Center on Budget and Policy Priorities

1275 First Street NE, Suite 1200
Washington, DC 20002

Tel: 202-408-1080
Fax: 202-408-1056

center@cbpp.org
www.cbpp.org

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Better State Budget, Policy Decisions Can Improve Health

By Jennifer Sullivan

States' and localities' decisions significantly affect their residents' health. While this includes their decisions about Medicaid and the other important health care programs they administer, it also includes a wide array of budget and policy decisions that affect the "social determinants of health" — the conditions in which people live, work, learn, and play. States and localities can improve their residents' health — as well as their own economies and opportunities for greater prosperity — by making smarter and deeper investments in health programs, education, the environment, infrastructure, transit, and other public services.

A broad body of research has documented the effects that social determinants of health have on health outcomes, like life expectancy, maternal and child health, and rates of chronic disease, and on disparities in the health of people across racial groups and income levels. But even as this understanding grows, most efforts to improve health remain focused on the health care delivery system. Much more *can* be done to improve how the health care delivery system connects people to services and supports known to improve health. But focusing exclusively on health care ignores the importance of a wide variety of state and local investments in promoting better health.

Even the ways states and localities raise revenue have implications for health outcomes, given the deep connections between poverty, inequality, and health. In nearly every state, state and local tax systems require the poorest residents to pay more in taxes as a share of their income than the richest residents, an upside-down system that makes it even harder for the residents facing the greatest barriers to live healthy lives.

States' lack of investment in programs that would improve health as well as state and local fiscal policies that have worsened racial inequities have left the U.S. population less healthy than it could be, weakening the prospects for future widespread prosperity. When compared to other developed nations, the United States performs below average, and often near the bottom of the rankings, on traditional health measures like life expectancy, infant mortality, and low birthweight.[1] Health outcomes are particularly bad for certain communities of color and for low-income individuals.

[1] "Health at a Glance, 2017," Organisation for Economic Co-Operation and Development, November 10, 2017, http://www.oecd.org/health/health-at-a-glance-19991312.htm.

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States and localities can improve residents' health and help close health gaps between racial and ethnic groups by:

- Improving access to affordable health care, including by expanding Medicaid under the Affordable Care Act (ACA);
- Leveraging Medicaid to improve access to other economic and social programs known to improve health, like case management and supportive housing;
- Making deeper and smarter investments in education, infrastructure, economic security, housing, and other parts of the budget that can improve health;
- Enacting social and economic policies known to improve health; and
- Improving state and local tax systems so they are based more on a taxpayer's ability to pay, and so they raise adequate revenue for improving the conditions in which residents live, work, learn, and play.

Health Is Shaped by Combination of Factors and Varies by Race/Ethnicity and Income

Public health practitioners and researchers typically evaluate the effects of the social determinants of health by examining the health outcomes of various groups that make up a population. "Population health" focuses on overall health outcomes as well as their distribution across a community (see text box below).

A large body of domestic and international research conducted over the last half century has led to broad agreement among policy and public health researchers, clinicians, health systems, and insurers that many factors beyond health care access and quality shape population health.[2] Foundational population health studies conducted in the United Kingdom several decades ago revealed inverse connections between socioeconomic status and mortality rates[3] and attributed dramatic increases in life expectancy over the past century primarily to improved living conditions, rather than to advances in medicine.[4] Similarly, a review of population health data in the United States estimated that better medical care would reduce preventable mortality by only between 10 and

[2] Paula Braveman, Susan Egerter, and David R. Williams, "The Social Determinants of Health: Coming of Age," *Annual Review of Public Health*, November 22, 2010, 32:381-398, https://www.annualreviews.org/doi/abs/10.1146/annurev-publhealth-031210-101218.

[3] Michael Gideon Marmot *et al.*, "Health inequalities among British civil servants: the Whitehall II study," *The Lancet*, June 8, 1991, 337(8754):1387-1393, https://www.ncbi.nlm.nih.gov/pubmed/1674771.

[4] Thomas McKeown, R. G. Record, and R. D. Turner, "An Interpretation of the Decline of Mortality in England and Wales during the Twentieth Century," *Population Studies*, November 1975, 29(3):391-422, https://www.jstor.org/stable/2173935.

15 percent.[5] More recently, global health researchers found that more than half of the reduction in worldwide child mortality between 1990 and 2010 was due to investments outside the health sector in areas like education, civic participation, and infrastructure.[6]

Equity Is Central to Population Health

"Population health," a multi-disciplinary field, comprises epidemiology, biostatistics, medicine, social and behavioral science, economics, business, and more. While various definitions for population health have emerged,[a] we use the definition commonly used in public health, where it refers collectively to a community's health outcomes (as measured by life expectancy, infant mortality, incidence of disease, and so on) *as well as* how those outcomes vary across groups within the community — for instance, by race, ethnicity, gender, or economic group.[b] Equity is at the core of this definition.

A population can appear to perform well on overall health outcome measures, but face considerable population health challenges if variation exists among sub-groups. For example, Wake County, North Carolina ranks as the healthiest county in the state across aggregate measures of length and quality of life.[c] But a closer look at outcomes by racial/ethnic group reveals significant gaps:

- The county's overall low-birthweight rate is 8 percent, but there is a large gap between the rate among Black babies (12 percent) and white babies (7 percent). Low-birthweight babies are more likely to experience serious health complications as infants and are at higher risk for harmful health conditions like heart disease and high blood pressure later in life.
- The county's overall child poverty rate is 12 percent. But the rates among Black and Hispanic children are 25 percent and 37 percent, respectively, while the rate among white children is 5 percent. Children who experience poverty are at increased risk for lifelong health, social, and economic hardship.[d]

Improving population health requires confronting and addressing these kinds of inequities, both in the health outcomes themselves and the structural conditions that create them, including racism, income and wealth inequality, and unequal access to health care.

a In managed care or clinical care settings, the term typically refers to the health of a defined group of patients (e.g., enrollees in a specific managed care plan or patients of a specific practice or health system), often when payment rates are determined in part by health outcomes measured within the group.
b David Kindig and Greg Stoddart, "What Is Population Health?" *American Journal of Public Health*, March 2003; 93(3): 380–383.
c North Carolina Overview," County Health Rankings & Roadmaps, 2018, http://www.countyhealthrankings.org/app/north-carolina/2018/overview.
d "Poverty and Child Health in the United States," American Academy of Pediatrics, March 2016, http://pediatrics.aappublications.org/content/early/2016/03/07/peds.2016-0339.

Access to food, affordable housing, high-quality schools, and economic opportunity all figure significantly in whether people and communities are healthy. Various models have quantified these factors' influence. One widely recognized and validated model, from the University of Wisconsin

[5] J. Michael McGinnis, Pamela Williams-Russo, and James R. Knickman, "The Case for More Active Policy Attention to Health Promotion," *Health Affairs*, March 1, 2002, 21(2):78-93, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.21.2.78.

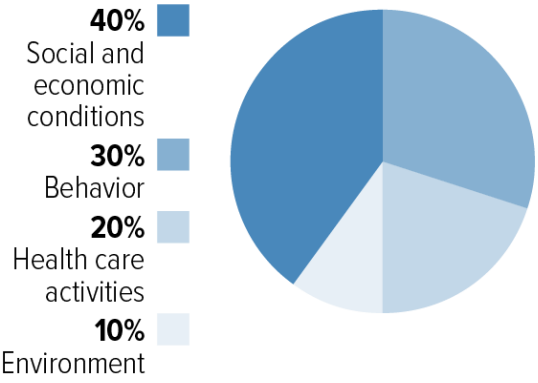
[6] Shyama Kuruvilla *et al.*, "Success factors for reducing maternal and child mortality," *Bulletin of the World Health Organization* 2014 (92)533-544, http://www.who.int/bulletin/volumes/92/7/14-138131/en/.

Population Health Institute, suggests that 80 percent of health outcomes are determined by social and economic, environmental, and behavioral factors; just 20 percent are attributable to health care.[7] (See Figure 1.)

