POLICY BRIEF

A Healthier Washington Through Increased Health Care Coverage and Reduced Tobacco Use

An Analysis of Initiative 773

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About the Author

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About the Economic Opportunity Institute

The Economic Opportunity Institute is a nonpartisan, nonprofit, public policy institute focused on creating economic security for working Americans. The institute builds a bridge to economic security through research, policy, and public dialogue.

The Economic Opportunity Institute is currently developing pragmatic policies in the following areas: Social Security, retirement security, early childhood education, health care, family leave, and workforce development.

Contents

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EXECUTIVE SUMMARY

Twenty-eight percent of people below the age of 65 with incomes below, at, or near poverty do not have health coverage. Public policy and the private sector are failing to insure many low and moderate-income working families in Washington state.

The foundation is already in place for a solution to this growing gap in economic security for working people. The Washington State Basic Health Plan provides no frills health insurance to low-income working families. However, the Basic Health Plan has been chronically underfunded so that thousands of people who qualify for and need this health insurance are unable to get it.

At the same time, the number of children and youth smokers has increased dramatically in the last ten years, and the cost of smoking related illness on health expenditures has reached $1.15 billion annually.

Initiative 773 proposes a $0.60 increase in the state cigarette tax as a funding source to expand health care coverage for the Basic Health Plan and as a proven way to decrease the number of people who smoke.

The revenues from the increased tax will:

- Fund 50,000 additional slots in the Basic Health Plan
- Fully fund the state's tobacco control and prevention plan
- Reduce smoking, especially among young people
- Finance programs that reduce disease among low-income families.

Initiative 773 acknowledges and remedies the outstanding health access problems and health practices that predominately affect low-income families. A detailed analysis of the impacts of Initiative 773 shows that it would significantly improve the health of thousands of adults and children in Washington state.

Introduction

Washington state is facing two major health problems which are taking a tremendous toll on the physical and economic health of families. Hundreds of thousands of people have no health insurance and the number of uninsured is rising as employers continue to cut back on benefits. The more than 750,000 individuals without health insurance have no access to the most basic health and preventative care, resulting in poor health. At the same time, the number of individuals who smoke, particularly children and youth, continues to rise, causing chronic illness and premature death to thousands. Lack of health care and the increase in tobacco use are two health policy issues with a ready solution at hand.

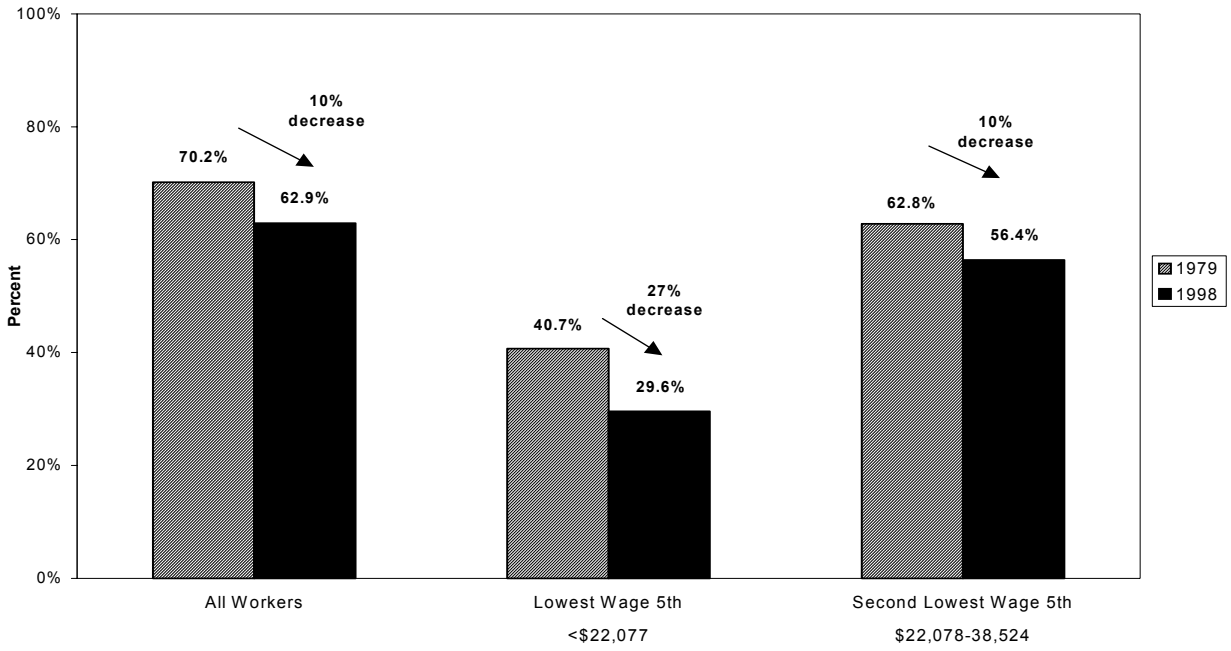
Health Insurance Coverage and Tobacco Use in Washington State

