

# Leveraging Evidence-Based Policies to Improve Health, Control Costs, and Create Health Equity



*A Report of the Promoting Health and Cost Control in States Initiative*



## Acknowledgements

**Trust for America's Health (TFAH)** is a non-profit, nonpartisan public health policy, research, and advocacy organization that promotes optimal health for every person and community and makes the prevention of illness and injury a national priority.

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### REPORT AUTHORS

**Adam Lustig, MS**

*Senior Policy Development Manager*

**Marilyn Cabrera, MPH**

*Policy Development Manager*

### REPORT CONTRIBUTORS

**Jeanette Kowalik, PhD, MPH, MCHES**

*Director of Policy Development*

### EXTERNAL REVIEWERS

**David Fleming, M.D.**

*TFAH Distinguished Visiting Fellow*

**Danyelle Solomon, JD**

*Microsoft*

**Gregory Miao, JD, MS**

*ChangeLab Solutions*

**Jennifer Sullivan, MHS**

*Center for Budget and Policy Priorities*

**Anne de Biasi, MHA**

*Health Policy Consultant*

**Tobi Kinsell, M.Ed.**

*College Advising Corps*

**Lynn Silver, M.D., MPH**

*Public Health Institute*

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## Executive Summary

A person's health is shaped by the circumstances they encounter in their everyday life, such as where they live and work, what they eat, and whether or not they have access to medical care. People may experience better or worse health outcomes based on their access to resources and opportunities in their community. For many Americans, difficulty accessing affordable and quality housing, food, jobs, and healthcare have led to poor health outcomes. These differences in community conditions are largely driven by decades of policy decisions and their impacts, some of which were discriminatory or had unintended consequences. Policy decisions and their implications continue to shape and contribute to persisting inequities and health differences.

Everyone has felt the health and economic impacts of the COVID-19 pandemic. However, some communities and people of color have been impacted more severely. Some people were left more vulnerable to infection because they are essential or frontline workers. If infected, living conditions impacted whether or not a person could safely isolate from others in their household. Family income, savings, and wealth allowed some families to weather economic uncertainty better than lower-income workers, who were more likely to lose employment during the pandemic. The differences in access to resources, economic security, and health status prior to the pandemic all contributed to the patterns in infection rates and deaths from COVID-19, in which people of color and tribal nations carried a disproportionate burden.

We know that inequities and barriers to health and economic well-being existed long before the COVID-19 pandemic. Historical and present-day discrimination, including racism, in U.S. systems have created and contributed to inequities. Populations that are marginalized like racial and ethnic minority groups, sexual and gender minorities, people living in poverty and in rural communities, and people who are formerly incarcerated all face barriers to attaining their optimal health status. It is important to acknowledge how these inequities were created prior to the pandemic, how they have been

made worse, and which communities have been disproportionately affected. Policymakers at every level of government have an opportunity to create healthier communities by supporting an equitable health and economic recovery.

To assist policymakers, Trust for America's Health's Promoting Health and Cost Control in States (PHACCS) initiative has identified a set of policy recommendations focused on creating healthier and more equitable communities.

### What's in this report?

*The Leveraging Evidence-Based Policies to Improve Health, Control Costs and Create Health Equity: A report of the PHACCS initiative* focuses on highlighting evidence-based policies that can be implemented to address the root causes of disease. These policies and strategies have the potential to improve health outcomes, reduce costs, and promote health equity.

The report identifies policies related to:

- Supporting access to high-quality health services;
- Promoting economic mobility;
- Ensuring access to affordable housing;
- Promoting safe and healthy learning environments for children; and
- Health-promoting excise taxes.

This report provides a description of each of the recommended policies, gives summaries of the health and economic evidence, identifies the main components of the policy, identifies a case example, and recommends action steps for policymakers. The intent is to guide policymakers,

advocates, and other stakeholders in adopting evidence-based, health-promoting policies. The PHACCS initiative understands that COVID-19 has impacted state and local revenue streams, which is why this report also includes a set of recommendations on how to fund health-promoting policies.

