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On Behalf of the American Academy of Pediatrics

Before the U.S. House of Representatives

Ways and Means Committee

Worker & Family Support Subcommittee

“Combating Child Poverty in America”

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Chairman Davis and Ranking Member Walorski, thank you for the opportunity to speak here today. I am Dr Marsha Raulerson, a practicing pediatrician from Brewton, Alabama. I am testifying today on behalf of the American Academy of Pediatrics. The American Academy of Pediatrics (AAP) is a non-profit professional membership organization of 67,000 primary care pediatricians and medical and surgical pediatric subspecialists dedicated to the health and well-being of children.

I'm here to add the voice of a pediatrician to one of the most significant non-communicable diseases our nation's children face today: Poverty. Poverty is in every community—urban, suburban, rural—and children are the poorest members of our society. Nationally, roughly 18 percent of children under 18 live in poverty but in the state of Alabama 24 percent of children live in poverty.ⁱ For children under age 5, it's 26 percent.ⁱⁱ On a population level, research shows that children born into poverty—and who persistently live in poor conditions—are at great risk for a host of health and developmental challenges throughout their lives. Poverty has profound negative effects on infant mortality, immunization rates, nutrition, language and social development. Children living in poverty are also more likely to be exposed to violence and suffer from injury and chronic illnesses. What's more, the effects of persistent poverty can lead to toxic stress, which alters the way a young child's brain develops. This leads to lower educational attainment and higher rates of crime, teen pregnancy and substance abuse.

Experience of My Patients Living in Poverty

In my hometown of Brewton, Alabama—a small town in Escambia County where I have lived and practiced for 40 years-- I see the effects of poverty every day. Brewton is a wonderful community filled with hardworking people who care about each other, yet we struggle with the effects of intergenerational poverty. Twenty-four percent of people in Escambia County live in poverty and the number is much higher for children, hovering above thirty percent.ⁱⁱⁱ The impacts of growing up in a poor household are far-reaching, affecting access to healthcare, education, housing, food, and opportunity.

In my practice where I care for patients with special needs, I am a witness to the day to day challenges that my patients and their families who live in poverty face, including securing transportation to a doctor's appointment, finding someone to watch their children while they work, and making sure they have access to nutritious meals that will help their children grow. The vast majority of the parents of my patients have jobs—some have multiple jobs—but their jobs do not pay well and it is difficult to get time off for things like doctor's appointments or meetings with their children's teachers.

One of my patients, for example, is on the autism spectrum and would benefit from therapy to improve his abilities and reduce his symptoms. His mom works a full-time job and is unable to get any time off from work to take her son to therapy appointments. Another one of my patients is a boy who is having a lot of challenges in school. He would benefit greatly from afterschool support but that is not an option for him because his mom works in Florida so he must take the school bus if he is to get home each night. However, where he sleeps at night depends on whether his mother is working. Some nights are spent at his grandmother's house. The lack of consistency in his life and his inability to participate in school-based services lead to a vicious cycle of continued problems in school.

In fact, I've heard from the parents of many of my patients that if they miss a single day of work during the first 90 days of their employment, they will lose their jobs. That means not being able to take a day off if your child is sick and needs to go to the doctor. Barriers like these make it difficult for someone who wants to work to

keep a job. If a parent is unable to take time off from work to take her child to the doctor and still keep her job, she's unlikely to be able to stay employed. If parents are not able to stay employed, a family will have less income coming into the household, thus driving the family into even deeper poverty.

The single most significant challenge my patients face that contributes to their poverty and to poorer health outcomes is lack of access to transportation. Most of the families that I see have one car. That one car is used by a working parent to get to their job each day. This often leaves the other parent and the children at home without a means of transportation during the workday. In Brewton there is no public transportation system. So, keeping the car functioning and able to get the parent to work becomes a families' highest priority.

The grandmother of one of my patients transports two different daughters to work and she herself has a part-time job. It's understandable, therefore, that her granddaughters' type II diabetes and obesity are not being addressed adequately. In fact, she had been taking the bus home every day and locking herself inside her home until her mom got home at 10 pm. I am proud to say that I have worked with her grandmother to come up with an alternative plan that will better meet her health care needs.