FIGURE 1

Most Health Outcomes Determined by Factors Other Than Health Care

Factors that shape health



Source: County Health Rankings model, University of Wisconsin Population Health Institute, 2014

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Opportunities to be healthy are not distributed equally across communities. As noted above, researchers have documented the direct relationship between income and health back to the earliest population health studies.[8] Across all racial and ethnic groups, low-income Americans have poorer self-reported health status.[9] A history of structural racism and income and wealth inequality have contributed to particularly poor health outcomes for people of color, who are likelier to report their health as fair or poor than are white people.[10] (See Figure 2.) And while self-reported health among Asian Americans is comparable to that of white people, there is considerable variation among people of different Asian heritages, with some reporting fair or poor health at rates similar to or worse than other communities of color.[11] Among racial groups where data are available (Black, Hispanic or Latinx, and white), low-income people of color

[7] Patrick L. Remington, Bridget B. Catlin, and Keith P. Gennuso, "The County Health Rankings: rationale and methods," *Population Health Metrics*, April 17, 2015, https://pophealthmetrics.biomedcentral.com/articles/10.1186/s12963-015-0044-2. Note that the County Health Rankings model does not account for genetics and biology, which are not measurable or modifiable.

[8] See for example, Paula A. Braveman *et al.*, "Socioeconomic Disparities in Health in the United States: What the Patterns Tell Us," *American Journal of Public Health*, April 2010, 100 (S1): S186–S196. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2837459/.

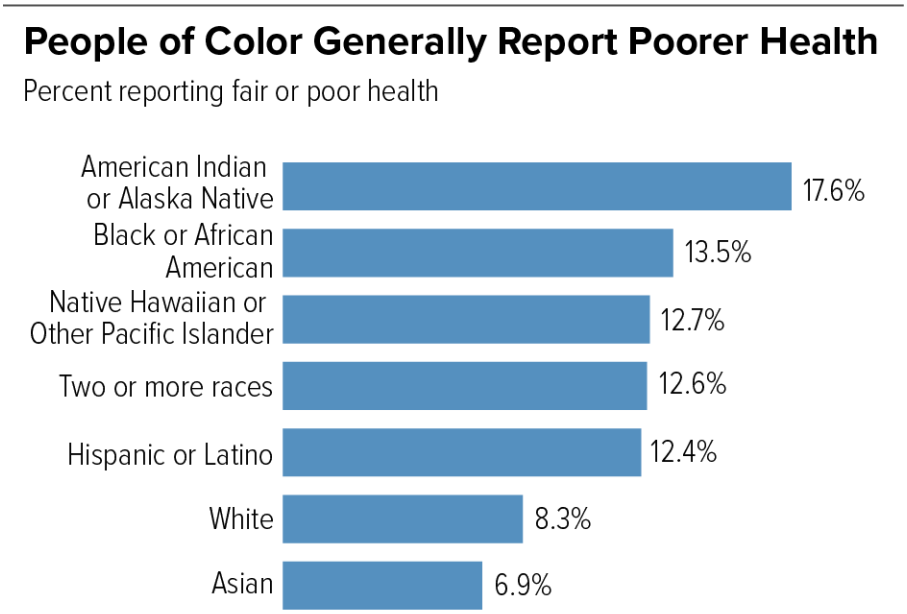
[9] Data are only available by income for Black, Latinx, and white people. However, American Indians and Alaska Natives have lower incomes and are more likely to have incomes below the poverty level than whites. See: "Profile, American Indian/Alaska Native," U.S. Department of Health and Human Services Office of Minority Health, last modified March 28, 2018, https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=62.

[10] National Center for Health Statistics, *Health, United States, 2017: With Special Feature on Morality*, See Table 45, "Respondent-assessed fair-poor health status, by selected characteristics: United States, selected years 1991–2016," https://www.cdc.gov/nchs/data/hus/2017/045.pdf.

[11] See for example, Paulani Mui *et al.*, "Ethnic Group Differences in Health Outcomes Among Asian American Men in California," *American Journal of Men's Health,* September 2017, 11(5):1406-1414, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5675204/.

have the poorest self-reported health status of all, with more than 1 in 5 low-income Black and Latinx people[12] reporting fair or poor health.[13]

FIGURE 2



Note: The race groups white, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander, and 2 or more races include persons of Hispanic and non-Hispanic origin.

Source: National Center for Health Statistics, 2016

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Similarly, outcomes on a range of common population health metrics like life expectancy, low birthweight, and infant mortality are worse among people of color than among white people.[14] (See Figure 3 and Appendix Table 1.) For example, on average, Black people die more than three and a half years sooner than white people, and Black babies are nearly twice as likely as white babies to be born with low birthweight, and more than twice as likely as white babies to die before their first birthday.

[12] People who identify with a Latin American or Hispanic ethnicity may prefer to be identified in various ways including as Hispanic, Latino, Latina, Latinx, or with a more specific country of origin. In this report we use the gender-neutral term "Latinx." We also use "Hispanic" where appropriate, for instance in cases when a data source uses that term.

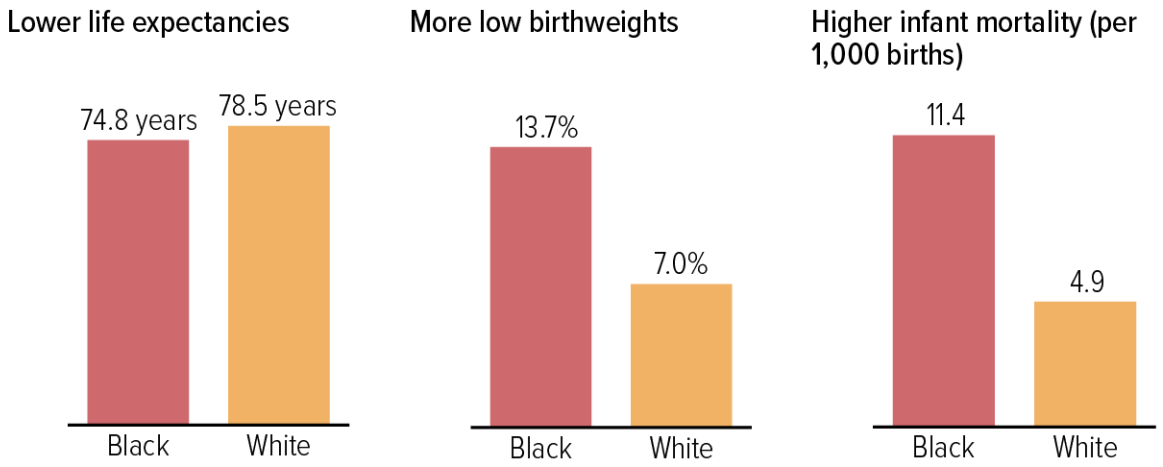
[13] National Center for Health Statistics, *op. cit.*

[14] Although life expectancy for Latinx people is higher than for white people and higher than the U.S. average, the data include individuals born in the United States as well as individuals born outside the United States. Latinx individuals born in the United States tend to have lower life expectancy than those born outside the United States. A growing body of research explores other potential reasons for longer life expectancy among Latinx populations relative to what would be expected based on their income and education levels. See: Neil K. Mehta *et al.*, "Life Expectancy Among U.S.-born and Foreign-born Older Adults in the United States: Estimates From Linked Social Security and Medicare Data," *Demography*: August 2016, 53(4): 1109-1134, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5026916/; Paola Scommenga, "Exploring the Paradox of U.S. Hispanics' Longer Life Expectancy," Population Reference Bureau, July 12, 2013, https://www.prb.org/us-hispanics-life-expectancy/.