Goal	Policies
<b>Supporting Access to High-Quality Health Services</b>	<ul style="list-style-type: none"> <li>● Adopting Medicaid expansion</li> <li>● Expanding access to home-visiting programs</li> <li>● Supporting increased use and training of community health workers</li> </ul>
<b>Promoting Economic Mobility</b>	<ul style="list-style-type: none"> <li>● Earned Income Tax Credit</li> <li>● Living wage</li> <li>● Paid Sick &amp; Family Leave</li> </ul>
<b>Ensuring Access to Affordable Housing</b>	<ul style="list-style-type: none"> <li>● Low-income housing tax credits (LIHTCs)</li> <li>● Housing choice vouchers</li> <li>● Legal supports for tenants in eviction proceedings</li> </ul>
<b>Promoting Safe and Healthy Learning Environments for Children</b>	<ul style="list-style-type: none"> <li>● Increasing access to high-quality early childhood education programs</li> <li>● Integrating social-emotional learning programs in schools</li> <li>● Promoting access to and National School Lunch and School Breakfast Programs</li> <li>● Supporting school-based health centers</li> </ul>
<b>Health-Promoting Excise Taxes</b>	<ul style="list-style-type: none"> <li>● Tobacco taxes</li> <li>● Alcohol taxes</li> <li>● Sugar-sweetened beverage taxes</li> </ul>

## 1

# Introduction

Everyone should have the opportunity to reach their full health potential and lead a healthy life regardless of who they are or where they live. Policy decisions have created differences in access to resources and opportunities for some groups across the country. The COVID-19 pandemic laid bare inequities that have long existed and worsened during this public health emergency. As policymakers address the health and economic impacts of COVID-19, it is imperative that they work together to rebuild a more equitable nation to achieve better health and economic opportunities for all.

The health, social, and economic impacts of the COVID-19 pandemic have touched the lives of everyone across the country. As of July 2021, over 600,000 people have died of COVID-19 in the United States, accounting for approximately 15 percent of the worldwide death toll.<sup>1,2</sup> The number of deaths has been so staggering that in the first half of 2020, life expectancy at birth for the total U.S. population declined a full year, from 78.8 in 2019 to 77.8 in 2020.<sup>3</sup>

As the COVID-19 pandemic demonstrates, a number of factors influence a person's health status. Where a person lives, what they eat, where they work, the nature of their social interactions and relationships, and whether or not they have access to health services all have a profound impact on their health.<sup>4</sup> Referred to as the "social determinants of health," these are the conditions in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.<sup>5</sup> These social and economic conditions are interconnected, and can explain why some people experience better health outcomes compared with others partly due to differences in access to resources and opportunities. Focusing solely on medical care and promoting healthy choices without changing the social and economic conditions that shape a person's health will not eliminate these differences.

The disparities exposed and exacerbated by the pandemic are the result of deeply rooted inequities in people's opportunities for health and wealth. For many people, a lack of access to affordable and

quality housing, food, educational opportunities, jobs, and healthcare have resulted in poorer health.<sup>6</sup> Health inequities are systematic differences in the opportunities that groups have to achieve optimal health, leading to unfair and avoidable differences in health outcomes.<sup>7</sup> Such differences are in part a result of decades' worth of interrelated policies and their impacts, some of which were deliberately discriminatory or had unintended consequences. For example, the history of "redlining" and discriminatory lending practices continues to contribute to persistent, intergenerational racial and ethnic wealth inequities and health disparities seen today.<sup>8</sup> Policy decisions drive investments in communities and affect the distribution of resources. Policies that foster inequities at any level are critical drivers of health inequities, whether they be policies at an organizational, community, county, state, or national level.<sup>9</sup> Segregation and chronic disinvestment in low-income and communities of color shape the inequitable conditions seen today.<sup>10,11</sup> Policies do not need to be deliberately discriminatory to create different living conditions and health outcomes. Even policies that were meant to be neutral or affect everyone equally can have unintended consequences or a disparate impact. For example, tying school funding to local property taxes has created differences in resources, where predominantly white schools receive more funding compared with schools serving Black, Indigenous, and people of color (BIPOC).<sup>12</sup> Correcting the disparate impact of one policy requires more than simply undoing the policy itself. So, while redlining practices are no longer formally in effect, the impact of the policy created disparities in residential



property values, home ownership, and generational transfer of wealth that have been difficult to overcome.<sup>13</sup>

It is important to acknowledge both the history of policymaking and its implications, specifically because they continue to shape and contribute to persisting inequities. Historic and present-day discrimination and structural racism are linked to the negative health outcomes seen today.<sup>14</sup> Inequities may also occur on the basis of gender, socioeconomic status, and other factors. In this report, Trust for America's Health (TFAH) addresses some of these inequities through the lens of structural racism, as disparities based on race and ethnicity remain persistent and difficult to address.<sup>15</sup> By understanding and acknowledging the historical and present-day context of policies, policymakers and advocates can identify current barriers to achieving optimal health. Understanding how policy decisions can be used as a tool to remove existing barriers and create new opportunities for building healthy and equitable communities is critically important to developing equitable policy that promotes health for all individuals and communities, not just a subset.

