Issue Brief

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Breaking the poverty cycle:
Funding programs that impact future generations

U.S. birth rates dropped two percent between 2016 and 2017. Among teens, the birthrate has steadily dropped 55 percent over the last decade, while the birthrate at the other end of the age scale—women between age 40 and 44—has ticked *upward*.[1] While commentators conjecture about the "why" behind declining fertility rates, the combined statistics hold promise that more women may be choosing *when* to start families rather than drifting into a parenting role before they're ready.

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> **— Isabel V. Sawhill, Ph.D., Senior Fellow in Economic Studies, Center on Children and Families, Brookings Institution**

From a societal perspective, choosing when to have children is a positive sign. Unintended pregnancy can change the trajectory of a family's life—particularly in lower income communities. Plans to finish high school or attend college are disrupted. Career plans or other dreams can be delayed or deferred. And the effect on social equity—for both parent and child—can persist for generations.

Reducing risks for families—and costs for everyone

Reducing the rate of unintended pregnancies through education and greater use of effective contraception is a long-held public health policy goal. The Affordable Care Act required health plans to cover contraception at no out-of-pocket cost, with few exceptions. In many states that expanded Medicaid coverage like Colorado, efforts to support uptake of long-acting reversible contraceptives (or LARCs) are already paying dividends for women, children and state budgets.[2]

"Almost half of American babies are now born on Medicaid, and a typical birth can cost around $14,000," says Isabel Sawhill, Ph.D., senior fellow in

[1] Hamilton, Brady E, et al. "Births: Provisional Data for 2017." *National Vital Statistics System,* Centers for Disease Control and Prevention, National Center for Health Statistics, May 2018, www.cdc.gov/nchs/data/vsrr/report004.pdf.

[2] Colorado Department of Public Health and Environment, *Taking the Unintended Out of Pregnancy: Colorado's Success with Long-Acting Reversible Contraception,* January 2017. https://www.colorado.gov/pacific/sites/default/files/PSD_TitleX3_CFPI-Report.pdf

> *"It was the intersection of provider mindset change, consumer awareness and funding ability to pay for LARCs."*
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> **— Liane Jollon, RN**
> **Executive Director,**
> **San Juan Basin Health Department**

economic studies, Center on Children and Families at the Brookings Institution. "Although LARCs can be expensive, costs have come down in recent years. And they save money over the long term. From a purely budgetary perspective, this is a big win for states." Sawhill says she has met with "quite a number of state directors of health care or human services" who recognize the value proposition for LARCs.

LARCs are "set it and forget it" contraceptives. The category includes intrauterine devices and match-stick-sized hormonal implants that can be inserted just below the skin on a woman's arm. Administered by a primary care provider in a clinic setting, LARCs are 99 percent effective for preventing pregnancy for up to 12 years and safe for most women across all age ranges. Unlike birth control pills or other short-acting contraceptives, LARCs eliminate the human factor that can lead to failure, like forgetting to take a pill or improperly using an alternate method.[3]

Despite their efficacy, LARCs are used by only eight percent of women.[4] Cost, access and education are historically the key barriers to uptake. Intrauterine devices as a class of contraceptives was tainted by the Dalkon Shield medical device safety recall and ensuing lawsuits in the early 1970s.[5] Although both the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists support LARC methods of contraception,[6,7] practitioners sometimes lack experience using LARCs and lack training in how to educate patients about their safety and appropriateness.

That was the case in Colorado a decade ago, where less than 10 percent of federally-funded family planning clinics had the capacity—training, equipment and access to IUDs and implants—to insert LARCs.

Turning the tide in unplanned pregnancy in Colorado

The consequences of unplanned pregnancy on mothers, their families and the communities in which they live were behind Colorado's successful effort to expand its Colorado Family Planning Initiative (CFPI). Beginning in 2008, the Colorado Department of Public Health and Environment secured funding from a private donor to launch CFPI, which focused on increasing accessibility to low- or no-cost LARCs to low-income women, as well as the staff training and operational support that Title X[8] family planning clinics in Colorado would need to support the effort.

"It was the intersection of provider mindset change, consumer awareness and funding ability

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[3] "Reproductive Health: Teen Pregnancy." *Centers for Disease Control and Prevention,* Centers for Disease Control and Prevention, 4 Apr. 2018, www.cdc.gov/teenpregnancy/health-care-providers/improving-contraceptive-access.html.

