Coverage Matters:

Why the decline in Medicaid and private insurance is putting people with tobacco-related illnesses at risk

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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

Cardiovascular disease (heart disease and stroke) and cancer are the number one and number two killers in the United States, causing nearly 60% of all deaths in the US in 2000, including 53.1% of non-elderly adult deaths.[1] A significant percentage of these and several other diseases, including emphysema and chronic bronchitis, are caused by tobacco use. It is estimated that smoking is responsible for 21% of all coronary heart disease deaths, 18% of all stroke deaths, and 30% of all cancer deaths in the nation each year.

While Medicare and private insurance play a large role in treating people with cardiovascular disease and cancer, Medicaid, the joint federal/state health insurance program for certain low-income or disabled populations, is an important source of coverage for people with these illnesses. However, people with cardiovascular disease, cancer, and other tobacco-related illnesses on Medicaid are at risk of losing their coverage due to declining state revenues and rising health care costs. Loss of Medicaid coverage is particularly serious because of Medicaid's disproportionate role as an insurer of at-risk populations. Without this critical coverage, low-income people are likely to be uninsured, and thus unable to receive the vital care that they need.

This paper gives a brief overview of the Medicaid program and its significance as a source of coverage for people with cancer, cardiovascular disease and tobacco related illnesses in general. It goes on to explain why this coverage is at risk and the serious consequences to people with the aforementioned illnesses of the potential loss of coverage.

Medicaid Background

Medicaid was created in 1965 as part of Title XIX of the Social Security Act. While the federal government provides a framework for the program with certain groups of people and certain benefits that states must cover, states have significant power in deciding which optional populations and what benefits to include. States are not required to cover any of the following groups:

- Pregnant women and children under 6 with incomes greater than 133% of the FPL ($24,470 for a family of four)
- Children over 6 with incomes greater than 100% of the FPL ($18,400 for a family of four)
- Parents with incomes greater than approximately $8,500 for a family of three[2]
- Disabled and elderly with incomes greater than approximately $6,600 for an individual[3]
- Childless non-disabled adults under age 65 regardless of how low their income.

Optional benefits include prescription drugs, adult dental care, artificial limbs, physical therapy/occupational therapy/speech therapy, screening/preventive/rehabilitative services, hospice care services, and personal care services. Nearly two-thirds of Medicaid spending is for these optional populations and benefits that states have chosen to cover.[4] Over one third of Medicaid spending is for filling in the gaps for services that Medicare does not provide (e.g. prescription drugs) for income-eligible adults over 65.

Medicaid provides health coverage for over 51 million people, including 25.9 million children, 12.7 million non-elderly adults, 4.8 million elderly, and 8.2 million individuals who are blind or disabled.[5]

Medicaid's Importance as an Insurer for Cancer, Heart Disease and Other Tobacco Related Illnesses

The Medicaid population is generally sicker than the privately insured. Publicly insured adults under the age of 65 are 1.6 times more likely to have cancer than the privately insured. They are also 2.3 times as likely to suffer from a stroke.[6] Medicaid also covers a high proportion of the sickest adults over age 65, those who are most likely to suffer from heart disease, stroke, and cancer.[7] Over half of older individuals on Medicaid have a health status rated as fair or poor compared to only 26% of other Medicare beneficiaries. Seventy-seven percent of this population had incomes lower than $10,000, in sharp contrast to 18% of all Medicare beneficiaries.[8]

Medicaid is the disproportionate insurer for racial and ethnic minorities, who often suffer from higher incidence and mortality rates of cardiovascular disease, cancer, and tobacco-related illnesses. In particular, African-Americans and Hispanics make up large portions of the Medicaid population, but relatively small percentages of the general population. African Americans and Hispanics account for roughly 46% of the Medicaid population[9] but only a little over 25% of the overall population.[10] African Americans, who are 30% more likely to die from either heart disease[11] or cancer than the general population,[12] make up 24.1% of Medicaid enrollees but only 12.5% of the general population.