### **How the pandemic has cast a light on social and racial injustice in United States**

Prior to the COVID-19 pandemic, certain communities faced inequitable opportunities to attain optimal health, economic prosperity, and well-being.<sup>16</sup> In the United States, certain populations, including racial and ethnic minorities, sexual and gender minorities, people with disabilities, people living in poverty and in rural communities, and people who were formerly incarcerated often have worse health outcomes compared with other groups.<sup>17</sup> In this report, TFAH focuses on the racial and ethnic

health disparities that were further exposed during the pandemic.

The drivers of health inequities are not inherent to one's race or ethnicity but to systems built around those factors, such as social environment, physical environment, income, housing, and health systems. Differences in living conditions, access to resources, and exposure to traumatic events can also create these health inequities. Long-standing social and health inequities meant that many of these same communities were at increased risk of being infected with and dying of COVID-19.<sup>18</sup>

For racial and ethnic groups and populations that are marginalized, the social determinants of health have historically prevented them from having fair opportunities to achieve their optimal economic, physical, and emotional health status.<sup>19</sup> Data show people of color and communities experiencing discrimination have had higher rates of hospitalizations and are dying at higher rates from COVID-19 compared with their white counterparts.<sup>20</sup>

Everyone has been affected by COVID-19, yet evidence shows that communities of color and tribal nations are being impacted more severely than white communities. Studies have found that there is a disproportionate burden of COVID-19 deaths among some racial and ethnic minority groups.<sup>21,22</sup> Data from the Centers for Disease Control and Prevention (CDC) show that the death rate among Latino people is 2.3 times the rate of white deaths. Among hospitalizations, American Indians/Alaska Natives have a hospitalization rate 3.3 times that of whites, and Blacks and Latinos have a rate approximately three times that of whites.<sup>23</sup> A lack of accurate and timely demographic data on COVID-19 infections,



hospitalizations, and deaths also masks the full extent of these disparities. As of July 11, 2021, Hispanic/Latino and non-Hispanic Black people made up 30.99 percent of the U.S. population and yet, 40.1 percent of all COVID-19 cases were Hispanic and non-Hispanic Black people.<sup>24</sup>

Factors that contribute to increased risk of COVID-19 hospitalization and death include discrimination, healthcare access, housing, occupation, underlying health conditions, and gaps in education, income, and wealth.<sup>25,26,27,28</sup> These interrelated factors combined with historical inequities have left people of color and groups that are marginalized more vulnerable to the health and economic impacts of COVID-19.

Dr. Rochelle Walensky, the director of the CDC, stated that “the pandemic illuminated inequities that have existed for generations and revealed for all of America a known, but often unaddressed, epidemic impacting public health: racism.”<sup>29</sup> Historical and present-day discrimination, including racism, are associated with elevated physical and mental health risks.<sup>30</sup> Discrimination and racism can lead to chronic and toxic stress, which has

physiological impacts that can lead to poor health.<sup>31,32</sup> Discrimination and racism continue to be present in several U.S. systems, including healthcare, housing, criminal justice, and more.<sup>33,34</sup> Just like the social determinants of health are interconnected, racism and its impacts are not bound to one sector or level of society. Racism manifests itself in different forms throughout society and depends on the context, from overt discrimination at the individual-level, to biased hiring practices at the organizational level, and residential segregation at the policy level.<sup>35</sup> Because discrimination and racism cannot be separated or bound to one type of interaction or one system, their effects may look different depending on the social determinant of health in discussion.