[4] "Long-Acting Reversible Contraception: Implants and Intrauterine Devices." The American College of Obstetricians and Gynecologists ACOG Practice Bulletin, Nov. 2017, https://www.acog.org/Clinical-Guidance-and-Publications/Practice-Bulletins/Committee-on-Practice-Bulletins-Gynecology/Long-Acting-Reversible-Contraception-Implants-and-Intrauterine-Devices.

[5] Byrne, K. "Medical Records in Litigation: the Dalkon Shield Story." *Advances in Pediatrics*, U.S. National Library of Medicine, Feb. 1992, www.ncbi.nlm.nih.gov/pubmed/10117045.

[6] Adolescence, Committee On. "Contraception for Adolescents." *Pediatrics,* American Academy of Pediatrics, 1 Oct. 2014, pediatrics.aappublications.org/content/134/4/e1244.

[7] American College of Obstetricians and Gynecologists, op. cit.

[8] The Title X National Family Planning Program, administered by the U.S. Department of Health and Human Services, Office of Population Affairs, is the only federal program dedicated solely to supporting the delivery of family planning and related preventive health care through approximately 90 public health departments and community health, family planning, and other private nonprofit agencies. See https://www.hhs.gov/opa/title-x-family-planning/index.html.

to pay for LARCs," says Liane Jollon, executive director of San Juan Basin Public Health. Jollon began her work in public health when she was hired as a clinic nurse under the CFPI initiative.

"The interesting thing is that when we interview women about what would be their ideal method for birth control, it often would be something that lasts a long time and required little intervention on the user's part. But before we implemented training and word-of-mouth began to circulate about the availability of free LARCs, we didn't have a ton of people coming in asking for them. They had fallen off the radar."

At San Juan Basin Public Health, grant funds supported investments in exam tables, lighting and equipment, as well as training for providers to encourage them to use LARCs. Because LARCs can cost up to $1,000 each, ensuring there was a ready supply and the funding to pay for them was also important.

Although the ACA and Colorado Medicaid expansion gave hundreds of thousands more people coverage in Colorado, the majority of clients seen in public health still don't have a payment source for care. The Title X clinics are a critical family planning hub for this population.

A brief history of Colorado's CFPI

In 2008, the Colorado Department of Public Health and Environment (CDPHE) secured funding from a private donor to launch the Colorado Family Planning Initiative (CFPI), an expansion of the family planning program that would provide training, operational support and low- or no-cost LARCs to low-income women at 68 Title X clinics throughout the state.

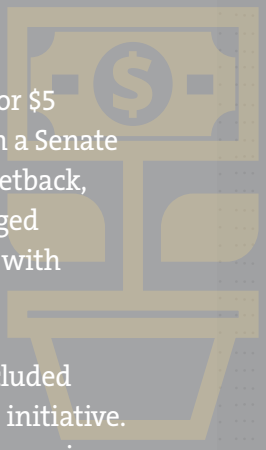
The initiative was established as a five-year pilot program through a private donation of about $25 million from the Susan Thompson Buffett Foundation. This expired in July 2015, and the program subsequently had longer waiting lists and was not able to offer as many services.

By that time, the initiative had provided LARCs to more than 36,000 women. Between 2009 and 2014, birth and abortion rates both declined by nearly 50 percent among teens aged 15 to 19 and by 20 percent among young women aged 20 to 24. Public assistance costs associated with births that were averted among women aged 15 to 24 totaled between $54.6 and $60.6 million for four entitlement programs.

During that period, the state saved about $23 million from averted Medicaid costs associated with birth. CDPHE officials predicted the program could save the state up to $40 million in Medicaid costs that would otherwise go toward pre- and post-natal care.

A bipartisan legislative spending bill for $5 million to continue the services died in a Senate committee in May 2015. Despite this setback, more than a dozen organizations pledged funding to help continue the program with private funding.

In May 2016, Colorado successfully included $2.5 million in the state budget for the initiative. Although this totaled about half of the previous funding, it is combined with about $5 million in Medicaid reimbursements each year, thus funding the program into the future.



"We primarily see people on our sliding fee scale; their income is below 250 percent of the poverty level," Jollon says. "We consider family planning to be a free to low-cost service for individuals without an alternative resource, and we have always served folks with very limited income." San Juan Basin Public Health serves individuals at clinics in La Plata and Archuleta counties, as well as in its Durango High School school-based health clinic.[9]

After four years of program implementation, La Plata County saw a 35 percent drop in its teen birth rate, Jollon says.