Health Insurance

Health care is a fundamental quality of life issue. People need to know that they can get access to medical attention when they need it. Unfortunately, this is not something that all Washingtonians can take for granted. More than 750,000 Washingtonians are without health insurance.[1]

While the majority of people receive health insurance coverage through their employment, this amount has been decreasing over the last decade. Currently, over one-third of all workers do not receive health insurance coverage from their employer and low-wage workers are even more unlikely to have coverage.[2] As a result, over 7 in 10 of the uninsured are from working families.[3]

Employment-Based Health Care Coverage, 1979 - 1998*



*Decreases were smaller in the other wage categories: 9% for the middle wage 5th, 8% for the fourth wage 5th, and 6% of the top 5th. Based on tabulation of March, 1999, Current Population Survey data samples of private wage and salary workers age 18-64, who worked at least 20 hrs/wk and 26 wks/yr. Coverage is defined as being included in an employer-provided plan where the employer paid for at least some of the coverage. From Mishel, L., Berstein, J., Schmitt, J. "The State of Working America 2000-01," Economic Policy Institute, 2001, p. 140.

Percent of Families of 4 with No Health Care Insurance

Annual Household Income*	Uninsured Full-time Workers	Uninsured Part-time Workers	Uninsured Non-Workers
Less than $16,450	46%	17%	36%
$16,450 to $32,900	79%	11%	10%
Over $32,900	86%	6%	7%

*Annual income in 1998 dollars. For families of 4, an annual income less than $16,450 is below the Federal Poverty Level; incomes from $16,450 to $32,900 are 100% -199% of the Federal Poverty Level; and incomes over $32,900 are above 200% of the Federal Poverty Level. Data is from March, 1999, Current Population Survey, Urban Institute 1999, Kaiser Commission on Medicaid and the Uninsured, Uninsured in America, A Chart Book, May 2000, p. 14 (http://www.kff.org/content/archive/1407/)

Medicare covers health care for almost all people 65 or older, and Medicaid covers health care for some of the very poor in our state.[4] But 28% of non-elderly people living below, at, or near poverty in Washington state do not have health coverage.[5]