**A number of factors have contributed to disparities and their impact on COVID-19 risks including:**

- **Access to healthcare:** Despite recent gains in health insurance coverage, racial and ethnic groups are more likely to be uninsured compared with their white counterparts.<sup>36</sup> Even then, health insurance does not always equate to healthcare access. Barriers such as lack of transportation,

inability to take time off of work for appointments, language barriers, and discrimination can impede access, quality, and utilization of healthcare services.<sup>37</sup>

- **Employment:** People from some racial and ethnic groups are disproportionately represented in frontline jobs or essential work settings and unable to work from home, leaving them at elevated risk of being exposed to or infected by COVID-19.<sup>38</sup> Lack of access to certain workplace benefits, like paid leave, also puts some workers at elevated risk of COVID-19, especially if workers are unable to take time off if they fall ill. For example, more than half of Latino workers and 38 percent of Black workers do not earn paid sick days through their job.<sup>39,40</sup>
- **Education:** Inequitable access to high-quality education can lead to lower high school completion rates, barriers to higher education, and lower completion rates of a college degree.<sup>41</sup> Educational attainment can impact employment and future earnings, meaning that racial and ethnic disparities that exist in education can persist in the labor market.<sup>42</sup>



- **Income and wealth:** Discrimination from the financial sector and credit markets, including loan denials and predatory lending practices, have limited many Black and Latino and Hispanic households' ability to accumulate wealth and pay down debt.<sup>43,44</sup> Black and Latino students with student loan debt have lower lifetime earnings and fewer assets to draw from to pay their debt.<sup>45,46,47</sup>
- **Housing:** Black, Indigenous, and people of color (BIPOC) are more likely to live in densely populated metro areas or in conditions that make it difficult to isolate if someone becomes sick.<sup>48,49</sup> Black, Latino, and Indigenous renters were more likely to be extremely low income, leaving them most at risk of eviction if they cannot pay their rent.<sup>50</sup> Latino, Native American, and Asian individuals, some of whom live in multigenerational households, disproportionately live in rental units that are not large enough, which can further exacerbate the spread of COVID-19 in a household.<sup>51,52</sup>
- **Incarceration:** BIPOC make up about 56 percent of the incarcerated population in the United States.<sup>53</sup> Jails, prisons, and detention centers are environments where respiratory diseases can easily spread due to overcrowding, poor sanitation, and a lack of ventilation.<sup>54,55</sup> The health of formerly incarcerated people can be further compromised due to stigma and the denial of opportunities in gaining employment, stable housing, education, and other conditions that can positively impact health.<sup>56</sup>

Understanding the inequities that existed prior to the pandemic, how they have been exacerbated, and who has been affected presents policymakers with an opportunity to rebuild an improved system. A return to normalcy would continue to perpetuate the inequitable

health and economic conditions that previously existed. Ensuring an equitable health and economic recovery that eliminates racial and ethnic disparities requires understanding the current data trends and barriers, and identifying evidence-based solutions.

### What is in this report?

This report is intended to strengthen policymakers capabilities by highlighting evidence-based and evidence-informed policies that can improve the health and well-being of the communities they serve. PHACCS also focuses on state-level policies that can control healthcare costs. The report identifies policies dedicated to:

- Supporting access to high-quality health services;
- Promoting economic mobility;
- Ensuring access to affordable housing;
- Promoting safe and healthy learning environments for children; and
- Health-promoting excise taxes

We provide detailed information on each recommended policy, including descriptions of the policies, summaries of their health and economic impact, case examples of policy implementation, and discrete recommendations for local, state, and federal policymakers. The policies highlighted in this report provide a menu of options for leaders at all levels of government to consider as they determine how to best utilize the resources available to improve the health and well-being of the individuals they serve. Addressing the social determinants of health and implementing policies to create more equitable communities can help decrease racial and ethnic disparities and improve health and economic outcomes for all.

## Supporting Access to High-Quality Health Services

In the United States, far too many people do not have access to timely, high-quality health services. While lack of health insurance is a major barrier for millions of individuals in the United States, there are other significant factors that contribute to an individual's ability to access health services, including but not limited to geographic location, immigration status, cost, and employment status. These barriers to care contribute to the current racial disparities in access to healthcare services, resulting in delayed care and people getting sicker.