Colorado's family planning success has made it a model for other states. After implementation of CFPI, Colorado saw:

- More Title X clinics beginning to use LARC methods, from 9.7 percent of all clinics in 2009 to 30.5 percent in 2015.
- Consequently, use of LARCs increased from 2,269 women in 2009 to 12,142 women in 2015.
- Unintended pregnancy rates dropped 40 percent among women in their teens and 20 percent for women between 20 and 24 over five years (2009 to 2014).
- In 2009, Colorado's fertility rate was 37.9 per 1,000 women compared to a national rate of 37.4. By 2014, Colorado's fertility rate dropped significantly faster than the national average and stood at 19.4, compared to a national rate of 24.2.
- The abortion rate among teens dropped from 10.3 in 2009 to 5.4 in 2014; this rate paralleled the drop in fertility rates, indicating unplanned pregnancies were being averted.
- Births to women without a high school education declined 38 percent.
- High risk births declined from 6.4 percent to 3.4 percent of all births.

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> **— Isabel V. Sawhill, Ph.D., Senior Fellow in Economic Studies, Center on Children and Families, Brookings Institution**

The big picture

The average unplanned child faces myriad social and economic challenges. Those who flourish over the long term emotionally, educationally and financially are often beating the odds.

"People who have children they really want and are ready to welcome into the world are likely to be better parents," says Sawhill. "They're likely to be a little older, they might have completed their education, they're likely either to be married or have a decent job as well as a decent education. Most importantly, they're likely to have found someone that they want to be a parent with and that they can imagine remaining with for the long period of time it takes to raise a child."

Sawhill has been researching and writing about the growth of unplanned pregnancy and single-parent families for more than 40 years. She acknowledges that many of the children who came into the world unplanned—45 percent of all births[10]—will do "just fine," and that there's a small but growing segment of parents who plan for single parenthood by

[9] LARC services at the Durango High School clinic are limited to hormonal implants.

[10] "Unintended Pregnancy Prevention." Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, 23 Dec. 2016, www.cdc.gov/reproductivehealth/contraception/unintendedpregnancy/index.htm.

choice. But unintended pregnancy rates are highest for those who are the least economically advantaged; pregnancy rates for poor and low-income women (annual income below $24,000) are more than triple the rate for women with higher incomes.[11] There is a preponderance of unplanned pregnancies among women under the age of 30 who are also unmarried.

"Many are in a relationship with the father of the child at the time the baby is born but those relationships tend to be very unstable," Sawhill says. "And so they break up and the mom becomes a single parent, and she faces all the struggles that single parents face, one of the most important being that she alone is responsible for everything—bringing in the income to the family, being the breadwinner, but also being the primary person responsible for the child and everything else in her life.

"This is in no way to disrespect single parents; they're doing the best they can. But it's a very hard road to have to go down."

Because poverty is more common in single parent households, children may not have the resources they need to succeed in school and beyond.

"The lifetime incomes of the children born to parents who wanted to be parents at the time the child was born are higher, even after adjusting for quite a number of other variables that affect those outcomes," Sawhill says.

The relationship between unplanned pregnancy, single parenthood and the cycle of poverty is well established. Educational attainment is critical to employment success, yet only 3.3 percent of never-married mothers have attained a bachelor's or post-graduate degree; 20.1 percent have not completed a high school education.[12] The unemployment rate for single mothers in 2017 was 9 percent, compared to 4.6 percent for married-couple families.[13]

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Without a support system, it's difficult for a single parent to work. Infant child care costs average $13,154 a year in Colorado, or $1,096 a month—roughly comparable to the cost of college tuition.[14]

"If you suddenly have a child to take care of, continuing your education may not be practical or possible," Sawhill says. "Similarly, your job prospects become more constrained. You may need to live where rents are low, or where your mother lives, for example, so she can take care of the baby while you're going to your job. Everything just gets a lot harder and with less flexibility."

Poverty and low income during childhood is, in itself, an indicator for children's developmental and health outcomes.

- Childhood obesity is 40 percent and asthma 30 percent more prevalent among poor families.[15]

[11] Sawhill, Isabel V., and Joanna Venator. "Reducing Unintended Pregnancies for Low-Income Women." Brookings, 28 July 2016, www.brookings.edu/research/reducing-unintended-pregnancies-for-low-income-women/.

[12] Sawhill, Isabel V., and Joanna Venator. "Three Policies to Close the Class Divide in Family Formation." Brookings, Brookings, 29 July 2016, www.brookings.edu/blog/social-mobility-memos/2014/01/21/three-policies-to-close-the-class-divide-in-family-formation/.