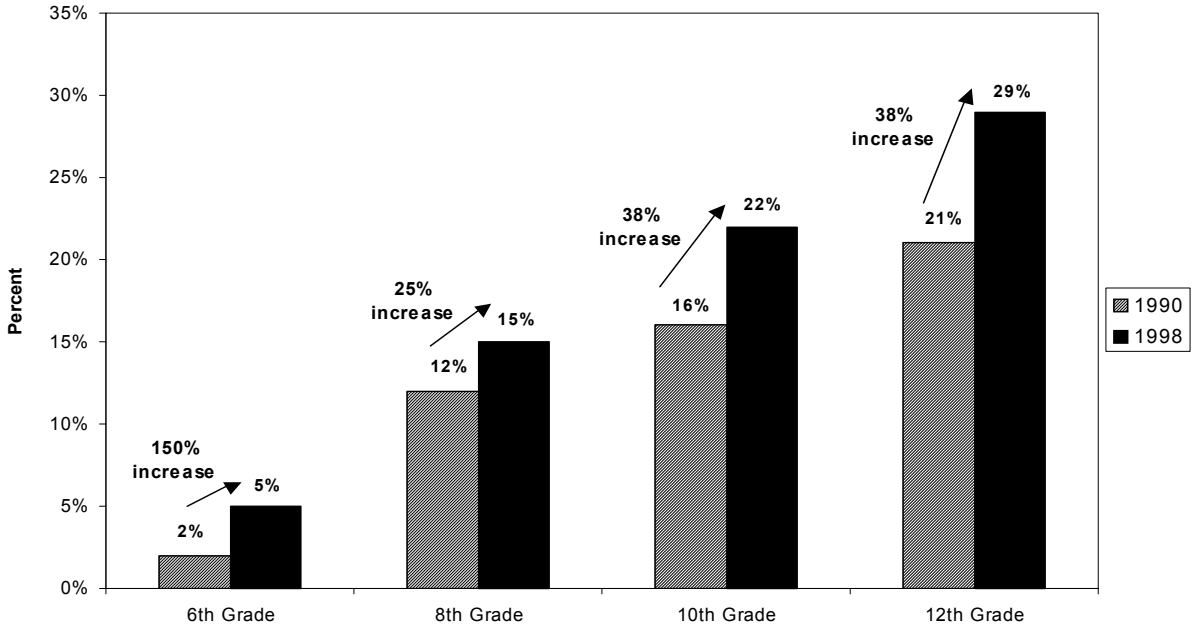
The uninsured are without access to the most basic health and preventative care and as a result have significantly worse health outcomes than those with insurance.[6] The uninsured have a general mortality rate 1.25 times higher than the insured.[7] When people are uninsured they don't get the care they need or delay care to the point where minor health concerns become major health problems, with enormous health and economic costs. When the uninsured do seek care, they are more likely to receive higher-cost medical care through emergency room visits.[8] On average, a non-urgent emergency room visit costs more than twice as much as a physician office visit.[9] Washington hospitals provided $102 million in charity care in 1997.[10] These increased costs are passed on to the insured or paid by taxpayers.[11]

Regardless of their insurance status, low-income families carry a disproportionate burden of disease. Adults with low incomes are far more likely than those with higher incomes to report fair or poor health status and have higher death rates and lower life expectancy.[12] Data show that mortality rates from heart disease, lung cancer, and diabetes increase as family income decreases, indicating that much of the burden of chronic disease is disproportionately concentrated among persons with fewer resources.[13]

Tobacco Use

Smoking is the leading cause of preventable death and disease in the United States.[14] It is now well-documented that smoking cigarettes causes heart disease, lung and esophageal cancer, and chronic lung disease. Tobacco use claims more lives than drugs, alcohol, firearms, and motor vehicle incidents combined.[15] Smoking imposes a substantial economic as well as health burden. In 1993 the estimated smoking-related medical expenditures for Washington totaled $1.15 billion, 11.6% of the total medical expenditures.[16]

Increases in Tobacco Use Among Washington Youth, 1990 - 1998



Note: 1990-98 Washington State Survey of Adolescent Health Behaviors, includes Washington's enrolled public school population in grades 6, 8, 10, and 12. Smokers include youth who reported smoking any cigarettes during the past 30 days. Washington State Department of Health, "Tobacco and Health in Washington State," April 1999 (http://www.doh.wa.gov/Tobacco/Report/report5.htm)

In Washington state the groups most likely to use tobacco are youth and young adults and low-income people. Particularly alarming are the increases in youth smoking at all age levels. Five percent of 6th graders, 15% of 8th graders, 25% of 10th graders, and 29% of 12th graders smoke.[17] There was a 38% increase from 1990 to 1998 in the number of high school seniors who smoke.