FIGURE 3

Black People Fare Worse Than White People on Health Measures

African Americans experience:



Source: National Center for Health Statistics, 2016

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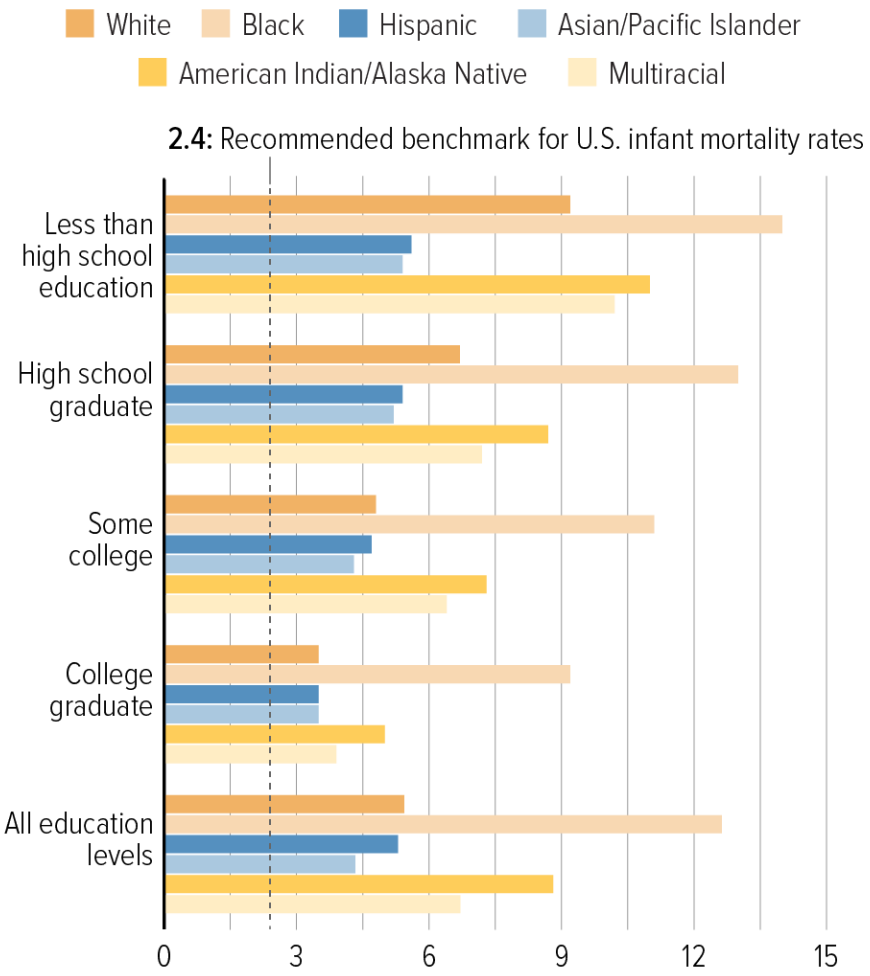
Health outcomes could be better for Americans of *all* racial and ethnic identities; health outcomes among white people are not an appropriate benchmark. The Health Opportunity and Equity (HOPE) Initiative, a project of the National Collaborative for Health Equity, used a rigorous methodology to identify 28 measures across five dimensions that reflect the systems and policies that affect health equity. The initiative calculated achievable benchmarks for each metric based on outcomes among Americans with high socioeconomic status (regardless of racial and ethnic identity).[15] They found, for example, that 17,000 more infants would need to survive each year to achieve the national goal for infant mortality (2.4 deaths per 1,000 live births). (See Figure 4.) Black people and people with less than a high school education are currently furthest from this goal, but people from all racial and ethnic and socioeconomic groups have room to improve. Similar patterns hold true across the other metrics that the initiative is tracking, with people of color and people with less education being furthest from the HOPE goals.

[15] Nadia Siddiqui *et al.*, "The HOPE Initiative: Data Chartbook," July 2018, http://www.nationalcollaborative.org/our-programs/hope-initiative-project/.

FIGURE 4

U.S. Infant Mortality Rates Don't Meet Experts' Benchmark Across Racial/Ethnic Groups, Education Levels

Infant deaths per 1,000 live births



Note: The Health Opportunity and Equity Initiative determined that an infant mortality rate of 2.4 is an achievable U.S. benchmark based on outcomes among Americans with high socioeconomic status (regardless of racial and ethnic identity).

Source: Health Opportunity and Equity Initiative, 2018

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States and Localities Fund Public Investments That Affect Health

Public investments and policies play a significant role in shaping the distribution of opportunities to be healthy. Access to clean air and water, affordable and safe housing, transit, high-quality education, economic opportunity, parks and places to exercise, nutritious foods, and reliable public health infrastructure, in addition to high-quality, affordable health care, can all affect health. Moreover, the interaction between these factors further influences health.

Policymakers play a considerable role in determining whether and where these conditions exist. For example, while individual behaviors like a nutritious diet and active lifestyle are important for health, policies shape where people can afford to live and whether those places are served by grocery stores with fresh foods, public transit that reduces car-dependence, and public parks and recreation spaces that provide safe places to be active. To dramatically improve health and eliminate health inequities, states and localities must also consider how the policies they implement come together to enable, or hinder, health.

States' and localities' influence over health care, as well as many other social and economic, behavioral, and environmental factors that shape health, is most apparent in their budget decisions.[16] Health is one of the largest categories of state and local spending, making up more than a quarter of state and local expenditures.[17] It includes health coverage programs like Medicaid and the Children's Health Insurance Program (CHIP), as well as spending on behavioral health services for people with mental health and substance use disorders, and public health departments that lead disease prevention and health promotion efforts such as vaccination programs, food safety, and disaster preparedness and response. These public investments directly affect residents' health, and they play a critical role in determining health outcomes.[18]

While less obvious, aspects of nearly every other category of state and local expenditures can also affect health:

- **Education**, like health, comprises more than a quarter of state and local expenditures. Investments to broaden access and improve the quality of education for students of all ages from early childhood through K-12 and higher education all are associated with students' economic prospects and health.
- **Transit and transportation** can improve health by broadening access to public transit and "active transportation" like bike and walking paths, connecting residents to jobs, health care, and other opportunities. Investments in public transit can facilitate more active lifestyles, reduce reliance on cars (which also improves air quality), and connect otherwise-isolated communities with broader opportunity.
- **Fire, safety, and police investments** can improve community health through injury prevention, and enhance public safety through specific policies, like community policing,

[16] State and local budget and policy decisions are often grouped together in this analysis, because states transfer a significant portion of their funding to localities to administer programs such as education and public health. Local expenditures often reflect budget or policy decisions made at the state level.

[17] U.S. Census Bureau, 2016 Annual Surveys of State and Local Government Finances, https://www.census.gov/programs-surveys/gov-finances.html.

[18] J. Mac McCullough, *The Return on Investment of Public Health System Spending*, AcademyHealth, June 21, 2018, https://www.academyhealth.org/publications/2018-06/return-investment-public-health-system-spending.

which evidence suggests reduces crime and facilitate positive relationships between police and the communities they serve.[19]

- **Water, sewer, and waste management investments** enable states and localities to replace aging infrastructure, ensure water quality, and reduce residents' exposure to harmful environmental toxins.
- **Parks, recreation, and libraries** provide opportunities for social engagement and physical activity. Research suggests that these investments are associated with better resident health.[20]
- **Housing investments** augment insufficient federal housing support and improve access to safe, affordable housing, which is integral for health.
- **Unemployment insurance** plays an important economic role by replacing income lost when individuals lose a job and sustaining consumer demand during an economic downturn. Greater state investment in unemployment insurance also improves recipients' access to health coverage and care following job loss and results in better self-reported health, research suggests.[21]

To the extent that these kinds of investments prevent or reduce poverty and promote economic opportunity — and the research suggests many of them do — they are likely to promote health. But these "non-health" investments also shape the opportunities available to people to engage in healthy behaviors (like eating nutritious foods and getting regular physical activity) and to avoid things that can harm health (like violence and environmental toxins).

States Can Do More to Improve Health

States and localities can promote health by investing in both health and other social and economic policies that shape health, implementing policy changes that can improve health, and taking steps to make their tax codes more equitable. Investments will make the greatest difference if they are focused in the communities that face the largest barriers to health and economic prosperity.

Increase Access to Affordable Coverage

States have a clear role in facilitating access to care given their responsibilities in administering, regulating, and establishing eligibility rules for health insurance programs like Medicaid, CHIP, the individual health insurance market, and state employee and retiree health benefit programs.

