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# Using Tobacco Taxes to Support Medicaid: A Win-Win Scenario

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## Acknowledgments

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Community Catalyst is a national advocacy organization that builds consumer and community participation in the shaping of our health system to ensure quality, affordable health care for all.

Our work is aimed at strengthening the voice of consumers and communities wherever decisions shaping the future of our health system are being made. Community Catalyst strengthens the capacity of state and local consumer advocacy groups to participate in such discussions. The technical assistance we provide includes policy analysis, legal assistance, strategic planning, and community organizing support. Together we're building a network of organizations dedicated to creating a more just and responsive health system.

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## Introduction

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Medicaid is in trouble. Caught between rising costs and stagnant state revenue, the Medicaid program, which currently insures about 50 million people, has come under fire as “the PAC man of state budgets.”<sup>i</sup> States have faced budget shortfalls of \$38-\$80 billion in each of the past 3 years. (\$38B SFY02<sup>ii</sup>, \$80B SFY03, \$79B SFY04<sup>iii</sup>) To date, states have relied on a variety of strategies to close their budget deficits, cutting Medicaid prominently among them. States are responding to their budget crisis by eliminating coverage for hundreds of thousands of low income people, cutting benefits and increasing cost-sharing and reducing provider payments.<sup>iv</sup>

In general, tax increases have figured less prominently in budget-balancing strategies although many states have turned to increasing tobacco taxes recently.<sup>v</sup> Nonetheless, a number of states have not increased tobacco taxes recently and continue to forgo substantial revenue while also failing to realize the public health gains that come with raising tobacco taxes. Sixteen states have not raised tobacco taxes for at least a decade and eighteen states have tobacco taxes less than 50 cents (national average = 70.5 cents per pack).<sup>vi</sup> In fact, despite a spate of recent increases, state taxation of tobacco remains low by historic standards.<sup>vii</sup> Raising tobacco taxes could bring a welcome revenue boost to many states that would help sustain coverage.

Dedicating new tobacco revenue to Medicaid would also preserve the federal matching payments that Medicaid generates and that help sustain state economies and health care systems particularly in times of economic downturn. For example raising tobacco taxes in the ten states with the lowest tobacco taxes to the national average coupled with federal matching funds would bring in an annual average of \$4.05 billion for the next five years.<sup>viii</sup>

Yet, notwithstanding its potential to mitigate the intense pressure for cuts, linking tobacco tax increases to Medicaid has drawn mixed response from advocates<sup>ix</sup>. Generally health care advocates raise three arguments against using a tobacco tax for Medicaid: first, it is regressive; second it is a declining revenue source; and third, dedicating revenue is bad fiscal policy. This paper addresses those arguments and asserts that health care advocates have an important stake in increasing tobacco tax that goes beyond the revenue that can be raised.

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## Regressivity

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Tobacco taxes, like all excise taxes are regressive. That is, a \$.50 per pack increase in the price of cigarettes represents a greater share of the income of a person who earns \$10,000 than someone who earns \$100,000. Furthermore, lower income people are more likely to be smokers. Because of these facts, some critics of smoking have gone as far as to say that raising tobacco taxes to fund Medicaid is like asking poor people to self-finance their own benefits.

However, to leave the discussion there would be to leave uncorrected certain myths about cigarette use and to ignore the important health and economic benefits that flow to low-income people from an increase in tobacco taxes, benefits that are multiplied when tobacco tax dollars are spent on health care for low-income people.

While it is true that low income people are more likely to be smokers, this is less true than is commonly believed. Part of the income differential stems from the fact that smokers are more likely to be young people who are early in their work lives and not at the peak of their earning power. When age is factored in, the difference in income between smokers and non-smokers is reduced.<sup>x</sup>

In addition, in the aggregate, a tobacco tax increase is less regressive than the currently existing tax because low-income smokers are more likely to quit in response to a price increase. As a result, a higher proportion of the tax is paid by people in higher income brackets.<sup>xi</sup>

More important than these technical arguments is the fact that, even though the difference is not as great as is popularly believed, low-income people, many of whom are uninsured or on Medicaid, are still more likely to suffer from tobacco related illness.<sup>xii</sup> Raising tobacco taxes and using the money for coverage offers important benefits to low-income communities. First, raising tobacco taxes is perhaps the single most effective anti-smoking measure<sup>xiii</sup> and reducing smoking is among the most effective means we have available to reduce preventable illness<sup>xiv</sup>. As noted above, low-income people are particularly likely to quit smoking, and so enjoy improved health, in response to a price increase.