[13] "Employment Characteristics of Families Summary." U.S. Bureau of Labor Statistics, *U.S. Bureau of Labor Statistics,* 19 Apr. 2018, www.bls.gov/news.release/famee.nr0.htm.

[14] "Child Care Costs in the United States." Economic Policy Institute, www.epi.org/child-care-costs-in-the-united-states/#/CO.

[15] Chaudry, Ajay, and Christopher Wimer. "Poverty Is Not Just an Indicator: The Relationship Between Income, Poverty, and Child Well-Being." Academic Pediatrics, vol. 16, no. 3S, Apr. 2016, pp. S23–S29.

- Poor children are almost nine times more likely to have very low food security.[16]

- Children in poverty are more likely to be uninsured and to use the emergency room.[17]

- Girls who are poor more than a quarter of their childhood are more likely to have a teen birth than those who are poor for less time.[18]

Sawhill and fellow researchers see a growing class divide in America based on family formation itself—between single-parent families and married families.[19] The poor and less educated are more likely to become single parents. Children of married parents have better economic mobility years down the road than those reared in single-parent households.

Sawhill says government plays a role in helping people become intentional parents through planning. She offers two policy recommendations:

1. **Provide women with both the *motivation* and the *means* to be planners.** "We must create more educational and economic opportunities for less advantaged women. If you have a sense of opportunity in your future, you will be more planful. You will be more motivated to care about when you have children and who you have children with. That's one reason why I think well-educated women are more likely to be better planners than less educated or more disadvantaged women. One of the reasons they plan is because they have more reasons to plan. They have more hope for their future."

2. **Provide women with the means to achieve their goals, to plan for the future.** That means access to birth control, especially the most effective forms of birth control—LARC. This must include education for providers to overcome myths about the safety and efficacy of LARC, and that's a culture change. "One of my favorite ideas is getting one key question on every woman's health intake form in the entire country: 'Do you want to have a baby in the next year?' Among women who say 'yes,' you give them all the information about nutrition, smoking and so forth to make their pregnancy more successful. If they say 'no,' then you ask them, 'what are you doing to prevent that,' and then you have a conversation about access to birth control and the kind that they want."

Ending a cycle of poverty through intentional parenthood

Educationally, childhood poverty is strongly associated with negative cognitive development and educational outcomes. Children in poverty are more likely to miss school because of illness, have higher rates of learning disability or serious emotional or behavioral problems.[20] They repeat school grades more often and have higher high school dropout rates.[21] Educational shortfalls limit job opportunities for the children—feeding a poverty cycle that becomes multi-generational.

"If you're going to end the cycle of poverty, LARCs are the place to start," says Don Coram (R), state senator for Colorado's District 6. Coram co-sponsored bills to increase access to contraception while he served in the Colorado House, especially for women in rural areas. His support for family planning initiatives goes back to his days as a school board member.

"We set up a state pilot program in three counties to deal with the teen pregnancy situation. It was

[16] Ibid.

[17] Ibid.

[18] Ratcliffe, Caroline. *Child Poverty and Adult Success.* The Urban Institute, Sept. 2015, www.urban.org/sites/default/files/publication/65766/2000369-Child-Poverty-and-Adult-Success.pdf.

[19] Sawhill, Isabel V., and Joanna Venator. "Three Policies to Close the Class Divide in Family Formation." op. cit.

[20] Chaudry, et al. op. cit.

[21] Ratcliffe, op. cit.

education based—we didn't provide any birth control—but we did pregnancy prevention education," he says. "Later, we set up the legislation for the whole state and got it done."

Coram says helping prevent unplanned pregnancies is in everyone's best interest.

"The fact is the Colorado Family Planning Initiative has a track record. We don't have to guess at the numbers—we have the numbers to prove what it has done. In Colorado, we've cut the abortion rate and saved the state in the neighborhood of $70 million in four years,"[22] he says. The savings accrue through reduced pregnancy delivery care costs in Medicaid, as well as reductions in payments for social programs.

"It's a great program. It's just plain common sense," he says. "Colorado is one of the innovators. We'll go in and look at these difficult issues and realize this isn't a republican or democrat issue. This is a quality-of-life issue." ■

[22] Colorado Department of Public Health and Environment, op. cit.

What's next:

Colorado Collaborative for Reproductive Health Equity

To extend Colorado's family planning success story, the Caring for Colorado Foundation and the Colorado Health Foundation are partnering in a joint effort called the Colorado Collaborative for Reproductive Health Equity. Still in its infancy, the Collaborative is envisioned to offer women and adolescents access to reproductive health counseling and effective contraceptive methods, like LARC, as well as evidence-based school and community sexual health education programs across the state.