My hometown of Brewton has many strengths. We have a program started by our hospital called Wheels of Wellness, or WOW, that provides transportation services for healthcare appointments for children and expectant mothers without other means of transportation. While this program is a lifeline for many families in our community, it books up quickly and patients who need transportation to a last-minute doctor's appointment are often unable to secure a ride. Again, this makes it difficult for parents to access care for their children. In fact, many of these patients end up seeking care in the emergency department after hours as they don't have access to a car until after most doctor's offices are closed. The emergency department is not an appropriate place for a child with a sore throat or ear infection, yet for many families this is the only place they can access care.

To add to this problem, rural hospitals around the country are closing at an alarming rate. In my area eight hospitals have closed in the last few years. While there are many reasons for these closings, one of the biggest factors is Alabama's decision not to expand Medicaid. In Alabama, non-pregnant adults are ineligible for Medicaid if they make more than 13% of the Federal Poverty Level.^{iv} As a result, many adults go without health insurance. When patients don't have insurance but are in need of emergency care, hospitals are obligated to provide that care regardless of whether they will receive payment. Providing high levels of uncompensated care is costly to hospitals and has led to many hospitals losing money and being forced to shut down.

Apart from the effect that the decision not to expand Medicaid has on adults and our local hospitals, it also impacts my pediatric patients. As a pediatrician, I know that parents who are enrolled in coverage are more likely to have children enrolled in coverage, and parents with coverage are also more likely to maintain their children's coverage over time. A comprehensive body of research highlights the powerful effect of increases in parental access to insurance coverage on their children's access to insurance coverage. In fact, from 2013-2015, 710,000 children gained coverage, despite the fact that children's eligibility for coverage did not change under the Affordable Care Act.^v This is due in large part to parents gaining coverage under the Medicaid expansion and realizing that their children had been eligible for Medicaid all along. Further, data shows that in Medicaid expansion states, the health-inclusive poverty rate is 10 percent lower than in non-expansion states, and deep poverty is 13 percent lower in expansion states versus non-expansion states.^{vi}

Research also demonstrates that when parents have health insurance, children are more likely to get the care they need. A recent study showed that increases in adult Medicaid eligibility levels were associated with a greater likelihood that children in low-income families received at least one annual well child visit.^{vii} Whereas children whose parents are insured are almost always insured themselves, 21.6 percent of children whose parents are uninsured are also uninsured, meaning when parents lose coverage, so do their children.^{viii}

I want to highlight a lesser known reality of living in poverty and lacking health insurance. When families in my community are having trouble coming up with the money to pay rent or a medical bill, they often turn to one of the many payday loan services that litter our community. One of my patients was diagnosed with liver cancer at 6 months of age. She needed weekly treatment at a children's hospital that was 200 miles away. Desperate to afford the transportation and health care costs, her mother took out a payday loan that carried with it 400% interest. The good news is that her daughter is now 6 years old and cancer free. But her mother lost her job and couldn't pay back the loan so she had to declare bankruptcy and now suffers the mental health effects of dealing with her daughter's diagnosis and the ensuing financial strain. Every day I see how these unregulated loans push my patients and their families further and further into poverty.

I hope these examples help to illustrate why we will not be able to alleviate poverty unless we approach it in a holistic manner. The ability to access health care is contingent on access to a clinic, reliable transportation, health insurance, and time off from work among many other factors. It is immensely difficult for a struggling family to lift themselves out of poverty when they are faced with all of these interconnecting barriers. While it may be difficult to address all of these varying factors, it is critical that we do so given the documented impact that experiencing poverty has on child health.

Health Impact of Poverty

Children who experience poverty, particularly during early life or for an extended period, are at risk of a host of adverse health and developmental outcomes through their life course.^{ix} Poverty has a profound effect on specific circumstances, such as birth weight, infant mortality, language development, chronic illness, environmental exposure, nutrition, and injury.^x Child poverty also influences genomic function and brain development by exposure to toxic stress, a condition characterized by "excessive or prolonged activation of the physiologic stress response systems in the absence of the buffering protection afforded by stable, responsive relationships."^{xi} Children living in poverty are at increased risk of difficulties with self-regulation and executive function, such as inattention, impulsivity, defiance, and poor peer relationships.^{xii} As I know from my own practice, poverty can make parenting difficult, especially in the context of concerns about inadequate food, energy, transportation, and housing.