Medicaid is particularly important for population health, because it covers such a large proportion of low-income individuals (nearly half of all non-elderly individuals with income below twice the

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[19] Charlotte Gill *et al.*, "Community-oriented policing to reduce crime, disorder and fear and increase satisfaction and legitimacy among citizens: a systematic review," *Journal of Experimental Criminology*, December 2014, 10(4): 399-428, https://link.springer.com/article/10.1007/s11292-014-9210-y.

[20] J. Mac McCullough and Jonathon P. Leider, "Government Spending in Health and Nonhealth Sectors Associated with Improvement in County Health Rankings," *Health Affairs*, November 2016, 35(11): 2037-2043, https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0708.

[21] Elira Kuka, "Quantifying the Benefits of Social Insurance: Unemployment Insurance and Health," National Bureau of Economic Research Working Paper No. 24766, June 2018, https://www.nber.org/papers/w24766.

poverty line) and people of color (28 percent and 24 percent of non-elderly Black and Latinx adults, respectively).[22] Medicaid can improve and sustain health in at least five ways:

- **Increase access to health care services.** Medicaid's core function is as a health coverage program for specific populations (primarily low-income people and people with disabilities). States that have not yet done so should expand Medicaid under the ACA to cover low-income adults who lack another source of affordable coverage. States that have expanded Medicaid have lower uninsured rates than states that have not, and enrollees have better access to health care and are more likely to receive high-quality care than low-income adults who are not enrolled.[23]
- **Improve health outcomes.** Multiple studies have documented an association between participating in Medicaid and improved health. For example, one analysis found a 23 percentage-point rise in the share of newly covered adults reporting excellent health by the third year Medicaid expansion was in effect, compared to before the expansion took effect.[24] Another found a decrease in infant mortality rates, particularly among African American infants, in states that expanded Medicaid.[25]
- **Protect enrollees against financial hardship.** Medical debt is a leading cause of bankruptcy, and a major threat to economic security (and hence, a major threat to health).[26] Medicaid enrollees have fewer debts, better credit, and are less likely to have trouble paying for health care compared to similar adults in states that have not expanded Medicaid.[27]
- **Promote connections to and coordination with other social services.** Although Medicaid cannot be used to pay directly for many non-health services, a growing number of states are using Medicaid flexibility to better connect enrollees with non-health supports and services that could improve their health. For example, living without stable housing can worsen health. States can allow Medicaid to cover more services that help certain people (such as people with mental illness and people with chronic illnesses) stay in their homes, including personal care services, intensive case management, and housing-specific supports such as help

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[22] "Health Insurance Coverage of the Nonelderly (0-64) with Incomes below 200% Federal Poverty Level (FPL), 2016" Kaiser Family Foundation, 2018, https://www.kff.org/other/state-indicator/nonelderly-up-to-200-fpl/; Samantha Artiga, Julia Foutz, and Anthony Damico, "Health Coverage by Race and Ethnicity: Changes Under the ACA," Kaiser Family Foundation, January 26, 2018, https://www.kff.org/disparities-policy/issue-brief/health-coverage-by-race-and-ethnicity-changes-under-the-aca/.

[23] "Chart Book: The Far-Reaching Benefits of the Affordable Care Act's Medicaid Expansion," Center on Budget and Policy Priorities, October 2, 2018, https://www.cbpp.org/research/health/chart-book-the-far-reaching-benefits-of-the-affordable-care-acts-medicaid.

[24] Benjamin Sommers *et al*., "Three-Year Impacts of the Affordable Care Act: Improved Medical Care and Health Among Low-Income Adults," *Health Affairs* epub ahead of print, May 2017, http://content.healthaffairs.org/content/early/2017/05/15/hlthaff.2017.0293.

[25] Chintan B. Bhatt and Consuelo M. Beck-Sagué, "Medicaid Expansion and Infant Mortality in the United States," *American Journal of Public Health*, April 2018, 108 (4):565-567, https://www.ncbi.nlm.nih.gov/pubmed/29346003.

[26] Michael Karpman and Kyle J. Caswell, "Past-Due Medical Debt among Nonelderly Adults, 2012-15," Urban Institute, March 2017, https://www.urban.org/research/publication/past-due-medical-debt-among-nonelderly-adults-2012-15.

[27] "Chart Book: The Far-Reaching Benefits of the Affordable Care Act's Medicaid Expansion."

searching for housing and working with landlords. States can also require Medicaid managed care organizations (MCOs) to provide supportive housing, which combines affordable housing with intensive coordinated services, and encourage more coordination between MCOs and supportive housing providers. Taking these steps can help people maintain stable housing, get the support they need to manage a chronic illness, and reduce the likelihood that they will experience homelessness, be incarcerated, or that their children will be placed in foster care.[28]

- **Advance health equity.** Medicaid serves a disproportionate number of people of color (because people of color are more likely to have low incomes, and Medicaid eligibility for most enrollees is based primarily on income). The Medicaid expansion, in particular, has been instrumental in reducing disparities in health coverage rates between white people and people of color.[29] States could make tremendous progress in continuing to close this gap by expanding Medicaid. Non-elderly uninsured Black people are more likely to fall in the coverage gap — with income below the poverty line in states that haven't expanded Medicaid — than uninsured, non-elderly white people, and as such, they would benefit disproportionately from Medicaid expansion.

Make Budget Decisions That Increase Opportunities to Be Healthy

The health care sector can respond to an individual's lack of housing, employment, or healthy food by trying to mitigate the impact of these unmet needs, but policymakers must make other budget and policy changes to directly dismantle the structural barriers to health.

Recent research underscores the connection between state and local spending on social and economic policies and better health outcomes. One study found that counties that ranked highest for quality of life and life expectancy invested a greater proportion of their expenditures in community and public health services, parks and recreation, sewerage, fire protection, and libraries compared to counties that ranked lower for quality of life and life expectancy.[30] Another found that residents in states that have higher *ratios* of spending on social services (including education, income supports, nutrition assistance, transportation, recreational programming, sanitation, air and water quality regulation, housing, and certain public safety expenditures) relative to spending on health care services performed better on several measures of health including prevalence of obesity and asthma; self-reported mentally unhealthy days and days with activity limitations; rates of death from heart attack, lung cancer, and type 2 diabetes; and infant mortality rates.[31] (See Figure 5.)