Prior to the passage of the Affordable Care Act (ACA) in 2010, more than 46 million individuals were uninsured and did not have the means nor ability to utilize health services.<sup>57</sup> In just nine years, 18 million people gained access to health insurance, dropping the uninsured population to 28.9 million.<sup>58</sup> States that expanded Medicaid had a much lower uninsured rate (8.3 percent) than non-expansion states (15.5 percent).<sup>59</sup> Despite these advancements, far too many Americans—especially low-income individuals and BIPOC—remain uninsured. Most BIPOC are at higher risk of being uninsured than white people. In 2019, Black (11.4 percent), Hispanic (20 percent), American Indian / Alaska Native, and Native Hawaiian or other Pacific Islander (12.7 percent) populations had much higher uninsured rates than their white (7.8 percent) counterparts.<sup>60</sup>

Racial and ethnic disparities, a result of historic and present-day systemic racism, have persisted and in some cases widened. Disparities continue to remain extremely high for mothers and infants. Despite maternal mortality deaths being largely preventable, they have significantly increased over the past decade in the United States. In 2018, the U.S. maternal mortality ratio (17.4 maternal deaths for every 100,000 live births) was more than double that of most other high-income

countries.<sup>61</sup> Black and American Indian and Alaska Native women are three and two times more likely, respectively, to have a pregnancy-related death compared with white women.<sup>62</sup> From 2015 to 2017, the fetal mortality rate among non-Hispanic Black women was more than double that among Hispanic women and non-Hispanic white women.<sup>63</sup> Even when individuals have access to health insurance coverage, that does not necessarily guarantee access to quality care, especially for low-income individuals, BIPOC, and rural communities who have long faced and continue to experience barriers to accessing care.<sup>64</sup>

More broadly, Black people, American Indians and Alaska Natives, and Native Hawaiians or Other Pacific Islanders are more likely to suffer from health conditions, such as asthma, cardiovascular disease, and diabetes than their white counterparts.<sup>65</sup> It is estimated that race- and ethnicity-based disparities total \$93 billion in excess medical costs and \$42 billion in lost productivity per year.<sup>66</sup>

Recognizing the numerous factors that contribute to health disparities, PHACCS has identified a number of policy actions that can help promote health equity and reduce long-standing racial and ethnic disparities related to accessing quality health services.

## POLICY: Adopting Medicaid Expansion

### What is Medicaid expansion?

Medicaid provides health coverage for eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. Administered by states and jointly funded by states and the federal government, Medicaid provides a lifeline to many individuals and families across the country who would not have access to health coverage without the program. Since the passage of the ACA in 2010, along with its major coverage provisions in 2014, the federal government has offered states the opportunity to expand Medicaid eligibility to all individuals with an annual income below 138 percent of the federal poverty level with the federal government covering a significant portion of the increased costs associated with covering a larger population.<sup>67</sup>

### Why is Medicaid expansion important?

If the 12 states that have yet to expand Medicaid expanded coverage, about 4 million uninsured non elderly adults would gain coverage. Currently, the federal government pays for 90 percent of the cost of Medicaid coverage for adults covered through ACA expansion. The American Rescue Plan Act has provided additional incentives for states that have yet to expand Medicaid by providing an additional five percentage points in the federal matching rate.<sup>68</sup> If these states were to adopt Medicaid expansion, these individuals would gain access to affordable health coverage that is currently not available to them.

State	# of Nonelderly Uninsured who Would be Eligible for Medicaid Coverage	Share of State's Total Uninsured Population
United States	3,987,800	36%
Alabama	204,100	49%
Florida	789,800	33%
Georgia	452,600	39%
Kansas	82,700	38%
Mississippi	166,600	51%
North Carolina	372,400	37%
South Carolina	188,000	40%
South Dakota	27,800	42%
Tennessee	226,200	38%
Texas	1,432,900	34%
Wisconsin	29,500	11%
Wyoming	15,200	28%

Source: Kaiser Family Foundation<sup>69</sup>

## What are the health benefits of Medicaid expansion?

The 2010 expansion of Medicaid eligibility has provided researchers with a natural experiment of the impacts of insurance coverage on individuals' health. Since January 2020, over 400 studies have been published examining the effects of Medicaid eligibility.<sup>70</sup> Below are some of the key health and economic findings. The expansion:

- **Reduces the number of uninsured individuals and increased access to health services:** In 2018 the uninsured rate among low-income, non-elderly adults in expansion states was 17 percent, almost half the rate in non-expansion states (32 percent).<sup>71</sup> In states that expanded Medicaid, low-income adults were 13.9 percent more likely to have insurance, 5 percent less likely to delay care due to cost, and 5.6 percent more likely to have a regular source of care.<sup>72</sup> The gap between Black and white adult uninsured rates dropped 51 percent in expansion states compared with 33 percent in non-expansion states.<sup>73</sup>
- **Improves access to quality healthcare services:** After Medicaid expansions, individuals in Kentucky and Arkansas skipped fewer medications due to cost (-11.6 percentage points), increased access to primary care (+12.1 percentage points), and accessed regular care for chronic conditions (+12 percentage points) compared to individuals in Texas.<sup>74</sup> The survey also showed that the number of adults reporting excellent health increased by 4.8 percentage points and quality of care ratings improved significantly.<sup>75</sup>
- **Increases access to dental and behavioral health services:** Medicaid expansion increased rates of dental coverage by about 19 percentage points in states that provide dental benefits in Medicaid.<sup>76</sup> Medicaid expansion has also been shown to increase access to behavioral health services for individuals with serious mental illness and/or substance use disorders. Individuals with serious mental illness were more likely to use mental health services after Medicaid expansion and individuals with opioid use disorders were more likely to receive treatment.<sup>77,78</sup> Medicaid expansion has also increased access to tobacco-cessation services, resulting in increased quit rates.<sup>79</sup>
- **Reduces mortality among adults and infants:** Approximately 19,200 adult (ages 55–64) lives were saved from 2014 to 2017 as a result of Medicaid expansion. It was also estimated that 15,600 people died as a result of states not expanding Medicaid coverage.<sup>80</sup> Average infant mortality rates declined in states that elected to expand Medicaid (from 5.9 to 5.6 percent), while non-expansion states saw a rise in their infant mortality rate (from 6.4 to 6.5 percent).<sup>81</sup> For Black infants, these findings were even more pronounced, with a 14.5 percent rate decline in mortality in expansion states compared with a 6.6 percent decline in non-expansion states.<sup>82</sup>
- **Reduces mortality among individuals with end-stage renal disease:** Medicaid expansion was associated with a decline in one-year mortality following initiating dialysis (0.8 percentage points reduction) compared with individuals with end-stage renal disease in non-expansion states (0.2 percentage points reduction). These effects were most prominent in Black patients (1.4 percentage points reduction).<sup>83</sup>

## What are the economic benefits of Medicaid expansion?

Many argue that states will end up footing a significant amount of the costs over time for newly eligible Medicaid beneficiaries. However, research to date has shown that not only has Medicaid expansion not increased states' budgets but it has also had a positive impact on the financial well-being of individuals and hospitals.

- **Reduces total state spending:**

Medicaid expansion was associated with a 4.4 percent to 4.7 percent reduction in total state spending from 2014-2017 on traditional Medicaid.<sup>84</sup>

- **Reduces uncompensated care:**

Kentucky (14 percent) and Arkansas (30 percent) saw significant reductions in uncompensated care.<sup>85</sup> In Montana, Medicaid expansion saved the state more than \$25 million and completely offset the state cost of expansion in fiscal year (FY) 2017.<sup>86</sup>

- **Increases financial well-being of Medicaid beneficiaries:** Medicaid expansion reduced the number of unpaid bills and the amount of debt sent to third-party collection among the most vulnerable individuals. It is estimated that Medicaid expansion reduced collection balances by about \$1,140 for individuals gaining coverage.<sup>87</sup>

- **Increases financial standing of hospitals:** Hospitals in Medicaid expansion states saved nearly \$6.2 billion in uncompensated care costs and were six times less likely to close in expansion states.<sup>88,89</sup> A separate analysis found that hospitals in expansion states had a 2.5 percent increase in mean annual Medicaid revenue as a percentage of total revenue from FY 2013 to FY 2017.<sup>90</sup>

## KEY CONSIDERATIONS AND POLICY RECOMMENDATIONS

**States should expand Medicaid eligibility to provide insurance coverage to more people.** Federal law requires states to cover certain groups of individuals. Low-income families, qualified pregnant women and children, and individuals receiving supplemental security income.<sup>91</sup> States have additional options for coverage and may choose to cover other groups, such as children in foster care.

- States that have not yet expanded Medicaid should leverage the newly established incentives in the American Rescue Plan Act to ensure coverage of as many individuals as possible.