Furthermore, if a tobacco tax increase is used to forestall a cut in health benefits or to expand coverage, then low-income people who would otherwise be uninsured will avoid the well-documented consequences of lack of coverage, including poorer health and shorter life spans.<sup>xv</sup> The uninsured are more likely to forgo necessary care – including screenings and regular doctor’s visits. Further, they are less likely to receive preventive services, resulting in delayed diagnoses, more hospitalizations, sicker people, and premature death.<sup>xvi</sup>

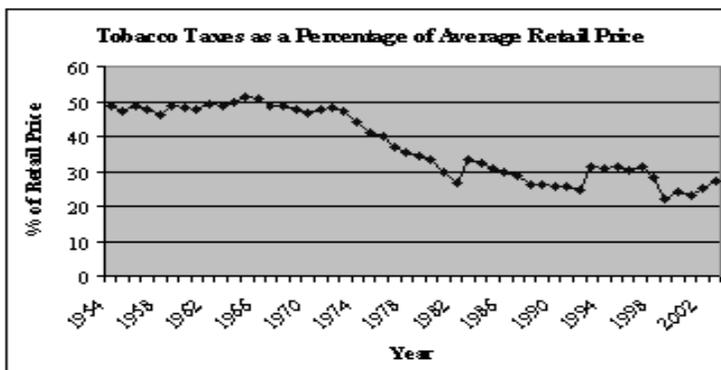
In addition, raising tobacco taxes and using the revenue from Medicaid coverage yields

important economic benefits. When looked at in the aggregate, a tobacco tax increase dedicated to Medicaid is a highly progressive net transfer of wealth. Low income smokers pay a small portion of the total cost of the Medicaid coverage, with an additional portion paid by middle and upper income smokers and a large share from federal matching funds. In addition, low income people gain the economic benefit of coverage and those who quit smoking avoid the costs of smoking and tobacco related illness. These costs are estimated at over \$3,000 per year per adult smoker, a substantial portion of which are born by smokers themselves.<sup>xvii</sup>

Furthermore, the health and economic benefits are not confined to low-income people. As an alternative to Medicaid cuts, raising tobacco taxes can generate millions of dollars in federal matching funds that can help sustain a state's health care delivery system and stimulate the economy.<sup>xviii</sup> In addition, raising cigarette taxes reduces the public outlay for tobacco related illness, a cost that exceeds the amount that states are currently collecting from tobacco taxes by \$3.9 billion.<sup>xix</sup>

A final argument about regressivity relates to the growing overall regressivity of state tax codes. However, this growing regressivity really results from a function of the types of tax-cuts that states have enacted over the years (for example cuts in estate taxes) not from excessive increases in tobacco taxes. Overall tobacco taxes as a percentage of the purchase price of cigarettes are low by historic standards and represent a minor source of state revenue.<sup>xx</sup>

In sum, tobacco related illnesses are epidemic among low income people and are the most prevalent preventable illnesses. Raising tobacco taxes is probably the single most effective tobacco control measure available and is more effective among lower income people than the general population. Raising tobacco taxes and using the money for health coverage for low income people provides both health and economic benefits to low income populations and to the state as a whole.



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## Declining Revenue

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The second objection to using tobacco taxes to fund Medicaid that is often heard is that Medicaid costs are rising while the revenue from a tobacco tax will inevitably decline over time, creating a gap between revenue and spending. In the extreme case, it is sometimes argued that revenue from the tax will vanish if people stop smoking (and isn't that what we want—people to stop smoking?). Unfortunately, we are in no immanent danger of having revenue from tobacco taxes disappear. If, however, people really did stop smoking, the lost revenue would be offset by reduced health care costs from decline in tobacco related illness.

In its less extreme form, the argument about declining revenue, as with the argument about regressivity, has some merit. However, it is possible to take steps to reduce the impact of declining revenue.

First, when using tobacco taxes to fund health care, it makes sense to only budget the average revenue over a multi-year period and only appropriate this average rather than spending 100% of the amount raised in year one. In this way, money reserved in year one will be available to supplement lower revenue in future years.

It is also important to remember that the real decline in tobacco tax revenue has two components. In part, it is due a decline in smoking over time but in part the real decline (inflation adjusted) of value of tax is due to the fact that the tax does not rise as the price of cigarettes rises. The static nature of the tax also reduces its value as a deterrent over time. However, this 2<sup>nd</sup> source of the decline in revenue can be addressed by building in step increases in the tax over time to keep it from declining relative to the price of tobacco as was done in both Vermont and Rhode Island.<sup>xxi</sup>

Although tobacco taxes do decline over time, they do have the advantage of being a fairly predictable revenue source, more so than many others (Tobacco tax revenue may even be countercyclical—that is, people may smoke more during bad economic times). This predictability makes it possible to plan and budget with a relatively high degree of accuracy.