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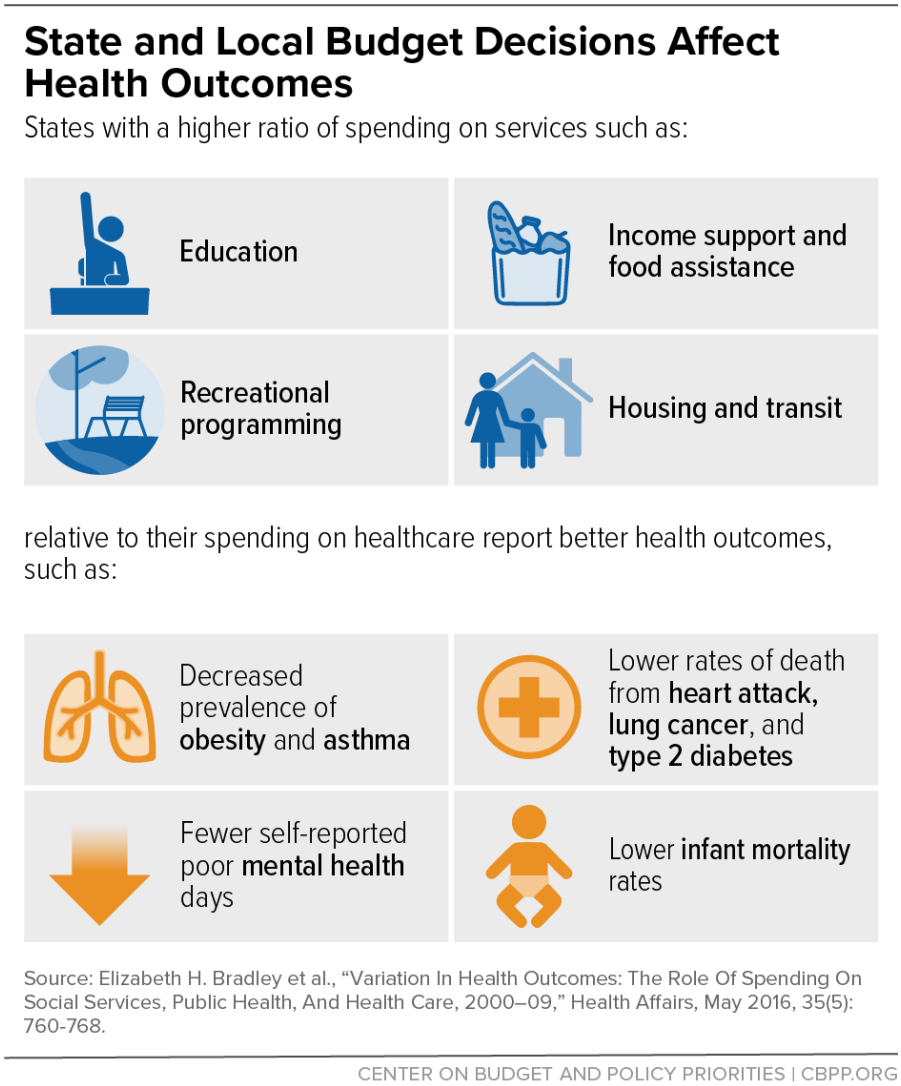
[28] Ehren Dohler *et al.*, "Supportive Housing Helps Vulnerable People Live and Thrive in the Community," Center on Budget and Policy Priorities, May 31, 2016, https://www.cbpp.org/research/housing/supportive-housing-helps-vulnerable-people-live-and-thrive-in-the-community.

[29] Artiga, Foutz, and Damico, *op. cit.*

[30] McCullough and Leider, *op. cit.*

[31] Elizabeth H. Bradley *et al.*, "Variation In Health Outcomes: The Role Of Spending On Social Services, Public Health, And Health Care, 2000–09," *Health Affairs,* May 2016, 35(5): 760-768, https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.0814.

FIGURE 5



Public spending on social, economic, and environmental factors is critical to closing existing racial gaps in health and advancing opportunities for all residents to achieve their full potential. Declining federal support (other than for Medicaid and CHIP) is part of the problem. (See box, "Declining Federal Support Threatens Population Health.") But most states and localities are also not allocating sufficient resources to ensure that these investments deliver their highest possible return. For example, evidence suggests that greater investment in K-12 education and more equitable distribution of education spending are associated with better student outcomes.[32]

Deeper and smarter state and local investment can improve health in areas including:

[32] Michael Leachman, Kathleen Masterson, and Eric Figueroa, "A Punishing Decade for School Funding," Center on Budget and Policy Priorities, November 29, 2017, https://www.cbpp.org/research/state-budget-and-tax/a-punishing-decade-for-school-funding; Bruce D. Baker, "Does Money Matter in Education? Second Edition," Albert Shanker Institute, 2016, http://www.shankerinstitute.org/resource/does-money-matter-second-edition.

- **Education.** Research suggests that people who have completed more education tend also to be healthier, in part because they can get better jobs and are likelier to have higher earnings, live in neighborhoods with more green space and less pollution and crime, and have more resources to invest in healthier foods and opportunities to be active.[33] Other studies have found that students who are healthy are more likely to succeed in school, possibly because they are less likely to miss class due to health problems, and have fewer problems with vision, hearing, paying attention, and behavior. It's clear that public investment in education — early childhood, K-12, and higher education — is crucial for children and families, and therefore communities, to thrive.

  So it's a problem for health that state funding for education has declined dramatically over the past decade in a substantial share of states. At least 12 states have cut school "formula" funding — the primary form of state support for elementary and secondary schools — by 7 percent or more per student over the last decade.[34] The picture is even more grim for higher education, where 45 states (of 49 analyzed) spent less per student in the 2018 school year than in 2008.[35] Per-student funding on state-funded preschool for 3- and 4-year-olds has also declined; states are spending 7 percent less per student in 2017 than in 2002 after adjusting for inflation.[36]

  There are many reasons why states should reverse these troubling trends, but one that's important and often overlooked is the effect that this underinvestment will have for decades to come on residents' health, and as a result, on their long-term economic prospects.

- **Infrastructure.** The built environment has a significant impact on health.[37] For example, an overinvestment in car-oriented infrastructure and underinvestment in public transit and active transportation options like sidewalks and bike paths has contributed to a number of undesirable health outcomes, including growing rates of obesity and related health problems, health complications related to air pollution (and climate change more broadly), and injuries and deaths from traffic collisions.[38] Failure to invest adequately in transit also isolates low-income communities from jobs, schools, grocery stores, and health care providers.

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[33] "Why Education Matters to Health: Exploring the Causes," Virginia Commonwealth University Center on Society and Health, February 13, 2015, https://societyhealth.vcu.edu/work/the-projects/why-education-matters-to-health-exploring-the-causes.html.

[34] Leachman, Masterson, and Figueroa, *op. cit.*

[35] Michael Mitchell *et al.*, "Unkept Promises: State Cuts to Higher Education Threaten Access and Equity, " Center on Budget and Policy Priorities, October 4, 2018, https://www.cbpp.org/research/state-budget-and-tax/unkept-promises-state-cuts-to-higher-education-threaten-access-and.

[36] Allison H. Friedman-Krauss *et al.*, "The State of Preschool 2017: State Preschool Yearbook," National Institute for Early Education Research, April 2018, http://nieer.org/state-preschool-yearbooks/yearbook2017.

[37] Wendy Collins Perdue, Lesley A. Stone, and Lawrence O. Gostin, "The Built Environment and Its Relationship to the Public's Health: The Legal Framework," *American Journal of Public Health*, September 2003, 93(9):1390-1394, https://ajph.aphapublications.org/doi/10.2105/AJPH.93.9.1390.

[38] Sara Zimmerman *et al.*, "At the Intersection of Active Transportation and Equity," Safe Routes to School National Partnership, 2015, https://www.saferoutespartnership.org/resources/report/intersection-active-transportation-equity.

In another example, water infrastructure has critical health implications; it can improve health as in the case of water fluoridation, or it can be harmful if toxins like lead are not eliminated. Most localities with community water systems (CWS) fluoridate water, which helps protect teeth against decay, cavities, and related health problems stemming from poor dental health. Community water fluoridation reduces tooth decay by 25 percent.[39] But, one-quarter of the Americans who get their water from CWS (rather than wells) are served by systems that do not fluoridate the water.[40] Neglected drinking water infrastructure can also be harmful to health because it puts people at risk for lead exposure, which can cause developmental delays and behavioral challenges among children and increase the risk of heart disease among adults.[41]

States and localities pay for more than three-quarters of public infrastructure spending.[42] But state and local infrastructure spending is at a 30-year low. Increasing investments in infrastructure, particularly in areas such as public transit and water infrastructure, can provide the foundation for a strong state economy and improve health.

- **Economic security.** Although income supports comprise a relatively small share of most state budgets, they are powerful tools to reduce and prevent poverty. These provide additional resources to low-income individuals and families and include policies like state Earned Income Tax Credits (EITCs) and state Child Tax Credits (CTCs), which augment existing federal tax credits in a total of 31 states and the District of Columbia (29 states and the District of Columbia have state EITCs and six have state CTCs). In 2017, the federal EITC and the low-income portion of the federal CTC lifted 8.9 million people out of poverty, including 4.8 million children.[43] State credits build on this success, further reducing poverty and inequality.

  A growing body of research also suggests that this additional income — specifically as provided by the federal and state EITC — improves the health of mothers, babies, and even entire neighborhoods.[44] For example, a study looking at the effects of state and local EITC

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[39] SO Griffin *et al.*, "Effectiveness of fluoride in preventing caries in adults," *Journal of Dental Research*, May 1, 2007, 86(5):410–414, https://www.ncbi.nlm.nih.gov/pubmed/17452559.