Another way to look at Medicaid's disproportionate role, is to look at differences in health status based on income. For example, low-income people, who are particularly heavily represented in the Medicaid population, are more likely to suffer from heart disease, emphysema and asthma than are the non-poor.[13] Among men 25-64 years old, those with incomes less than $10,000 were 2.5 times more likely to die of heart disease than those with incomes of $25,000 or more. Low-income women in the same age range were 3.4 times as likely to die of heart disease as those with higher incomes.[14] Children living in communities with an average family income below $20,000 were 2.4 times as likely to be hospitalized with asthma as those living in neighborhoods with an income of at least $40,000.[15] Low-income people are also often diagnosed with cancer at later stages than the overall population, resulting in lower chances for successful treatment and survival.[16]

Medicaid and Tobacco

Smoking greatly increases the risk of dying from heart disease and stroke. The risk of dying from heart disease is tripled from smoking among middle-aged men and women. 21% of all coronary heart disease is also attributed to smoking each year. Smoking also doubles the risk of ischemic stroke and accounts for 18% of all stroke deaths.[17] The CDC reports that over 170,000 Americans dies from smoking related cardiovascular diseases each year.[18] Smoking is also responsible for 30% of all cancer cases. Over 100,000 men and women die of lung cancer due to smoking each year.[19] Beyond causing 87% of lung cancers, smoking is also associated with cancers of the mouth, pharynx, larynx, esophagus, pancreas, uterine cervix, kidney, and bladder.[20]

In addition to cancer and heart disease, smoking causes 81% of all chronic obstructive pulmonary disease cases, which include emphysema and chronic bronchitis. Smoking is also associated with hearing loss, vision problems, chronic coughing, gastric ulcers, and weakened immune systems.

Smoking even seriously harms those who do not smoke but do breathe environmental tobacco smoke or secondhand smoke. The risks associated with secondhand smoke include low birth weight babies, Sudden Infant Death Syndrome, higher risks of respiratory tract infections, asthma, middle ear infections, and increased risks of lung cancer and heart disease mortality. Exposure to secondhand smoke causes an estimated 35,000 to 40,000 deaths from ischemic heart disease[21] and 3,000 deaths from lung cancer annually to nonsmokers.[22] Smoking during pregnancy results in approximately 1,007 infant deaths each year.[23]

Not only do these diseases have significant human impacts, causing much suffering and hundreds of thousands of deaths each year, but they also have a very real fiscal cost for our health care system. The cost of heart disease and stroke is estimated to be $351.8B in 2003, including direct health care expenditures and lost productivity from illness and death[24] ($209.3B medical expenditures, $32.4B lost productivity due to illness, $110.1B lost productivity due to premature death). According to the National Institutes of Health, overall costs for cancer in 2000 are estimated at $180.2B ($60B direct medical costs, $15B lost productivity due to illness; $105.2B lost productivity due to premature death).[25] Each pack of cigarettes sold costs the nation an estimated $7.18 in medical costs and lost productivity.

The burden of smoking and smoking-related illnesses falls particularly heavily on communities of color and hence on the Medicaid population. For example, although African Americans are slightly less likely to smoke than whites (22.5% vs. 24.1%[26]), African American men are at least 50% more likely to develop lung cancer than white

men.[27] Overall Medicaid plays a disproportionate role in covering treatment for tobacco related illnesses. In 1998, smoking caused an estimated $75B in health care costs annually, including $23.5B in Medicaid expenditures.[28] Thus Medicaid paid for more than 31% of smoking attributable health care expenditures but covered only about 11 % of the population.[29] This difference between expenditures and enrollment actually understates Medicaid's role, because Medicaid generally pays lower rates than other insurers. For example, Medicaid pays on average only about 87% of what the private sector pays to hospitals.[30]