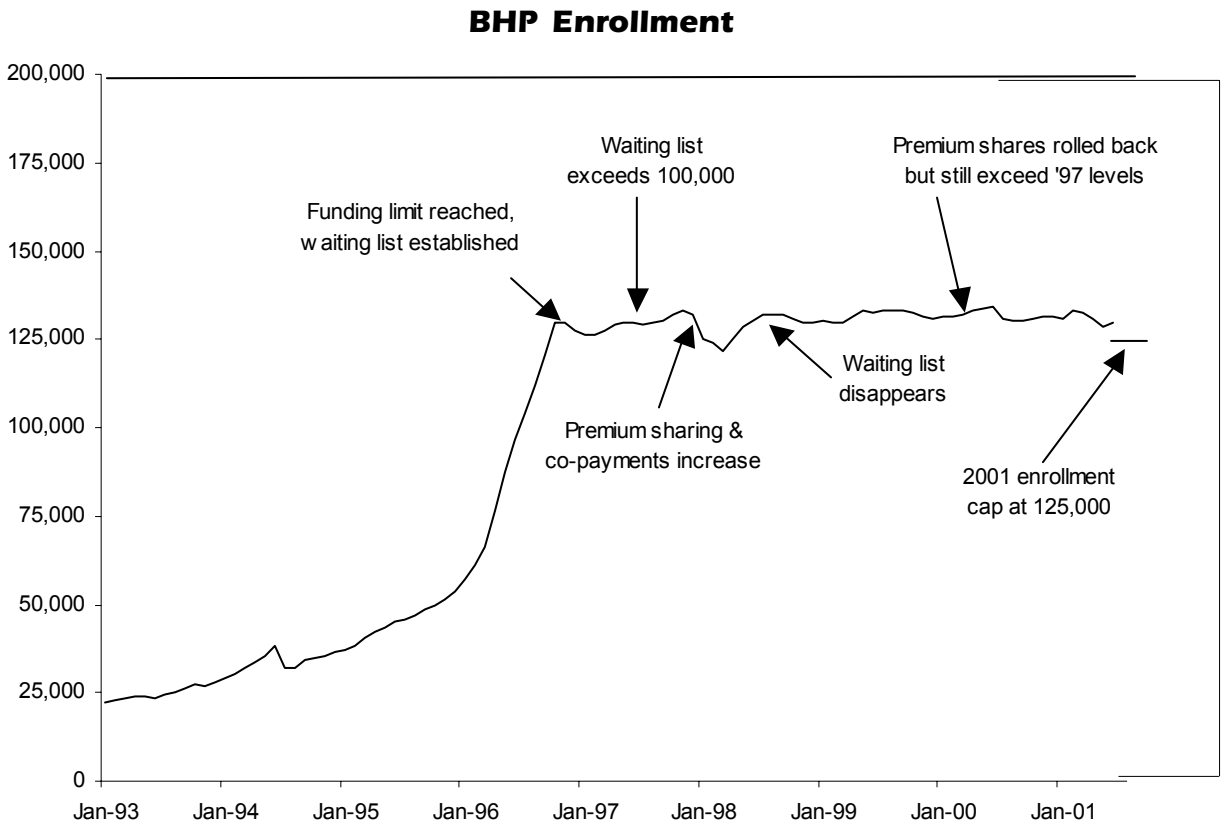
Tobacco use and addiction nearly always take root before the age of 18. Almost 90% of adult smokers began at or before age 18.[18] While many youth are optimistic about quitting, studies have shown that three-fourths of youth who try to quit are unsuccessful.[19] This underscores the importance of preventing youth from starting. Currently, the smoking rate for adults is 22%. The smoking rate exceeds 30% for people earning under $25,000 per year.[20]

Steps in the Right Direction

I. The Basic Health Plan

The Washington State Basic Health Plan (BHP) began in 1987 as a pilot project seeking to provide health insurance to the working poor. BHP provides a no-frills package of health care benefits to Washington residents with incomes at or below 200% of the Federal Poverty Level (FPL), which is $2942/month before taxes for a family of four,[21] about half of the typical family income in our state[22]. For those who qualify, state funds are used to help pay a portion of the monthly premium, on a sliding scale basis depending on family income.

BHP was made a permanent statewide program in 1993 when the Washington Legislature, with a Democratic majority, mandated the implementation of universal health coverage. When the universal coverage law was repealed two years later, the legislature, with a Republican majority, retained the BHP and set a statutory enrollment target of 200,000 adults.[23] Enrollment grew rapidly from 60,000 in January of 1996 to nearly 130,000 in October 1996.