[40] National Water Fluoridation Statistics, 2014, Centers for Disease Control and Prevention, last updated August 19, 2016, https://www.cdc.gov/fluoridation/statistics/2014stats.htm.

[41] American Academy of Pediatrics, "Prevention of Childhood Lead Toxicity," *Pediatrics*, July 2016, 138(1):e20161493, http://pediatrics.aappublications.org/content/138/1/e20161493; Bruce Lanphear *et al.*, "Low-level Lead Exposure and Mortality in US Adults: A Population-Based Cohort Study," *The Lancet: Public Health*, March 12, 2018, 3(4): e177-e184, https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(18)30025-2/fulltext.

[42] Elizabeth McNichol, "It's Time for States to Invest in Infrastructure," Center on Budget and Policy Priorities, August 10, 2017, https://www.cbpp.org/research/state-budget-and-tax/its-time-for-states-to-invest-in-infrastructure.

[43] Jennifer Beltrán, "Working-Family Tax Credits Lifted 8.9 Million People out of Poverty in 2017," Center on Budget and Policy Priorities, https://www.cbpp.org/blog/working-family-tax-credits-lifted-89-million-people-out-of-poverty-in-2017.

[44] Examples include: William N. Evans and Craig L. Garthwaite, "Giving Mom a Break: The Impact of Higher EITC Payments on Maternal Health," National Bureau of Economic Research, Working Paper No. 16296, August 2010, https://www.nber.org/papers/w16296; Hillary Hoynes, Doug Miller, and David Simon, "Income, the Earned Income Tax Credit, and Infant Health," *American Economic Journal: Economic Policy*, 2015; 7(1): 172-211, https://www.aeaweb.org/articles?id=10.1257/pol.20120179.

expansions on New York City residents found that an increase in the combined state and local EITC benefit from 20 percent to 35 percent of the federal credit was associated with a 0.45 percentage-point reduction in the rate of low-birthweight babies in low-income neighborhoods in New York City.[45] This reduction was observed neighborhood-wide, not just among individual households receiving the credit; by helping to reduce neighborhood poverty rates, the EITC's positive health effects spilled over to the wider community.

States that already have state EITCs and/or CTCs can expand on these by making more people eligible, increasing the size of the credits, or making the credits refundable. States without their own EITCs or CTCs should consider not only the economic benefits of these supports, but also how they can improve maternal health and promote child health and development.

- **Housing.** A large and growing body of research demonstrates the link between safe, stable, affordable housing and positive health outcomes. For people experiencing homelessness, finding housing means they won't be subject to extreme weather conditions, will have a safe place to store medication, can more easily make doctors' appointments, and are relieved of the trauma of living on the streets. Some people have housing but spend more than 30 percent of their income on their housing, which can force them to have to choose between filling prescriptions, buying nutritious food, meeting other basic needs and paying the rent. Finally, housing location or conditions can expose people to poor air quality, lead, and mold; can create barriers to accessing transportation, fresh food, and parks; and can create stress due to living in neighborhoods with high rates of poverty, blight, or violent crime.[46]

  Increasing access to affordable housing involves both increasing access to housing subsidies and creating more housing. For those with extremely low incomes, subsidies are particularly important.[47] Even housing units built through the Low-Income Housing Tax Credit program often are unaffordable for them, and they need subsidies to make up the difference between 30 percent of their income and the cost of rent. The federal government provides most affordable housing subsidies, but 75 percent of eligible households do not receive federal assistance due to lack of funding.[48]

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[45] Jeannette Wicks-Lim and Peter S. Arno, "Improving population health by reducing poverty, New York's Earned Income Tax Credit," *Social Science Medicine – Population Health*, December 2017, 3:373-381, https://www.sciencedirect.com/science/article/pii/S2352827316300829.

[46] Raj Chetty, Nathaniel Hendren, and Lawrence F. Katz, "The Effects of Exposure to Better Neighborhoods on Children: New Evidence from the Moving to Opportunity Experiment," *American Economic Review*, May 2015, 106(4): 855-902, https://opportunityinsights.org/paper/newmto/.

[47] The U.S. Department of Housing and Urban Development defines "extremely low-income families" as families whose incomes do not exceed the higher of the federal poverty level or 30 percent of area median income. See 42 U.S.C. § 1437a.

[48] "Three Out of Four Low-Income At-Risk Renters Do Not Receive Federal Rental Assistance," Center on Budget and Policy Priorities, updated August 2017, https://www.cbpp.org/three-out-of-four-low-income-at-risk-renters-do-not-receive-federal-rental-assistance.

To help address this gap in federal funding and increase access to affordable housing, states can fund their own rental assistance programs (and many have done so).[49] States can increase these programs' potential impact on health by targeting resources to people with chronic health conditions and/or histories of homelessness or institutionalization. To build more affordable housing units, state housing finance agencies that administer the Low-Income Housing Tax Credit program can create incentives for developers to build units targeted to the highest-need populations. States can increase access to opportunity and advance fair access to housing for people of color by not concentrating units in high-poverty neighborhoods and by ensuring new units are affordable and accessible to households with incomes at or below the poverty line.[50]

[49] Anna Bailey, Peggy Bailey, and Doug Rice, "Innovative Approaches to Providing Rental Assistance: States and Localities Seek To Support Health and Human Services Goals," *Cityscape*, 2018, 20(2), https://www.huduser.gov/portal/periodicals/cityscpe/vol20num2/ch4.pdf.

[50] Will Fischer, "Low-Income Housing Tax Credit Could Do More to Expand Opportunity for Poor Families," Center on Budget and Policy Priorities, August 28, 2018, https://www.cbpp.org/research/housing/low-income-housing-tax-credit-could-do-more-to-expand-opportunity-for-poor-families.

Declining Federal Support Threatens Population Health

Federal grants to state and local governments provide roughly 31 percent of state budgets and 23 percent of state and local budgets combined.[a] These grants — other than those for Medicaid and CHIP — are at historically low levels, comprising a lower share of the overall economy than in any year since 1980, and massive federal tax cuts have sharply reduced available federal revenue, adding to pressure for further cuts.[b] This federal fiscal climate makes it harder, but all the more important, for states and localities to invest in programs and policies that can promote health.

For example:

- **Education.** Appropriations for the Department of Education's K-12 programs fell by 13 percent between 2010-2017, and support for Title I grants that support high-poverty schools fell by $1.3 billion (an 8 percent reduction in purchasing power). Adjusting for inflation, federal funding for Head Start has increased less than 10 percent since 2001, failing to keep pace with the increase in the number of poor children under age 5.[c]
- **Public health.** The Centers for Disease Control and Prevention (CDC) redistributes approximately three-quarters of its budget to states and localities, and almost half of state public health spending comes from federal funds. However, after adjusting for inflation, the CDC's core budget has been about the same for nearly a decade. This is problematic given continued growth in public health threats such as increasingly frequent natural disasters, a national opioid epidemic, falling life expectancy, and growing rates of chronic disease.[d]
- **Water infrastructure.** Despite increased attention to water safety following the lead crisis in Flint, Michigan, and broad acknowledgment that the nation's aging infrastructure is in need of attention, federal funding for water infrastructure programs is 35 percent below its 2001 level after adjusting for inflation.[e]

a Iris J. Lav and Michael Leachman, "At Risk: Federal Grants to State and Local Governments," Center on Budget and Policy Priorities, March 13, 2017, https://www.cbpp.org/research/state-budget-and-tax/at-risk-federal-grants-to-state-and-local-governments.

b Sharon Parrott *et al*., "Trump Budget Deeply Cuts Health, Housing, Other Assistance for Low- and Moderate-Income Families," Center on Budget and Policy Priorities, February 14, 2018, https://www.cbpp.org/research/federal-budget/trump-budget-deeply-cuts-health-housing-other-assistance-for-low-and.

c David Reich and Chloe Cho, "Unmet Needs and the Squeeze on Appropriations," Center on Budget and Policy Priorities, May 19, 2017, https://www.cbpp.org/research/federal-budget/unmet-needs-and-the-squeeze-on-appropriations.

d Albert Lang, Molly Warren, and Linda Kulman, "A Funding Crisis for Public Health and Safety," Trust for America's Health, March 2018, https://www.tfah.org/report-details/a-funding-crisis-for-public-health-and-safety-state-by-state-and-federal-public-health-funding-facts-and-recommendations/.

e Reich and Cho, *op. cit*.