Medicaid is also a disproportionate insurer of children and pregnant women and the population covered is more at risk for tobacco related illnesses than the privately insured. Children made up 51.2% of the Medicaid population in 1998.[31] Many children suffer from asthma, which can be triggered by secondhand smoke among other things. From 1980 to 1994, the prevalence of asthma increased 74% in children ages 5 to 14. It is the third ranking cause of hospitalizations for those under age 15 years of age.[32] Asthma is particularly prevalent among low-income and minority children, who are represented disproportionately in the Medicaid population. Medicaid provides health coverage for 42% of low-income children, more than any other type of health insurance coverage.[33] Pediatric hospitalization for asthma is estimated to be five times higher in families of lower income. Indeed, asthma is the most prevalent admitting diagnosis in low-income children and adults.[34] Medicaid provides these low-income children with access to the emergency room, inhalers, and other types of necessary medications.

Smoking during pregnancy also causes tens of thousands of low birth weight babies each year. The CDC estimated that in 1995 there were between 32,000 and 61,000 additional low birth weight births as a result of maternal smoking.[35] The direct medical costs for low birth weight births from maternal smoking were $263 million in 1995.[36] Medicaid covered 39% of all births in 1995,[37] but approximately two-thirds of pregnant smokers are Medicaid recipients.[38] Thus Medicaid likely covers close to two-thirds of low birth weight births, resulting in approximately $175 million in medical costs.[39] Smoking during pregnancy also results in several other birth complications, including infant respiratory distress syndrome. In 1995, the CDC estimated the health care costs associated with smoking-attributable birth complications, including low birth weight births, to be as high as $2.0 billion.[40]

The Assault on Medicaid

In sum, for certain populations and certain diseases Medicaid plays an essential role in providing coverage and hence access to timely and effective treatment. Many people with cardiovascular disease, cancer, and tobacco-related illnesses depend on Medicaid for proper treatment and health coverage. Medicaid beneficiaries who suffer from these illnesses currently have access to vital prescription drugs, including beta-blockers to control high blood pressure and chemotherapy drugs to control tumor growth. Besides prescription drugs, stroke victims have access to rehabilitation therapies – physical, occupational, and speech therapies – that can enable them to live independently again.

As a result of their dependence on Medicaid to access and finance care, the continuing assault on the Medicaid program has the potential to create and widen gaps in access to care for people with cardiovascular disease, cancer, asthma, and other illnesses particularly within minority communities. The current state budget crises are particularly relevant for people suffering from all of these diseases because these groups are often optional or non-mandatory populations and many benefits are not required, most notably prescription drugs.

To balance their budgets, states could eliminate cancer screening, a critical step for early diagnosis and treatment of cancer. Medicaid recipients who suffer from a heart attack or stroke or who are diagnosed with cancer are also in jeopardy of losing access to home care. In addition, Medicaid could stop offering smoking cessation programs, which help reduce the risk for cardiovascular disease and cancer. This is particularly serious, because the low-income are already more likely to smoke, with 33.1% of adults below the poverty level smoking and only 23.4% of adults at or above the poverty level smoking; smoking greatly increases the risk for developing these diseases.[41] States are also cutting rates paid to providers who care for Medicaid recipients, which could further increase the existing shortage of providers willing to see those who are covered by Medicaid.

Medicaid is currently at risk because of declining revenues and rising costs. States are facing large budget shortfalls that total $79B for SFY04,[42] and that follow two years of shortfalls of $38B for SFY02[43] and $80B for SFY03.[44] While spending on Medicaid is up, the rate of increase is less than for private insurance.[45] Declining revenue is a much larger source of state budget woes than increased spending, accounting for an estimated 74% of the total shortfall in FY02.[46] As a result of the increasing revenues in the 1990s, states enacted significant tax cuts that "are currently costing states more than $40 billion each year", accounting for roughly half of the current state budget gaps.[47] Combined, these two factors, declining revenues and rising costs, have resulted in state budget crises across the nation, causing states to enact drastic reductions in their Medicaid programs. For example, Massachusetts has capped several of their Medicaid programs including

CommonHealth, a program that provides health coverage for working adults with disabilities. Other states, such as Tennessee, have already begun eliminating health care coverage for hundreds of thousands of adults and children. In Missouri, working parents must now earn less than 77% of the poverty line instead of 100% of the poverty line ($11,565 instead of $15,020 for a family of three) to qualify for Medicaid.[48] States have also eliminated benefits, such as adult dental care and eyeglasses, provided to Medicaid enrollees.