Child poverty is associated with lifelong hardship. Poor developmental and psychosocial outcomes are accompanied by a significant financial burden, not just for the children and families who experience them but also for the rest of society.^{xiii} Children who do not complete high school, for example, are more likely to become teenage parents, to be unemployed, and to be incarcerated, all of which exact heavy social and economic costs.^{xiv} A growing body of research shows that child poverty is associated with neuroendocrine dysregulation that may alter brain function and may contribute to the development of chronic cardiovascular, immune, and psychiatric disorders.^{xv}

The economic cost of child poverty to society can be estimated by anticipating future lost productivity and increased social expenditure. A study compiled before 2008 projected a total cost of approximately \$500

billion each year through decreased productivity and increased costs of crime and health care, nearly 4% of the gross domestic product.^{xvi} Other studies of “opportunity youth,” young people 16 to 24 years of age who are neither employed nor in school, derived similar results, generating cohort aggregate lifetime costs in the trillions.^{xvii}

The Need for Social Supports

The National Academies of Sciences, Engineering, and Medicine (NASEM) consensus report “A Roadmap to Reducing Child Poverty” published last year found that many federal programs that alleviate poverty have been shown to improve child well-being.^{xviii} As a pediatrician, I know this from my own experiences working with families.

Recognizing the impact that poverty has on child health, AAP published a major policy statement in 2016 calling on pediatricians to screen families for basic needs such as food, housing, and heat and to connect them with community-based resources and programs that address those needs. Despite poverty being one of the most widespread and persistent health risks facing children today, it can also be one of the hardest to detect. Poverty can’t be seen on an x-ray. Hunger can’t be heard through a stethoscope. And yet, we as pediatricians are now identifying poverty in the exam room. And just like we diagnose medical diseases and prescribe medications, we can identify a family who needs help putting healthy food on the table or safe, stable housing, or support for better parenting, and connect them to programs that can help.

The AAP policy statement calls on policymakers to invest in policies and programs we know help lift children out of poverty and improve their health.^{xix} Programs that help poor families and children take many forms and often involve stakeholders from multiple communities, including governmental, private nonprofit, faith-based, business, and other philanthropic organizations. Federal anti-poverty and safety net programs, including those that provide health care (and access to health care through Medicaid and CHIP), early education (such as Head Start and Early Head Start), quality child care, affordable housing and home visiting, as well as critical nutrition assistance programs like WIC, SNAP, school meals, and summer feeding programs must be protected and accessible to all families in need.

Access to Comprehensive Health Care

All children, adolescents, and young adults from birth to the age of 26 years who reside within our borders, regardless of income, family composition, or immigration status, should be covered by an affordable, quality health insurance plan that allows access to comprehensive essential care. Evidence shows that insurance coverage, whether private or public, results in improved health outcomes in children, such as: improved prenatal care (thus reducing infant mortality and low birth weight), reduced avoidable hospitalizations of children, and increased probability that children will receive recommended immunizations.^{xx} Other studies have shown that improved access to public health insurance at birth improved children’s performance on standardized reading tests.^{xxi}

In Alabama, nearly 50% of children are covered by Medicaid.^{xxii} In my practice, nearly all of my patients are covered by Medicaid. Medicaid’s core mission is to provide comprehensive health coverage to low-income people for the health care services they need. Children make up the single largest group of people who rely on Medicaid and in Alabama, virtually all people on Medicaid are children. Nationally, about 35 million children receive Medicaid coverage, including children with special health care needs and those from low-income families.^{xxiii}

Unlike many private health insurance plans, Medicaid guarantees specific benefits designed especially for children. Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits are the definitive standard of pediatric care, covering an array of services like developmental, dental, vision and hearing screenings, and allowing health problems to be diagnosed and treated appropriately and as early as possible. In fact, children in Medicaid are more likely to get medical check-ups, attend more days at school, graduate and enter the workforce than their uninsured peers.^{xxiv}

When children see providers who know their medical history and can monitor their physical and socioemotional development, they are more likely to have better overall health, be up-to-date on immunizations, perform better in school and receive care in the most cost-effective way.^{xxv} Moreover, child health is a strong predictor of adult health. Addressing health and development during childhood—from birth through adolescence—leads to improved life outcomes in many areas. Conversely, the inability to access health care services threatens the physical, mental, and social health and well-being of children and their caregivers.^{xxvi}

Nutrition Support

Access to sound, appropriate nutrition is fundamental to achieving and sustaining optimal child health and well-being into adulthood. Exciting new data shows the short- and long-term impacts of investments in nutrition and health care during the prenatal and early childhood years. The time period from pregnancy through early childhood is one of rapid physical, cognitive, emotional, and social development and because of this, this time period in a child's life can set the stage for a lifetime of good health and success in learning and relationships or it can be a time when physical, mental and social health and learning are compromised.