Make Policy Decisions That Increase Opportunities to Be Healthy

States and localities can enact other important policies largely outside the budget process that also meaningfully improve population health. In the examples below, the costs are typically borne primarily by the private sector but also in part by the public sector (in its role as an employer), making them smaller-ticket budget items.

- **Minimum wage**. A full-time worker earning the current federal minimum wage and supporting two children lives below the poverty line.[51] But states and localities can enact higher minimum wages so that workers can better make ends meet for themselves and their families. While more research is needed, existing evidence suggests that higher wages can improve health among low-paid workers by making it easier to afford health care services, by reducing the likelihood of experiencing poverty, and by reducing tobacco use (possibly due to lower stress levels).[52] Evidence also suggests that wage increases are associated with a decline in low birthweights and with workers experiencing fewer days with health limitations (which results in fewer missed days of work).[53]

  Higher state minimum wages are a particularly effective way to make work pay for families that earn low wages when coupled with the creation of (or an increase in) a state EITC.[54] Improving both policies at the same time provides an income boost for both minimum-wage workers and low-income families and individuals who earn somewhat higher wages but still qualify for the state EITC. It also staggers the support individuals receive, with some added support with every paycheck as well as an annual boost at tax time.

- **Paid leave.** States and localities can enact paid sick leave and paid family leave as ways to support workers, increase productivity, and improve health among workers and the communities where they live. Both paid sick and paid family leave are associated with improvements in health.

  Access to paid sick leave is associated with increased access to and use of health care services for workers and their children, as well as lower incidence of flu and other communicable illnesses among workers in the same work setting and in public settings like hospitals and

[51] Erica Williams and Samantha Waxman, "State Earned Income Tax Credits and Minimum Wages Work Best Together," Center on Budget and Policy Priorities, updated February 7, 2018, https://www.cbpp.org/research/state-budget-and-tax/state-earned-income-tax-credits-and-minimum-wages-work-best-together.

[52] Arindrajit Dube, "Minimum Wages and the Distribution of Family Incomes," IZA Institute of Labor Economics, February 2017, http://ftp.iza.org/dp10572.pdf; Brady P. Horn, Johanna Catherine Maclean, and Michael R. Strain, "Do Minimum Wage Increases Influence Worker Health?" *Economic Inquiry*, October 2017, 55(4): 1986-2007, https://onlinelibrary.wiley.com/doi/abs/10.1111/ecin.12453.

[53] George Wehby, Dhaval Dave, and Robert Kaestner, "Effects of the Minimum Wage on Infant Health," National Bureau of Economic Research, Working Paper No. 22373, Revised March 2018, https://www.nber.org/papers/w22373; Juan Du and J. Paul Leigh, "Effects of Minimum Wages on Absence from Work Due to Illness," *The B.E. Journal of Economic Analysis & Policy*, January 2018, 18(1), https://doi.org/10.1515/bejeap-2017-0097.

[54] Williams and Waxman, *op. cit.*

restaurants.[55] Paid sick leave also promotes economic security by preventing lost wages while an employee is sick and by increasing job security.[56]

Paid family leave has been shown to decrease rates of infant and child mortality, low birthweight, the likelihood of pre-term birth, and the likelihood mothers will experience postpartum depression.[57] By allowing mothers to maintain employment after the birth of a child, paid leave policies also contribute to greater family economic security.[58]

Raise Revenue Equitably

State and local tax codes play a fundamental role in shaping income and wealth distribution, which also affect residents' health. Where there is greater income and wealth inequality, there are also greater disparities in health.[59] In nearly every state, the state and local tax code is regressive; that is, states and localities collect more taxes from low-income families than high-income families as a share of their income.[60] This is due to a combination of factors, including states' tendency to have weak income tax systems and states' reliance on sales taxes (which hit low-income families particularly hard, since they spend a greater share of their income relative to higher-income families).[61]

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[55] LeaAnne DeRigne *et al.*, "Paid sick leave and preventive health care service use among U.S. working adults," *Preventive Medicine*, June 217, 99: 58-62, https://www.ncbi.nlm.nih.gov/pubmed/28189802; LeaAnne DeRigne, Patricia Stoddard Dare, and Linda Quinn, "Workers Without Paid Sick Leave Less Likely To Take Time Off For Illness Or Injury Compared To Those With Paid Sick Leave," *Health Affairs*, March 2016, 35(3): 520-527, https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.0965; Supriya Kumar *et al.*, "Policies to Reduce Influenza in the Workplace: Impact Assessments Using an Agent-Based Model," *American Journal of Public Health*, August 2013, 103(8):1406-1411, https://www.ncbi.nlm.nih.gov/pubmed/23763426.

[56] Heather Hill, "Paid Sick Leave and Job Stability," *Work and Occupations*, May 2013, 40(2): 143-173, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3825168/.

[57] Jenna Stearns, "The effects of paid maternity leave: Evidence from Temporary Disability Insurance," *Journal of Health Economics*, September 2015, 43: 85-102, https://www.sciencedirect.com/science/article/abs/pii/S0167629615000533; Rada K. Dagher, Patricia M. McGovern, and Bryan E. Dowd, "Maternity Leave Duration and Postpartum Mental and Physical Health: Implications for Leave Policies," *Journal of Health Politics, Policy and Law*, April 2014, 39(2): 369-416, https://www.ncbi.nlm.nih.gov/pubmed/24305845.

[58] Linda Houser and Thomas P. Vartanian, "Pay Matters: The Positive Economic Impacts of Paid Family Leave for Families, Businesses and the Public," Rutgers Center for Women and Work, January 2012, https://smlr.rutgers.edu/sites/default/files/images/CWW_Paid_Leave_Brief_Jan_2012_0.pdf.

[59] See for example, Paula A. Braveman *et al.*, "Socioeconomic Disparities in Health in the United States: What the Patterns Tell Us*," American Journal of Public Health*, April 2010, 100 (S1): S186–S196. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2837459/.

[60] Meg Wiehe *et al.*, "Who Pays? A Distributional Analysis of the Tax Systems in All 50 States, Sixth Edition," The Institute on Taxation and Economic Policy, October 2018, https://itep.org/whopays/.

[61] Elizabeth McNichol, "How State Tax Policies Can Stop Increasing Inequality and Start Reducing It," Center on Budget and Policy Priorities, December 15, 2016, https://www.cbpp.org/research/state-budget-and-tax/how-state-tax-policies-can-stop-increasing-inequality-and-start. Many state income taxes are flat or nearly flat, and seven states do not have an income tax (Alaska, Florida, Nevada, South Dakota, Texas, Washington, and Wyoming).

State and local tax policies, while not always explicitly race-based, have often cemented racial inequalities in power and wealth. States' regressive tax systems widen racial and ethnic inequities because households of color are more likely to have lower incomes and less wealth than white households, so they tend to pay a larger proportion of their income in taxes than white households do.[62]

All states could narrow racial and ethnic inequalities and improve residents' health by adjusting who pays taxes and how much they pay as a share of their income, as well as by increasing the overall funding available to support policies and programs that improve health. Policymakers should take stronger action to confront the fiscal systems and structures that perpetuate racial disparities and prevent residents from having an equal opportunity to live a healthy life.

State tax policies that can improve health by raising more adequate revenue and helping ensure all residents and corporations pay their fair share include:

- **Strengthening state income taxes.** Strengthening income taxes is crucial to building more equitable state tax systems, since income taxes are the only major state revenue source that is based on a taxpayer's ability to pay; typically, income tax rates rise as income grows. By raising tax rates for income over certain high thresholds, and by taking other steps to tax more of the income of wealthy residents, states can narrow income inequality and thus may also narrow health disparities.