In addition to cuts already made, there looms the threat of program restructuring that could place greatest risk on the sickest enrollees. There has been a continued threat of implementing a federal block grant system in place of the current "matching funds" reimbursement. This change would undermine the entire Medicaid program, fundamentally eliminating the incentives for increasing coverage. The proposed federal Medicaid block grant would add to the risk by severely limiting a state's ability to expand their Medicaid program, because the federal program funding would be capped.

Under a block grant, states would not be able to receive federal matching funds to cover more people or even to pay for a new, more effective treatment, such as drug-eluting stents to help heart disease patients or a more beneficial but more expensive medications to combat cancer or HIV. Crucial protections in the program would also be eliminated, because states would not need to receive federal approval to make changes to their program. For example, they could increase cost-sharing, such as co-pays and premiums, far beyond the current limits to unreasonable levels, making the program unaffordable even for those who qualify and limiting access to cost-effective preventive care.

The Bush administration proposal would create a federal block grant for two thirds of Medicaid spending. The guarantee of federal matching funds is eliminated. States that wanted to expand their Medicaid programs to cover additional populations or benefits (or to restore cuts) could not count on federal assistance. The proposal would also eliminate vital protections for beneficiaries. States would no longer have to make Medicaid available on a statewide basis or ensure that cost-sharing was affordable for low-income people. States would be able to limit enrollment and benefits and increase premiums and cost-sharing without federal approval.

States are only required to cover a narrow group of people and some health services. They are not required to cover disabled and elderly people with incomes over $6,600 for an individual, children 6 and older with incomes over $18,400 for a family of four and many other low-income groups. Optional benefits include:

- Prescription drugs
- Adult dental care
- Prostheses
- Physical therapy/occupational therapy/speech therapy

- Hospice care services
- Personal care services.

The federal block grant would apply to the two-thirds of Medicaid program spending that is for these optional groups and optional benefits.

People on Medicaid Would Otherwise be Uninsured

People who lose their Medicaid coverage are likely to become uninsured, because they are unlikely to be able to afford private insurance. Most people on Medicaid are either unemployed or are ineligible for employment-based coverage. In 2002, the average annual cost of a private insurance plan was $3060 for an individual and nearly $8000 for a family of four.[49] The typical income limit for a parent in a family of four was less than $15,500.[50] Thus, if a family was no longer eligible for Medicaid, premiums for a family plan would account for over 51% of their income.

The importance of Medicaid coverage was highlighted when disaster-relief Medicaid was created in New York to provide short-term health coverage to those who lost jobs and benefits after the September 11th attack. Due to the streamlined enrollment process to a one-page application, nearly 342,000 previously uninsured New Yorkers were enrolled in the program during the four-month enrollment period. A study of 75,000 of these disaster-relief Medicaid patients found that 1,587 people were diagnosed and treated for a malignant type of cancer. A significant number of the patients also suffered from heart disease, hypertension, and asthma.[51] Untreated and unmonitored, these diseases and conditions would likely have resulted in more deaths and poorer health status.