BHP Funding Shortfall: By the end of 1996, demand for Basic Health Plan coverage had already exceeded budgetary allocations. A cap was placed on enrollment. A waiting list was created, and marketing and outreach were curtailed. By June 1997, over 100,000 people were on the waiting list. In 1998 the legislature imposed steep cost-sharing increases on BHP participants. The waiting list disappeared in six months. The legislature had effectively succeeded in pricing BHP out of the reach of the very people it was designed to serve: low-income working families. In 1999, the legislature reversed itself, partially decreasing but still maintaining significant premium barriers for BHP participants.[24] (See Appendix A.) Due to medical inflation and budget constraints, the BHP, even with its limited enrollment and increased premium sharing and co-pays, is projected to run a deficit by 2003.[25]

As of 1999, the rate of uninsured in Washington reached its highest level in more than a decade and, at 15.8%, is higher than the national average as well as rates for Alabama, Arkansas, and Kentucky.[26] For non-elderly people living below, at, or near poverty (<200% of the FPL), the rate is almost twice as high, with 28% lacking health insurance.[27] This translates to over 400,000 low-income individuals eligible for but unable to get access to the BHP as long as the BHP is underfunded. The 2001-2003 state operating budget further limits the funding of the BHP, so that only 125,000 adults can be covered.[28]

II. Washington's Tobacco Prevention and Control Program

Washington state is committed to addressing rising rates of tobacco use. The 1999 legislature dedicated $100 million of the national tobacco settlement funds for tobacco prevention. As a result, the Department of Health appointed a council to recommend the most effective measures to prevent children from becoming addicted to tobacco and help adults quit. The council developed the Tobacco Prevention and Control Plan (TPCP) and recommended $26.2 million for fiscal year 2001 that, over 10 years, could prevent 84,000 deaths and save more than $3 billion in medical costs.[29] Based on the successful strategies of other states, Washington's plan was comprised of six key elements: community-based programs, school-based programs, cessation, public awareness and education, reducing youth access to tobacco, and assessment and evaluation.

TPCP Funding Shortfall: In 2000, legislators reviewed the plan and appropriated $15 million for fiscal year 2001, only 60% of the original request for the first year of the program. This smaller amount necessitated that some activities were eliminated or reduced including the elimination of school programs for grades K-4 and 10-12, programs to reach underserved populations, and cessation services.[30]

Initiative 773:

An Incremental Step in Improving Health in Washington State

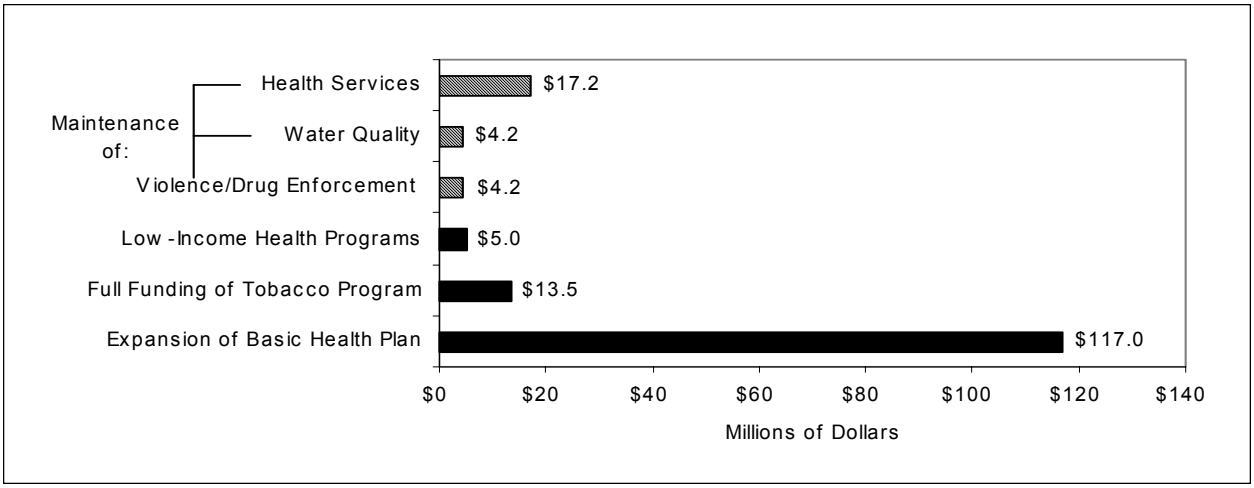
Initiative 773 (I-773) gives the residents of the state of Washington the opportunity to improve the health of low-income adults and children by expanding access to basic health care, discouraging smoking, and reducing tobacco-related diseases and other illnesses that disproportionately affect low-income persons.