Children deserve the best possible chance at success and that means no child should have to struggle with food insecurity. Families and children do not only feel the effects of hunger just as missed or meager meals; food insecurity manifests itself in many other biopsychosocial outcomes, including health, education, and economic prosperity.^{xxvii} As with many pediatric conditions, the health effects of food insecurity and associated malnutrition may persist beyond early life into adulthood.^{xxviii} A substantial body of literature also links early childhood malnutrition to adult disease, including diabetes, hyperlipidemia, and cardiovascular disease.^{xxix} Studies of the outcomes of food insecurity in childhood suggest that it may be an example of ecologic context modifying individual physiologic function.^{xxx} Combined, these negative effects can contribute to a less competitive workforce for the nation and higher health costs.^{xxxi}

SNAP is the largest program in the domestic hunger safety net and offers nutrition assistance to millions of eligible, low-income individuals and families. Like poverty, food insecurity is a dynamic, intensely complex issue. For many families, seemingly small changes to income, expenses, or access to federal or state assistance programs may instantly reduce the ability to purchase healthy food and result in increased vulnerability to food insecurity. In fact, about one in seven children in this country live in food insecure households.^{xxxii} In an average month, more than 40 million Americans access SNAP benefits.^{xxxiii}

Beyond its role in fighting food insecurity, SNAP significantly reduces child poverty and helps struggling families to make ends meet: SNAP benefits lifted 1.5 million children out of poverty in 2017 alone.^{xxxiv} Further, SNAP has also been shown to improve beneficiaries' dietary intake, health and well-being. Young children in low-income families that receive SNAP are less likely to be underweight or at risk for developmental delays

than similar children whose families do not receive SNAP. Children who receive SNAP benefits are 18% more likely to complete high school and 16% less likely to be obese as an adult.^{xxxv}

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) is a targeted, time-limited supplemental public health nutrition program that serves roughly 7.6 million women, infants, and young children across the United States each month. The WIC food package is specifically designed to ensure that pregnant mothers and young children receive the nutrients that are essential to a healthy pregnancy, proper brain development, and long-term health. Prenatal WIC participation is associated with lower infant mortality rates, higher birth weights, and fewer pre-term births.^{xxxvi} WIC also improves breastfeeding rates. It has been estimated that \$13 billion per year would be saved if 90% of US infants were breastfed exclusively for six months.^{xxxvii}

By connecting families to preventative health services and improving health outcomes for its participants, WIC is contributing to substantial healthcare cost savings. For example, pre-term births cost the U.S. over \$26 billion a year,^{xxxviii} with average first year medical costs for a premature/low birth-weight baby of \$49,033 compared to \$4,551 for a baby born without complications.^{xxxix} For very low birth-weight babies, a shift of one pound at birth saves approximately \$28,000 in first year medical costs.^{xi}

Good nutrition is essential to health, and good health is essential to effective learning. The National School Lunch program provides nutritionally balanced, low-cost or free lunches to about 30 million children each school day. Roughly 14 million children receive breakfast in their school. Children typically consume up to half of their daily calories in school, and for some children, the only food they eat each day comes from the federal school meal programs.

Fear, stigma, paperwork requirements, and financial constraints are all barriers to children participating in free- or reduced-price school meals. All children should have access to the school meals they need to help them thrive.

The Community Eligibility Provision (CEP) is an example of an innovative program that increases access to school meals. CEP allows schools in low income communities to serve free breakfast and lunch to all students without requiring their families to complete individual applications, thereby reducing stigma and making participation in the school meals programs easier for families. CEP has been critical to lessening the administrative burden on schools, increasing participation, and facilitating implementation of alternative breakfast service models but more eligible school districts in Alabama need to take advantage of this opportunity.

Early Childhood Education

Early Head Start and Head Start are federally funded, community-based programs that provide educational, nutritional, health, and social services to low-income families with young children. Early Head Start serves pregnant women and families with infants and toddlers up to 3 years of age; Head Start serves families with preschool aged children 3 to 5 years of age.