Uninsured Don't Get the Care They Need

The loss of Medicaid coverage can have serious health consequences. For example, people with hypertension, or high blood pressure, when they lost their Medicaid or their Veterans Administration coverage experienced significant increases in blood pressure relative to those who did not lose their coverage, with 41% of the uninsured having uncontrolled high blood pressures 13 months later as compared to 17% of the comparison group. After 17 months, nearly twice as many of those who had lost coverage had reduced their use of prescribed medications (47% vs. 25%). Medicaid plays a key role in treating this and other risk factors for these diseases.[52]

The fact that the uninsured are not getting the health care they need to receive – lacking everything from prevention to care for chronic illness – takes a very real toll on their health and the nation's economic health. During the first six months after diagnosis, uninsured cancer patients under 65 pay more out-of-pocket than the privately insured, $1,343 versus $549, but the uninsured receive significantly less care, $4,806 versus $8,419.[53] Evidence from available medical and scientific literature suggests that, as compared to those with insurance, the uninsured are less likely to receive preventive care,[54] resulting in more serious illnesses[55] and avoidable hospital and emergency room visits.[56] They are also three times more likely to die in the hospital.[57] Overall, those who lack health insurance have a 25% greater chance of dying than those who have private health insurance.[58]

The higher mortality rates for racial and ethnic minorities are at least partially due to the higher rate of uninsurance of minorities. The lack of access to care results in diagnosis at later stages and worse disease outcomes. Minority Americans are at least twice as likely to be uninsured as whites, largely reflecting lower rates of private coverage. Latinos are the most likely to be uninsured with about 1 in 3 (36%) nonelderly persons uninsured in 1997. In comparison, 14% of whites were uninsured in the same year.

Timely access to medical care can make a significant difference. For example, many of the risk factors for cardiovascular disease can be greatly reduced through changes in behavior. Hypertension and high blood cholesterol are two of the primary independent risk factors for cardiovascular disease. Approximately 90% of all middle-aged Americans will develop high blood pressure in their lifetime, and 70% of those with high blood pressure do not have it under control.[59] Monitoring hypertension and blood cholesterol to identify elevated levels allows health care practitioners to treat patients at risk for cardiovascular disease, but the uninsured are less likely to have regular contact with practitioners.

Patients who are aware of their own risk are also more likely to recognize the signs and

symptoms of heart attacks and strokes and to understand the importance of calling 911. The CDC estimates that 70% of deaths from heart disease occur before a person can be admitted to a hospital, and that 48% of stroke victims die before emergency medical personnel arrive.[60] The uninsured are at a marked disadvantage in learning about the necessary steps to prevent cardiovascular disease and in receiving the necessary life-saving treatment after a sudden heart attack or stroke. Many studies have shown that the uninsured are significantly less likely to have received proper screenings and necessary treatments, including that:

- The uninsured were 59% less likely than the privately insured to have received anti-hypertensive drug therapy.
- 58% of the uninsured have been screened or checked for hypertension within the past year as compared to 75.2% of the insured.
- Uninsured people admitted to a hospital with a heart attack are 14% to 43% less likely to receive arteriography, coronary bypass, or angiography (all major therapeutic procedures) than the privately insured.
- On average, the uninsured also waited 11.2 hours compared to 7.8 hours for insured patients before deciding to seek care for their chest pain symptoms
- Uninsured heart attack patients were significantly more likely to die in the hospital or within 30 days of discharge, with relative odds ranging from 1.29 to 1.77[61]

Similarly in the fight against cancer, early treatment means a better chance of survival, which leaves the uninsured at a tremendous disadvantage in their fight against cancer. They are less likely to undergo routine screening tests that can find cancer at its earliest states, when the chances for treatment of cure are best, contributing to the fact that the uninsured are more likely to be diagnosed with late stage cancer.[62] Being uninsured also results in greater out-of-pocket spending. Uninsured adults under 65 paid for $1343 of $4806 (27.9%) spent on medical care, as compared to the privately insured who paid only $549 out of $8419 (6.5%), during the first six months after the person's first cancer visit.[63] Research has repeatedly shown that not having health insurance results in poorer health outcomes for those with cancer. Research studies indicate that:

- Uninsured women are 49% more likely to die than insured women, during the four to seven years following an initial breast cancer diagnosis.[64]
- The uninsured have a 70% greater chance of being diagnosed with late vs. early state colorectal cancer, more than 150% greater chance of being diagnosed with late state melanoma, and a 50% greater chance of being diagnosed with late stage prostate cancer.[65]
- Forty-nine percent of uninsured women have had a pap smear in the past year as compared to 76% of insured women.[66]

- The uninsured are more likely than the insured to have skipped medical treatments (39% vs. 13%) or not to have filled prescriptions (30% vs. 12%) because of the cost.[67]

Clearly prevention is a major factor for many types of cardiovascular disease and cancer. Besides early screening and treatment, reducing tobacco use is another critical way to lessen risk for these illnesses. Tobacco use is the greatest cause of preventable death in the United States today, responsible for killing more than 440,000 people every year. Millions more suffer from a serious tobacco-related illness. The uninsured have less access to care for tobacco-related illnesses and to tobacco cessation programs.[68]

Conclusion

Cardiovascular disease, cancer, and other tobacco-related illnesses have a significant impact of the lives of millions of Americans and cause over 1.4 million deaths each year.[69] It is critical that people suffering from these illnesses have access to regular health care and preventive services. Health insurance coverage, particularly Medicaid, plays a key role in the treatment of these illnesses. However, people who depend on Medicaid are at risk for losing their coverage due to declining state revenues and rising health care costs. Racial or ethnic minorities and low-income people are doubly affected, because they are more likely to suffer from these illnesses and more likely to be uninsured if Medicaid is cut. Without Medicaid, the newly-uninsured will be unable to receive the care that they need.

Endnotes

1 Health, United States 2002 Table 32

2 CBPP. Broaddus, M., et al. *Expanding Family Coverage: States' Medicaid Eligibility Policies for Working Families in the Year 2000*. 2/13/02. www.cbpp.org/1-2-02health.htm

3 Income and assets up to the federal SSI level, approximately 74% of the FPL.

4 KCMU. Medicaid: Fiscal Challenges to Coverage. May 2003.

5 CBO. Fact Sheet for CBO's March 2003 Baseline: Medicaid and the State Children's Health Insurance Program. 3/11/2003.

6 Hadley, Jack; Holahan, John, "Covering the Uninsured: How Much Would it Cost?" W3-256

7 Schneider, A; Fennel, K; Keenan, P. Medicaid Eligibility for the Elderly. KFF. May 1999. http://www.kff.org/content/archive/2145/elderly.pdf

8 Dual Enrollees: Medicaid's Role for Low-Income Medicare Beneficiaries. KFF. February 2003.

9 Urban Institute and Kaiser Commission on Medicaid and the Uninsured, analysis of March 2002 Current Population Survey.

10 US Census Bureau. Resident Population Estimates of the United States by Race and Hispanic or Latino Origin: April 1, 2000 and July 1, 2002. United States Department of Commerce News. 6/18/03. http://www.census.gov/Press-Release/www/2003/cb03-100.html

11 CDC. Health, United States, 2002.

12 ACS. Cancer Facts & Figures 2003. 29. Heart disease mortality rates – overall: 257.9/100,000, blacks: 333.4/ 100,000 (Health, United States 2002. Table 37.) Cancer incidence rates – whites: 480.4, blacks: 526.6 (ACS. Cancer Facts & Figures 2003. 29. Cancer mortality rates – blacks 267.3

13 Pleis JR, Coles R. Summary Health Statistics for US Adults: National Health Interview Survey 1998. National Center for Health Statistics, 10(209) 2002

14 CDC. Health, United States, 1998. Socioeconomic Status and Health Chartbook. http://www.cdc.gov/nchs/data/hus/huscht98.pdf

15 CDC. Health, United States, 1998. Socioeconomic Status and Health Chartbook. 82.

16 Bradley, CJ; Given, CW; Roberts, C. Disparities in Cancer Diagnosis and Survival. Cancer. 91(1): 178-188. January 1, 2001.