To fund these expanded services and programs, I-773 raises the current Washington state cigarette tax by $0.60, from $0.825 to $1.425, per package of 20 cigarettes and imposes a comparable surtax on other tobacco products, such as chewing tobacco. The new revenues are expected to generate $160 million in fiscal year 2003, $159 million in fiscal year 2004, and more than $155 million in every fiscal year thereafter.[31]

These tax revenues will be allocated to the expansion of services to improve low-income health care and coverage.

- The majority of new funds ($117 million in fiscal year 2003) will be used to enable an increase in the number of persons covered through the Basic Health Plan by 50,000 for a total enrollment of 175,000 participants by December 31, 2003. The initiative mandates that the state shall first fund 125,000 slots in the BHP before it can access the new revenue to expand coverage to 175,000.
- Approximately 10% of the additional revenue will be dedicated to restoring the full funding to implement the state's tobacco control and prevention plan. The initiative mandates that the legislature fully fund the Tobacco Prevention and Control Program as originally proposed and that the increased tax revenues augment the current funding stream.
- Additionally, $10 million will be allocated to fund programs that improve the health of low-income people. These include chronic disease programs to promote early detection and increase access to treatment.

Allocation of Revenues Under I-773



Note: Estimates from Office of Financial Management, March 2001, for fiscal year 2003.

- The current tobacco tax funds several state programs including water quality, violence reduction and drug enforcement, and health services. Because of the elasticity of demand (higher prices discourage consumption), the current revenue streams for the accounts listed above will be reduced by the new tax. Proceeds from the proposed tax increase will include allocations to maintain these accounts and hold them harmless.

Estimates of the tax increase revenues were completed by the Washington Department of Revenue for the period through fiscal 2007. The forecast is based on estimates of taxable sales of cigarettes and other tobacco products. Estimates were adjusted to address the elasticity of demand including decreases in cigarette consumption and smoking initiation and increases in purchasing on Indian reservations, across state and national borders, and the illegal black market.

Preliminary reports from other states which have raised their cigarette tax rates indicate that state revenues have increased despite decreased sales or increased smuggling or other tax-avoidance sales. The revenue losses from fewer cigarette sales were more than made up for by the increased state revenues per pack.[32]

Impacts of Initiative 773

1. Increase in Health Insurance Coverage Rates

Within two years, funding from the new tax will increase BHP enrollment by 50,000 slots to cover 175,000 people. In the biennium 2001-2003, BHP may enroll up to 20,000 additional people and in the next biennium, 2003-2005, 50,000 additional people may be enrolled above the baseline of 125,000.

2. Reduction in Smoking and Smoking Initiation Rates

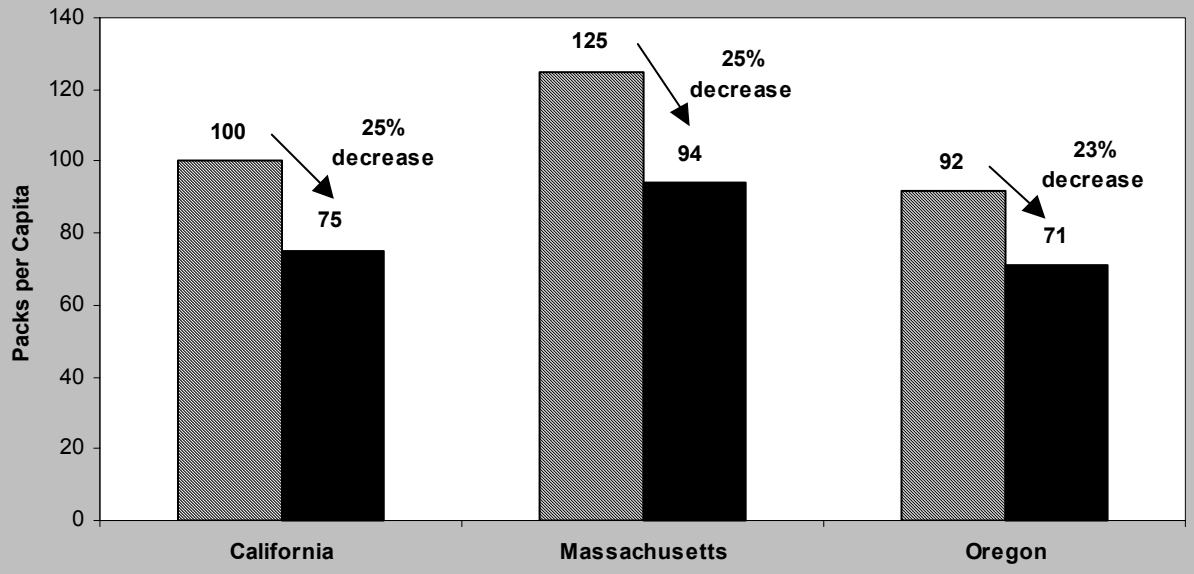
The cigarette tax increase will also have significant public health impacts. The higher cost of cigarettes will lead to substantial reductions in cigarette smoking by deterring smoking initiation, prompting smoking cessation, and reducing the average cigarette consumption among continuing smokers.[33] This is particularly true for adolescents, young adults, and low-income people who are more sensitive to price factors.

