

Research increasingly finds that certain investments in social assistance and health care for children experiencing ACEs linked to poverty have favorable long-term impacts. These impacts include improvements in children's overall health status, academic achievement, and future economic success. As an organization, AHA supports policies and programs that strengthen economic security for low-income families, helping to prevent and reduce the occurrences of poverty and its negative effects.

Tax policies and direct financial assistance

The **Earned Income Tax Credit (EITC)** is one of the largest federal income support programs designed to support low- and moderate-income working individuals. Recipients receive a credit equal to a fixed percentage of earnings from the first dollar up to a maximum credit. Both the credit and maximum rates vary by family size, with larger credits available to families with more children. States have the option to create a state income tax credit to further augment take-home pay for eligible recipients. According to the Center on Budget and Policy Priorities, the EITC lifted approximately 5.7 million individuals out of poverty, including three million children in 2017.[32] AHA supports measures to improve the EITC to better serve the economic stability of low-income workers.

The **federal minimum-wage laws** established by the Fair Labor Standards Act are designed to raise wages directly for the lowest paid workers in the U.S. Although there is some disagreement among economists, existing research is consistent with the proposition that increasing minimum wages likely reduces poverty. A full-time worker making the federal minimum wage earns $15,080 per year — an annual income that sits below the federal poverty level of $16,020 for a family of two.[33,34] Connecticut is among the most recent to join California, Illinois, Maryland, Massachusetts, New Jersey, and New York, as well as the District of Columbia to pass laws requiring a $15 minimum wage be in place by 2025 or earlier.[35] According to a recent report by the Congressional Budget

Office, increasing minimum wage to $15 per hour by 2025 would raise the earnings of 17 million workers whose wages would be below $15 per hour otherwise, helping to lift 1.3 million Americans out of poverty.[36] Further, available data derived from a recent literature review suggests minimum wage increases improve the following health outcomes: smoking; birthweight; and days with health limitations, including absence from work due to illness.[37] AHA supports efforts to raise the federal minimum wage to a level that will allow low-income families to sufficiently fund their basic needs, such as housing, food, and health care.

The **Child Care and Development Fund (CCDF)**, including the Child Care and Development Block Grant (CCDBG), is a federal funding stream administered by states used to provide child care subsidies to low-income working families through certificates, grants, or contracts. States have substantial flexibility in establishing eligibility criteria, benefit levels, and child care provider reimbursement rates. Additionally, states have the authority to use CCDF funds to improve the quality and availability of child care for all families through activities such as offering training to providers or targeting funds to increase the supply of limited types of care, including care for infants. According to the most recent available data, an estimated 8.6 million children under the age of 13 were eligible for CCDF benefits according to the eligibility policies in their states in 2012, and about 1.5 million received them.[38] AHA supports continued federal spending and program authority for the CCDF.

The **Child and Dependent Care Tax Credit (CDCTC)** helps to offset expenses of working parents. CDCTC is a nonrefundable tax credit that reduces a taxpayer's federal income tax liability based on child and dependent (including spouses) care expenses incurred. A taxpayer must meet eligibility criteria in order to qualify. Families can claim up to $3,000 in dependent care expenses for one child/ dependent or $6,000 for two children/ dependents per year. Data from the Tax Policy Center indicates that on average approximately 13 percent of taxpayers with children claim CDCTC.[39] AHA supports policies that update and improve the CDCTC to provide families with tax relief to offset the rising cost of child care.

The **Temporary Assistance for Needy Families (TANF)** block grant funds monthly cash benefits as well as other supports for very low-income families based on eligibility criteria set by states. Unlike its predecessor, Aid to Families with Dependent Children, TANF is not an entitlement program and aims to transition recipients to employment so that assistance is no longer necessary. As such, under federal rules, states are required to impose sanctions (by reducing or terminating benefits) if recipients do not meet ongoing work requirements as laid out by the TANF work participation rates (WPRs). In addition, federal rules have established a lifetime benefit limit of five years for most recipients, though states have discretion to shorten or use state TANF funds to extend the limit. According to the Congressional Research Service, approximately 1.2 million families received cash assistance in September 2018, a steep decline from the 5.1 million in March of 1994, a historical peak for TANF and its predecessor program.[40] AHA supports continued federal spending and program authority for the TANF block grant.

Supports for health and well-being

Beginning in 2014, the Affordable Care Act (ACA) expanded health care coverage to 20 million previously uninsured individuals through the expansion of Medicaid and the establishment of the Health Insurance Marketplace.[41] Coverage for children whose parents gained Medicaid eligibility through the expansion increased more than double the increase observed for children whose parents were ineligible (5.7 verses 2.7 percentage points).[42] Families with incomes below 100 percent of the federal poverty level are among those who are both

ineligible for public health insurance and unqualified for Marketplace premium subsidies. These families fall into the "coverage gap" that results from state decisions not to expand Medicaid. Research shows **expansions in public health insurance** for low-income children and adults are associated with decreased out-of-pocket costs, increased financial stability and improved material well-being for families.[43] By decreasing the financial burden and risk of health care spending, public health insurance has the potential to reduce the extent to which families live in poverty. AHA supports policies that advocate for Medicaid expansion in states that have not yet done so and for strong patient protection along with any public health insurance reforms.

The **Supplemental Nutrition Assistance Program (SNAP)** and the **Women, Infants and Children Supplemental Food Program (WIC)** are two federal food and nutrition programs that serve a substantial percentage of young children who live in households with food insecurity. Food insecurity, defined as having limited or uncertain capacity for acquiring sufficient, safe, and nutritious food to meet one's dietary needs, affects more than 16.7 percent of children in the U.S. [44,45] According to 2016 data, SNAP kept 3.3 million children out of poverty while lifting 1.9 million children above the poverty line.[46] Further, in 2017, WIC provided assistance to 22.0 percent of all children ages zero to four years, with total spending equaling to $5.6 billion of which $3.6 billion was spent on food.[47] Research on SNAP and WIC quantifies the importance of these programs for low-income families, noting improvements in overall health status and lower health care costs.[48] AHA supports efforts to preserve access to and maintain benefit levels of SNAP and WIC for low-income families.

Workplace benefits such as **paid family leave (PFL) and paid sick days (PSD)** help low-income workers with children address family health needs without compromising their economic security. While there is no federal requirement for PFL in the U.S., the Family and Medical Leave Act (FMLA) of 1993 requires eligible employers to provide unpaid, job-protected time off. According to research, only 17 percent of workers have access to PFL through their employers, while 40 percent have access to personal medical leave through employer-provided short-term disability insurance.[49] Similarly, there is no federal requirement that employers allow workers to take sick days when they or a family member has a short-term illness that prevents them from working. Data suggests approximately 34 million workers in the private sector lack access to PSD.[50] Currently, 11 states, the District of Columbia, and 22 localities have PSD in effect that guarantee millions of workers the ability to maintain their jobs and financial security while caring for family.[51] AHA supports federal mandates requiring employers to provide adequate PFL and PSD.

The **Community Services Block Grant (CSBG)** is a federally funded anti-poverty block grant aimed at addressing the causes of poverty by implementing programs and services in areas such as employment, education, income management, housing, and nutrition, aimed at empowering low-income families and individuals. Beginning in 1974, the CSBG is the longest continuously operating program at the Department of Housing and Urban Development (HUD). The CSBG provides annual grants on a formula basis to local governments and states and is operated through a state-administered network of community and faith-based, not-for-profit organizations. AHA supports maintaining funding for the CSBG program through the annual appropriations process.

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