17 Campaign for Tobacco-Free Kids, "Health Harms from Smoking and Other Tobacco Use."

18 Office on Smoking and Health, CDC, "Cigarette Smoking – Related Mortality," http://www.cdc.gov/tobacco/research_data/health_consequences/mortali.htm

19 Campaign for Tobacco-Free Kids, "Health Harms from Smoking and Other Tobacco Use."

20 US DHHS in Cancer Facts & Figures 2001, 29

21 Steenland K. Passive smoking and the risk of heart disease. *JAMA*. 1992; 267:94-99.

22 US EPA. *Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders*. Washington DC: US EPA; 1992. (Report # EPA/600/6-90/006F).

23 MMWR Highlights, April 2002

24 American Heart Association/American Stroke Association: Heart Disease and Stroke Statistics – 2003 update.

25 CFF 2001 (4)

26 CDC Early Release of Selected Estimates Based on Data from the 2002 National Health Interview Survey. 41. http://www.cdc.gov/nchs/data/nhis/earlyrelease/200306_08.pdf

27 CDC. African Americans and Tobacco Fact Sheet. Reference to US DHHS. *Tobacco Use Among U.S. Racial/Ethnic Minority Groups – African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics: A Report of the Surgeon General*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1998.
28 Lindblom, Eric. State Tobacco-Related Costs and Revenues. Campaign for Tobacco-Free Kids. 12 September 2003.
29 Ibid and KFF State Health Facts Online, http://www.statehealthfacts.kff.org
30 Massachusetts Health Care Task Force. Final Report 2002. 49. http://www.state.ma.us/healthcare/pages/pdf/final.pdf
31 KCMU. The Medicaid Resource Book. July 2002.
32 CDC Asthma's Impact on Children and Adolescents http://www.cdc.gov/nceh/airpollution/asthma/children.htm
33 Health Coverage for Low-Income Children. KCMU. May 2002.
34 Seminar on Health Care. Team 2: Childhood Asthma. Wednesday, April 9, 2003. New Brunswick http://www.leadershipnj.org/archives/healthcare_and_human_services/hs_team2-2.html
35 Lightwood, JM; Phibbs, CS; Glantz, SA. Short-term Health and Economic Benefits of Smoking Cessation: Low Birth Weight. Pediatrics. 104(6). December 1999. 1312-1320.
36 Lightwood, JM, et al. Short-term Health and Economic Benefits of Smoking Cessation: Low Birth Weight.
37 Krause, M. States Have Expanded Eligibility Through Medicaid and the State Children's Health Insurance Program. Table 2. NGA Center for Best Practices. 10 February, 1999. http://www.nga.org/cda/files/1990210MCHUPDATE.pdf
38 Cornell, EV. Issue Brief: Preventing Maternal Smoking. NGA Center for Best Practices. 24 July 2001. www.nga.org/cda/files/071101SMOKING.pdf
39 Lightwood, JM, et al. Short-term Health and Economic Benefits of Smoking Cessation: Low Birth Weight.
40 CDC. MMWR. Medical-Care Expenditures Attributable to Cigarette Smoking During Pregnancy – United States, 1995. 7 November 1997. 46(44): 1048-1050.
41 Cigarette Smoking Among Adults – US 1999. MMWR. 50(40): 869-873. Oct. 12, 2001. www.cdc.gov/tobacco/research_data/adults_prev/ccmm5040.pdf
42 CBPP. Severe State Fiscal Crisis May Be Worsening. 5/9/03.
43 National Governors' Association and National Association of State Budget Officers, *Fiscal Survey of the States, November 2002* (Washington, DC, 2002).
44 CBPP. Severe State Fiscal Crisis May Be Worsening. 5/9/03.
45 Medicaid: Fiscal Challenges to Coverage, Kaiser Commission on Medicaid and the Uninsured, 5/03
46 Estimation based on drop in revenue collections of $61.8 billion (KCMU) and –5.6% change in state tax revenue collections for 2002 (Rockefeller Institute of Government). $28.4 billion of $38 billion shortfall was result of revenue shortfall. Wachino, Victoria. Medicaid and the State Children's Health Insurance Program: Fiscal Challenges to Coverage. KCMU. 27 June 2003. http://www.kaisernetwork.org/health_cast/uploaded_files/Vicky_Wachino_Presentation.pdf. Jenny, NW. A Bad Year: Fiscal Year 2002 Tax Revenue Summary. State Fiscal Brief No. 67. May 2003. Fiscal Studies Program of the Nelson A. Rockefeller Institute of Government.