As with most consumer products (including addictive products), the demand for cigarettes is expected to decrease when price is increased. Over the past decade, many states have raised their cigarette tax rates. These tax increases significantly reduced cigarette consumption in every single one of these states below what it would otherwise have been.[34] For over 15 years, economic research studies have consistently documented the link between cigarette price increases and reduction in smoking and smoking initiation rates.[35] These studies currently conclude that every 10% increase in the price of cigarettes will reduce overall smoking among adults by approximately 4%.[36] The U.S. General Accounting Office has estimated that smoking rates among youth will decline by 7-12% for every 10% increase in the price of cigarettes.[37]

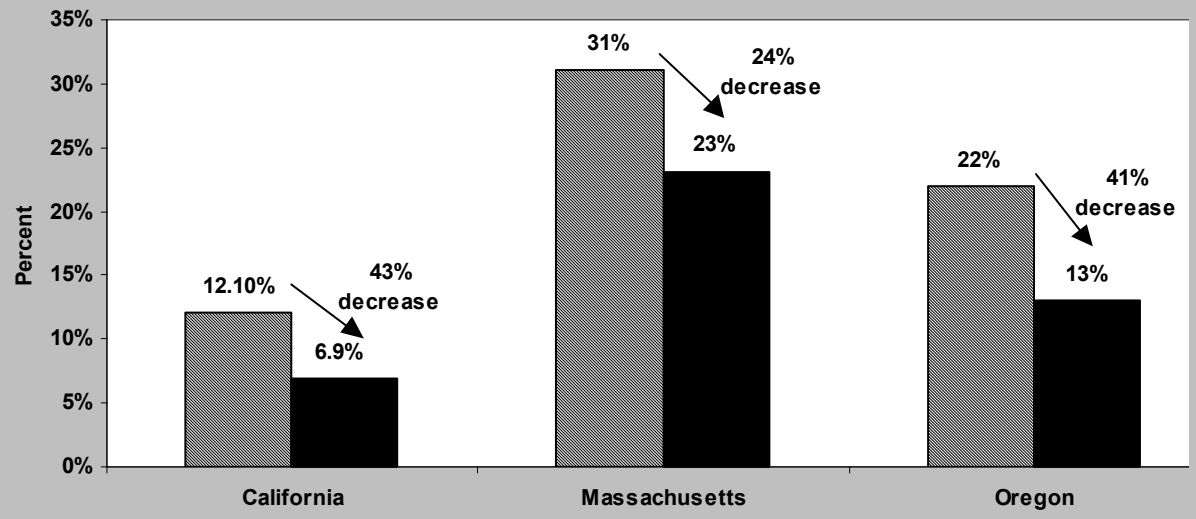
Price increases are most effective as a deterrent and disincentive to youth smoking when integrated into a comprehensive program. Youth smoking rates declined significantly in Oregon, California, and Massachusetts as a result of the combined effect of a tax increase and a strong tobacco control program.[40] California saw youth smoking decline 43%, Massachusetts youth smoking was reduced by 24%, and more recently Oregon had a 41% decrease in youth smoking. This is precisely what will be put into place with I-773. For Washington state, a $0.60 tax increase (or 15% price increase[41]) should result in a 10.1%[42] decline in youth smoking and prevent over 33,300 kids[43] from smoking. The effect of the price increase combined with the implementation of a fully funded tobacco prevention and control program should result in even further health and economic savings.