  Raising income taxes for high-income households also can produce revenue for investments that improve health outcomes for middle- and lower-income families, without harming state economies.[63] And by strengthening income taxes relative to other sources of state revenue, states can help sustain investments in health over time since income taxes are the one major state revenue source that reliably increases along with normal expenditure growth. By contrast, sales tax revenue typically does not keep up with the cost of services over time, in part because sales taxes often exempt a large share of consumption including many services and online purchases.[64]

- **Adequately taxing wealth.** Wealth is even more concentrated than income in the United States: 10 percent of the U.S. population owns 80 percent of the wealth (which includes things like real estate, savings, stocks and bonds, and personal property).[65] States can use a number of policy tools to ensure that the wealthiest pay their fair share of state taxes, including adopting or expanding estate and inheritance taxes, taxing specific forms of wealth such as

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[62] Michael Leachman *et al.*, "Advancing Racial and Ethnic Equity with State Tax Policy," Center on Budget and Policy Priorities, November 15, 2018, https://www.cbpp.org/research/state-budget-and-tax/advancing-racial-equity-with-state-tax-policy.

[63] Wesley Tharpe, "Raising State Income Tax Rates at the Top a Sensible Way to Fund Key Investments," Center on Budget and Policy Priorities, February 7, 2019, https://www.cbpp.org/research/state-budget-and-tax/raising-state-income-tax-rates-at-the-top-a-sensible-way-to-fund-key.

[64] Elizabeth McNichol, "Strategies to Address the State Tax Volatility Problem," Center on Budget and Policy Priorities, April 18, 2013, https://www.cbpp.org/research/strategies-to-address-the-state-tax-volatility-problem.

[65] Jesse Bricker *et al.*, "Changes in U.S. Family Finances from 2013 to 2016: Evidence from the Survey of Consumer Finances," *Federal Reserve Bulletin*, September 2017, 103(3), https://www.federalreserve.gov/econres/scfindex.htm.

high-value homes, and boosting taxes on capital gains.[66] This helps secure the funding needed to make budget investments that can improve population health.

- **Ensuring that corporations pay reasonable state taxes.** The average profitable Fortune 500 corporation pays less than half the statutory state tax rate, and many profitable corporations pay nothing at all.[67] Between 2008 and 2015, this added up to $126 billion that states could have used to support programs that would have enabled more broadly shared prosperity, including investments that support population health. States should eliminate costly corporate tax breaks, establish strong corporate minimum taxes, and adopt combined reporting by parent and subsidiary corporations to ensure that corporations pay reasonable taxes on the profits they generate.[68]
- **Eliminating or easing property tax limits.** Property taxes are an important part of a healthy state-local revenue system. They decline less than income and sales taxes during economic downturns, and they are, in part, a tax on wealth rather than sales or consumption. But 44 states impose one or more kinds of limits on localities' ability to raise property taxes, and states haven't made up the lost revenue (and some states have simultaneously cut local aid).[69] This puts pressure on localities to either reduce services or raise revenue through increased sales taxes and fees, which fall harder on low-income households. Both of these local budget-balancing options can harm population health, either by reducing services that promote health or by widening income inequality.
- **Increasing tobacco taxes.** Tobacco taxes are an effective way to raise revenue while simultaneously improving health, particularly as part of a broader revenue package that requires the wealthiest residents to pay more as a share of their income.[70] Tobacco is the leading cause of preventable death in the United States, with nearly half a million Americans

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[66] Elizabeth McNichol, "State Taxes on Capital Gains," Center on Budget and Policy Priorities, December 11, 2018, https://www.cbpp.org/research/state-budget-and-tax/state-taxes-on-capital-gains; Elizabeth McNichol, "State Taxes on Inherited Wealth," Center on Budget and Policy Priorities, December 12, 2018, https://www.cbpp.org/research/state-budget-and-tax/state-taxes-on-inherited-wealth; Michael Leachman and Samantha Waxman, "State 'Mansion Taxes' on Very Expensive Homes," Center on Budget and Policy Priorities, January 24, 2019, https://www.cbpp.org/research/state-budget-and-tax/state-mansion-taxes-on-very-expensive-homes.

[67] Matthew Gardner *et al.*, "3 Percent and Dropping: State Corporate Tax Avoidance in the Fortune 500, 2008 to 2015," Institute on Taxation and Economic Policy, April 2017, https://itep.org/3-percent-and-dropping-state-corporate-tax-avoidance-in-the-fortune-500-2008-to-2015/.

[68] Timothy Bartik, "Who Benefits From Economic Development Incentives? How Incentive Effects on Local Incomes and the Income Distribution Vary with Different Assumptions about Incentive Policy and the Local Economy," W.E. Upjohn Institute for Employment Research, Report No. 18-034, March 2018, https://research.upjohn.org/up_technicalreports/34/; Michael Mazerov, "A Majority of States Have Now Adopted a Key Corporate Tax Reform — 'Combined Reporting,'" Center on Budget and Policy Priorities, revised April 3, 2009, https://www.cbpp.org/research/a-majority-of-states-have-now-adopted-a-key-corporate-tax-reform-combined-reporting.

[69] Iris J. Lav and Michael Leachman, "State Limits on Property Taxes Hamstring Local Services and Should Be Relaxed or Repealed," Center on Budget and Policy Priorities, July 18, 2018, https://www.cbpp.org/research/state-budget-and-tax/state-limits-on-property-taxes-hamstring-local-services-and-should-be.

[70] Iris J. Lav, "Cigarette Tax Increases: Cautions and Considerations," Center on Budget and Policy Priorities, revised July 11, 2002, https://www.cbpp.org/archiveSite/7-3-02sfp.pdf.

dying prematurely each year due tobacco use.[71] Tobacco also exacts a high price on the U.S. economy, costing at least $130 billion each year in direct medical costs and generating productivity losses worth more than $150 billion annually.

Tobacco taxes are highly effective at reducing tobacco use and deterring people, especially youth, from starting to use tobacco.[72] Every state has a per-pack cigarette tax, but the amounts of the taxes vary widely (from just $0.17 in Missouri to $4.35 in New York).[73] States can reduce tobacco use and its toll on health and their economies by increasing these taxes. To fully realize the health benefits of tobacco taxes, they should also reinvest the revenue in policies and programs that promote economic opportunity and improve health for low-income people, such as a state EITC, Medicaid, or tobacco cessation programs for low-income people.

[71] U.S. Department of Health and Human Services, "The Health Consequences of Smoking: 50 Years of Progress. A Report of the Surgeon General," U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, January 2014, https://www.surgeongeneral.gov/library/reports/50-years-of-progress/full-report.pdf.

[72] Chuck Marr and Chye-Ching Huang, "Higher Tobacco Taxes Can Improve Health and Raise Revenue," Center on Budget and Policy Priorities, updated March 19, 2014, https://www.cbpp.org/research/higher-tobacco-taxes-can-improve-health-and-raise-revenue.

[73] "State Cigarette Excise Taxes Rates & Rankings," Campaign for Tobacco-Free Kids, September 18, 2018, https://www.tobaccofreekids.org/assets/factsheets/0097.pdf.

APPENDIX TABLE 1

Health Outcomes by Race/Ethnicity

Race/Ethnicity	Life Expectancy (years)[a]	Infant Mortality Rate (per 1,000 live births)[b]	Low Birthweight[c]
Non-Hispanic			
White	78.5	4.9	7.0%
Black	74.8	11.4	13.7%
American Indian or Alaskan Native	--	9.4	7.8%
Asian	--	3.6	8.4%
Native Hawaiian or Other Pacific Islander	--	7.4	7.7%
Hispanic	81.8	5.0	7.3%
U.S. Average	78.6	5.9	8.2%

[a] National Center for Health Statistics, National Vital Statistics System, Table 3: Mortality, 2016, https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_05.pdf.

[b] National Center for Health Statistics, Linked Birth/Infant Death Public Use File, 2016, ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/DVS/periodlinked/LinkPE16Guide.pdf.

[c] National Center for Health Statistics, National Vital Statistics System, Table 13: Natality, 2016, https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_01.pdf.