47 McNichol, L. The State Fiscal Crisis: Extent, Causes, and Responses, CBPP, 4/24/03
48 Ku, L; Nathanson, M; Park, E; Cox, L; Broaddus, M. Proposed State Medicaid Cuts Would Jeopardize Health Insurance Coverage for One Million People. CBPP. Revised Jan. 6, 2003. www.familiesusa.org/site/DocServer/CBPP_Proposed_Medicaid_Cuts.pdf?docID=504
49 Kaiser Family Foundation. 2002 Employer Health Benefits Survey: Report. Section 1: Cost of Health Insurance. http://www.kff.org/content/2002/3251/
50 Derived from Families USA Special Report July 2001. The Health Care Safety Net: Millions of Low-Income People Left Uninsured. Table 3: 2001 Annual Eligibility Levels for Adults: Medicaid or Medicaid-like State Programs. Unweighted average taken of % of poverty for 50 states and 87.8% of FPL calculated from 2001 FPLs.
51 Ramirez, Margaret. Health Plan Finds New Cancer Cases. Newsday. August 8, 2002. www.newsday.com/news/health/nycanc082814503aug08.story
52 Medical Care Research and Review. Sicker and Poorer—The Consequences of Being Uninsured: A Review of the Research on the Relationship between Health Insurance, Medical Care Use, Health, Work, and Income. Jack Hadley. June 2003. Supplement to v60 (2) 38-39S.
53 Thorpe, KE and Howard, D. Health Insurance and Spending Among Cancer Patients. Insurance & Cancer. Health Affiars. 9 April 2003. W3-189-W3-198.
54 Uninsured in America, May 2000.
55 Uninsured in America, May 2000.
56 Weissman JS, Gatsonis C, Epstein AM. Rates of avoidable hospitalization by insurance status in Massachusetts and Maryland. JAMA. 1992: 268:2388-2394.
57 American College of Physicians – American Society of Internal Medicine, *No Health Insurance? It's Enough to Make You Sick*. Philadelphia, PA: American College of Physicians – American Society of Internal Medicine, 2000.
58 Institute of Medicine. Care Without Coverage: Too Little, Too Late. May 2002.
59 CDC. Preventing Heart Disease and Stroke: Addressing the Nation's Leading Killers 2003.
60 Preventing Heart Disease and Stroke: Addressing the Nation's Leading Killers 2003.
61 Hadley, J. Medical Care Research and Review. Sicker and Poorer—The Consequences of Being Uninsured. Supplement to v60 (2) 38-50S.
62 *The Uninsured and Their Access to Health Care*. Kaiser Commission on Medicaid and the Uninsured. May 2000.
63 Thorpe, KE and Howard, D. Health Insurance and Spending Among Cancer Patients.
64 Health Coverage 2000: How Much Does Insurance Matter? (Washington: Alliance for Health Reform: May 2000)
65 Uninsured in America, May 2000.
66 Uninsured in America, May 2000.
67 Uninsured in America, May 2000.
68 Healton, C. Health Costs of Smoking. Community Voices: HealthCare for the Underserved – Informative Articles. www.communityvoices.org/Article.aspx?ID=238
69 CDC. Health, United States, 2002. Table 32. Leading causes of death and numbers of deaths, according to sex, race, and Hispanic origin: United States, 1980 and 2000.