Early childhood interventions have been found to have a high rate of return in both human and financial terms. Early interventions in high-risk situations have the highest return, presumably through mitigating the effects of toxic stress by providing nurturance, stimulation, and nutrition.^{xli} Child benefits include improved

cognitive functioning, improved self-regulation, and advancement of development in all domains.^{xliii} Research as early as 2005 by the Rand Corporation found a range of return on investment from \$1.80 to \$17 for each dollar spent on early childhood interventions.^{xliiii} More recent studies of preschool (birth to age 5 years) education estimate a return on investment as high as 14% per year on the basis of improved academic and occupation outcomes, in addition to lowered costs of remedial education and juvenile justice involvement.^{xliiv}

In my hometown of Brewton, I have been working for seven years to help establish an Early Head Start program for children 0-3 to have a place to go while their parents are working. I am proud to report that we just got approved in my county, and while it currently only serves 15 children, it is making a positive impact on the lives of these children. For the first time, Brewton will have a Summer Head Start Program this summer so that kids have a safe place to go to learn and grown while school is out.

Tax Policies

The earned income tax credit (EITC) plays a critical role in helping families in poverty. Because most of the parents of my patients work, the EITC helps supplement income for low-wage workers and it incentivizes employment. The EITC has been shown to increase workforce participation among single women with children and help families pay for basic essentials.^{xliv} Additional research also has connected the EITC to improvements in infant health. An analysis of families who received the largest EITC under the 1990s expansions of the credit showed lower rates of low birth weight children, fewer preterm births, and increased prenatal care among these families.^{xlvi}

The child tax credit provides tax refunds to low-income working families who pay payroll taxes but who might not owe federal income tax. Although only partially refundable, this direct cash benefit helps reduce childhood poverty.^{xlvii}

Home Visiting

The AAP is a longstanding supporter of the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) because home visiting programs support improved child health, well-being, and development. MIECHV funds evidence-based programs focused on a variety of important child outcomes, including preventing maltreatment, fostering child development, promoting school readiness and improved long-term academic outcomes, and supporting parents' development of educational and work-related skills. These programs make a major difference in the health and economic trajectories of child beneficiaries and their families, and MIECHV is a critical public policy intervention to improve access to these programs. While MIECHV reaches many families, it is currently far below serving all eligible families. Of the 18 million current and expectant parents who could benefit from MIECHV, only 150,000 currently benefit from the program. AAP strongly supports doubling funding for MIECHV to \$800 million annually to better meet the needs of vulnerable children and families.

The AAP thanks Chairman Davis for his leadership on the AAP-endorsed *Home Visiting to Reduce Maternal Mortality and Morbidity Act*, which passed the U.S. House as part of H.R. 3. This legislation would invest in this successful program by increasing MIECHV funding to \$600 million in Fiscal Year (FY) 2021 and to \$800 million in FY 2022. Increased funding will expand the program's capacity, support further innovation in developing effective models, and address ongoing public health needs, including the impact of maternal mortality and the opioid crisis on children and families. Home visiting is an essential child health intervention that makes a

difference in the lives of children and families, and this legislation will greatly expand this successful program. We urge the advancement of this important MIECHV expansion without delay.

Conclusion

As a practicing pediatrician in a rural small town in Alabama, I've seen firsthand how the intergenerational cycle of poverty impacts my community. The physical and behavioral effects of growing up in poverty along with the lack of social mobility and educational attainment that my patients face can be heartbreaking at times. However, I've also seen the positive difference that community interventions can have in the lives of these children. Twenty-five years ago, I started the Reach Out and Read Program in Alabama. Reach Out and Read prepares our youngest children to succeed in school by partnering with doctors to prescribe books and encourage families to read together. Beginning at birth, our pediatricians coach parents at all infant and toddler well visits about the critical role that reading and language-rich interactions play in their daily routine. In the 25 years since I started this program, I have been able to see the impact it has had on child poverty. There's nothing like seeing the excitement on children's faces when they know they are about to go home with a new book. For some patients, this excitement grows into a love of learning that will help them succeed and, hopefully, outgrow the poverty that they faced as children.

My hope is that community interventions like Reach Out and Read as well as national programs like Medicaid, WIC, SNAP, and Head Start can be strengthened and expanded so that fewer children have to grow up facing the consequences of poverty. Thank you for the opportunity to testify today, I look forward to working with you to achieve this goal.

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