The two foundations will invest $5 million over three years to support programs and services that drive "non-directive, confidential, person-centered, culturally responsive, comprehensive contraceptive care," according to Colleen Church of the Caring for Colorado Foundation. That will include provider training and other clinic support, such as help keeping LARC devices readily available. In addition to the statewide efforts, the Collaborative will provide focused support for a group of 10 to 12 safety net systems to increase their capacity to efficiently and sustainably provide LARC. The Collaborative plans to engage community partners to bolster the effort to overcome access and information barriers to safe, effective reproductive health and contraception.

ISABEL V. SAWHILL, PH.D.

Senior Fellow in Economic Studies, Center on Children and Families Brookings Institution

ISABEL V. SAWHILL is a senior fellow in Economic Studies in the Center on Children and Families at the Brookings Institution. She previously served as vice president and director of the economic studies program and was a co-director of the Center on Children and Families. Prior to joining Brookings, she was a senior fellow at The Urban Institute. She served in the Clinton Administration as an associate director of the Office of Management and Budget, where her responsibilities included all of the human resource programs of the federal government.

Over the past decade, Sawhill's major research focus has been on how to improve opportunities for disadvantaged children in the U.S. She has authored or edited numerous books and articles including *Generation Unbound: Drifting Into Sex and Parenthood Without Marriage.* She is a recipient of the Exemplar Award from the Association for Public Policy Analysis and Management (2014) and the Daniel Patrick Moynihan Prize with Ron Haskins, from the American Academy of Political and Social Science (2016). She was named a Distinguished Fellow by the American Economic Association in 2016.

LIANE JOLLON, RN

Executive Director San Juan Basin Health Department

LIANE JOLLON was named executive director of San Juan Basin Public Health in 2013, after first joining the agency as a family planning clinic nurse in 2010 and after serving as immunization and family planning clinic manager and health services division director. San Juan Basin Public Health is a local agency serving residents of Archuleta and La Plata counties. In her role, Jollon works to advance health equity, behavioral health integration and cross-system collaboration. Prior to her work at SJBPH, she served as executive director for a sexual assault services organization and as a counselor in a safehouse for victims of domestic abuse. She earned a bachelor's degree in history and sociology from Columbia University and an associate's degree in nursing from Southwest Colorado Community College in 2010, and is currently a candidate for a master of arts degree in security studies at the Naval Postgraduate School Center for Homeland Defense and Security.

DON CORAM

Colorado District 6 Senator

SEN. DON CORAM (R) was raised on his family ranch in Montrose County. His interests in ranching, mining, environmental reclamation and local business carried over into public service. Prior to his election to the Colorado legislature, he served as director and treasurer on his local school district board, as treasurer and president of the Delta-Montrose Vocational Center, as well as on the boards for the Western Small Miners Association and the San Juan Regional Council of the El Pomar Foundation.

He was elected to Colorado's House of Representatives in 2010, having first served as second vice-chairman of the Montrose County Republican Central Committee. In January 2017, he was selected by the Senate District 6 vacancy committee to replace State Senator Ellen Roberts after her resignation. He serves on the Agriculture, Natural Resources & Energy Committee and the Judiciary Committee, but he is also co-sponsor of a range of bills in the health and human services arenas.

About Rocky Mountain Health Plans

Founded in Grand Junction, Colo. in 1974, as a locally owned organization, Rocky Mountain Health Plans provides access to affordable, quality health care enabling its more than 229,000 members across the Western Slope to live longer, healthier lives.

About the Community

Western Colorado is creating an accountable community that uses health IT in a meaningful way, adopts value-based payment models, coordinates care and empowers patients to take charge of their health.

We aspire to ensure the following:

- High-quality health care is affordable and accessible to all.
- Those who purchase health care are assured that care is effective, safe and appropriate.
- Patient care is a team effort, with roles that are well-defined, connected and collaborative.
- Patients have access to the support and information they need to take charge of their health and make their own decisions.
- Payment reform will foster reimbursement models that support accountability for population health and resource use.
- Information technology supports population health, helping providers predict outcomes, prioritize interventions and prevent disease.
- Health data is a community resource used in a secure way to support coordinated care at the population, practice and personal levels.
- Investments in information technology and health system transformation will improve quality of life and economic well-being across the state.
- Health is a community resource that requires leadership, stewardship, individual responsibility, community support and ongoing maintenance.

For more information:

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