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## **Other Factors to Consider When Weighing a Tobacco Tax**

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### **POLITICAL SUPPORT**

Tobacco taxes are popular. Increasing tobacco taxes enjoys 2-1 support pretty much across the nation, even in tobacco growing states. Nineteen out of 22 state polls confirmed that to “balance state budgets, voters strongly prefer increasing state tobacco taxes over either other tax increases or cuts to vital state programs.” In the other three states, raising the tobacco tax ranked just 1 to 5 percentage points behind the most popular choice for addressing the budget deficit.<sup>xxii</sup> As the most politically palatable tax, a tobacco tax can offer political cover for a larger tax package.

### **A STRONG ALLIANCE**

Potential allies in a campaign to raise tobacco taxes for Medicaid include voluntary health organizations like the American Cancer Society and American Heart Association as well as physician organizations, particularly pediatricians, oncologists and emergency physicians. Not only do these groups add to the organizational strength of health care advocates, but working together also creates an opportunity to build relationships that can be transferred to other health issues.

### **THE ALTERNATIVE TO RAISING TOBACCO TAX IS TO LEAVE MORE MONEY ON THE TABLE FOR THE TOBACCO INDUSTRY.**

The price of tobacco will go up with or without an increase in tobacco taxes. The tobacco industry has raised the price of cigarettes 18 times since 1993 resulting in a \$1.49 increase over 10 years. In contrast, federal and average state tax increases combined have only been \$0.32.<sup>xxiii</sup> By failing to raise tobacco taxes, states simply leave more room for the industry to raise prices themselves and continue to profit from people’s addiction. Alternatively, by raising the tobacco tax, at any given price, more of the money is dedicated to public purposes that can include not only Medicaid, but also tobacco control, and smoking cessation activities.

### **DEDICATING FUNDS**

A third argument that is often heard against using tobacco taxes to support Medicaid is that dedicating funds is bad fiscal policy and reduces the flexibility that budget writers need to respond to changing circumstances over time.

It may be true that experts in fiscal policy consider dedicating funds to be bad fiscal policy but it is good politics. With trust in government low, dedicating funds may be

the key to winning popular support for a tax increase (of any type) by assuring the public that the funds will go where people want. If the alternative to dedicating revenue is not to have the revenue at all, making deeper cuts in services necessary, then dedicating funds is clearly the lesser of two evils.

A variant of the argument against dedicating funds is that funds can be dedicated, but shouldn't be dedicated to Medicaid but instead should go to some other purpose like the state rainy day fund. Unfortunately, by using tobacco taxes for a purpose like replenishing a state rainy day fund, many of the factors that offset the regressivity of tobacco taxes, when used for Medicaid, are diminished. Not only are the federal matching funds lost, but there is no guarantee that the services would primarily be used to benefit low-income people. It seems inconsistent to argue against tobacco taxes on regressivity grounds and then suggest a far more regressive use for such taxes.

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## Caveat

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Raising tobacco taxes is not **the solution** to funding Medicaid. States and Medicaid programs do have long term structural problems that cannot be addressed by raising tobacco taxes. Real solutions to these problems require states that rely heavily on taxes on goods to fund state services to address the changing economy, in which most of the economic growth is in the exchange of (largely untaxed) services. States also have to reassess whether the billions of dollars in tax cuts that they enacted in 90s were truly affordable.

On the Medicaid front, the growing cost of dual eligibles—Medicaid enrollees who are also eligible for Medicare must be addressed. Medicaid's share of the cost of care for this population is growing, rising from 30% in 1984 to 40% in 1998.<sup>xxiv</sup> The federal government should address this problem by filling in the gaps in Medicare coverage, particularly for prescription drugs and long term care. At the same time, steps can be taken at the state level that would simultaneously improve the quality of health care and also reduce cost. If states make a real effort to avoid preventable hospitalizations and reduce medical errors, state Medicaid programs will reap savings. Over the long term, reducing smoking will itself help make Medicaid more affordable by reducing the cost to Medicaid of tobacco related illness.

## CONCLUSION

Few policy changes have greater upside potential than raising tobacco taxes and using the money to fund Medicaid. States that undertake such an effort can simultaneously reduce tobacco related illnesses, tunity for a win-win scenario.

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