The Experiences of Three States

Effect of Tobacco Tax and Tobacco Control Program on Consumption[38]



Effect of Tobacco Tax and Tobacco Control Program on Youth Smoking[39]



Note: Although all three states found significant declines in tobacco consumption, the amount of tax decrease and the content and magnitude of tobacco program differed between the states. California: Proposition 99, passed in 1988, raised cigarette taxes $0.25/pack; 20% of revenues were used to fund tobacco program (started in spring 1990). Massachusetts: Referendum Question 1, passed in 1992, raised cigarette taxes $0.25/pack; part of new tax revenue funded tobacco program (started in 1993). Oregon: Measure 44, passed in 1997, raised the cigarette tax $0.30/pack and used 10% of the revenue to fund a comprehensive tobacco program. Per capita rates in packs/yr were based on the resident population aged greater than or equal to 18 years in each state.

3. Improved Health Status and Economic Savings

Increased rates of health insurance coverage through expansion of the BHP and decreased rates of smoking will save lives, improve health status, and save money in Washington. If I-773 is passed by the voters:

- 10,600 kids would be saved from premature death from smoking.[44]
- $630 million would be saved in long-term health spending from avoided tobacco-related health care.[45]
- Expansions in health insurance coverage will increase access to timely and effective health services that can save and improve the quality of lives and will decrease avoidable hospitalizations and utilization of other more expensive types of care.[46]
- Low-income health programs will improve the health status and lessen the disproportionate burden of disease on Washington's low-income families.

Conclusion

Expansion of BHP enrollment will provide access to affordable, quality health care for 50,000 low-income working families who don't have health insurance now. The higher tax on cigarettes will lead to decreases in the number of adult smokers and will deter a new generation of youngsters from ever starting. The full funding of the Washington State Tobacco Prevention and Control Program and the funding for programs aimed at improving the of low-income people will extend and enhance the health and quality of life of many Washington citizens.

Endnotes

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APPENDIX A

Premium Sharing for BHP Enrollees

Household Income			Monthly premium for 2 adults (age 40-54) in a family of four				
Monthly Income (before tax)	% of Federal Poverty Level	% of Median Income	Year 1997	Year 1998	**% Increase 1997-98**	Year 2001	**% Increase 1997-2001**
$2,942	200%	58%	$94	$158	**68%**	$153	**63%**
$2,721	185%	53%	$73	$131	**81%**	$126	**73%**
$2,500	170%	49%	$52	$107	**108%**	$100	**92%**
$2,280	155%	45%	$30	$88	**191%**	$76	**153%**
$2,059	140%	40%	$21	$64	**201%**	$50	**138%**

Source: Health Care Authority, BHP Premium Tables, HCA Document 24-375 (1996-2001).

APPENDIX B: Characteristics of BHP Members

Income Distribution of Members		
Gross Family Income (% of FPL)	**Members**	**Percent**
Up to 65% FPL	46,632	36%
65 - 99%	26,679	20.6%
100 - 124%	20,769	16%
125 - 139%	10,429	8.1%
140 - 154%	8,631	6.7%
155 - 169%	7,113	5.5%
170 - 184%	5,489	4.2%
185 - 200%	3,771	2.9%
TOTAL	**129,513**	**100%**

Age Distribution of Members		
Rating Type*	**Members**	**Percent**
Child Rated A 0 - 22 yrs	9,168	7%
Adult Rated B 0 - 39 yrs	60,487	47%
C 40-54 yrs	41,933	32%
D 55 - 64 yrs	16,785	13%
E 65+ yrs	1,140	1%

*Note on Rating Type: "Child Rated" reflects dependents age 0 -22 including students and disabled dependents. "Adult Rated" reflects ALL subscribers and spouses regardless of age and disabled dependents over age 22. From Washington Health Care Authority, BHP Enrollment Summary, June 2001.