**Make enrollment simple to increase access and prevent loss of coverage for eligible individuals.**

- State policymakers should reevaluate policies that have been shown to have a negative impact on access and coverage, such as work requirements. For example, the Centers for Medicare & Medicaid Services recently rescinded approval for work requirements in Arkansas due to concerns around coverage losses.<sup>92</sup>
- States should align Medicaid enrollment in benefit programs to reduce the burden on individuals applying for multiple forms of government support. For example, states can develop an integrated application process across multiple government programs, such as Medicaid and the Supplemental Nutrition Assistance Program (SNAP).
- Localities should coordinate with state agencies to boost enrollment for eligible individuals. In 2018, approximately 22 percent of uninsured adults may have been eligible for Medicaid expansion or traditional Medicaid.<sup>93</sup>



- Localities should offer assistance in different languages and specifically target individuals already receiving other forms of assistance.

**States can use the Section 1115 waivers to meet the unique needs of their population** through demonstration or pilot projects.<sup>94</sup>

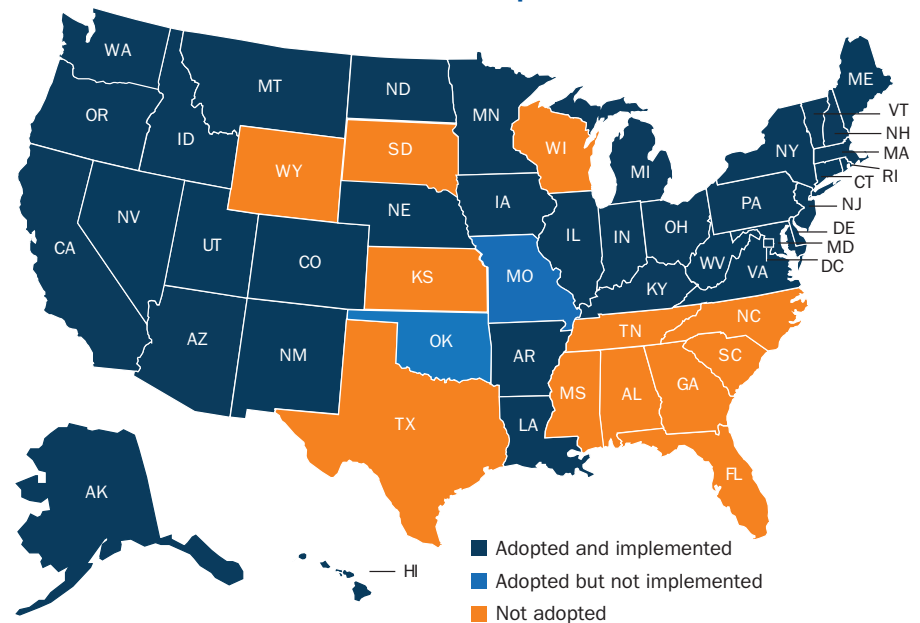
- Federal policymakers should require state Medicaid programs to cover additional necessary services, such as post-partum care and oral health for adults gaining coverage through Medicaid expansion.

- Federal policymakers should expand access to health services such as addiction treatment for Medicaid-eligible individuals 30 days prior to their release from prison, as proposed in the Medicaid Reentry Act.<sup>95</sup>

### Where has Medicaid been expanded?

As of May 2021, 38 states and DC have adopted Medicaid expansion; both Oklahoma and Missouri recently adopted Medicaid expansion but have yet to implement the program.<sup>96</sup>

### Status of State Action on the Medicaid Expansion Decision



Source: Kaiser Family Foundation<sup>97</sup>



### EXAMPLE: OREGON

Since 2012, Oregon has used the Centers for Medicare & Medicaid Services' Section 1115 demonstration waiver to establish and maintain a set of Accountable Care Organizations to coordinate care for all individuals who receive healthcare coverage through Medicaid.<sup>98</sup> Referred to as coordinated care organizations (CCOs), these healthcare entities provide comprehensive medical, behavioral, and dental care services for

Medicaid beneficiaries in their region of the state. Oregon incentivizes CCOs to improve quality by withholding 3 percent of their monthly payments and redistributing these payments among all CCOs based on their reporting of over 30 measures of healthcare quality.<sup>99</sup> As a result of this program, Oregon has continued to meet its spending goals and has seen significant reductions in emergency department visits and some preventable hospital admissions.<sup>100</sup>

## POLICY: Expanding Access to Home Visiting Programs

### What are home visiting programs?

Early childhood home visiting programs provide pregnant women and families, especially those considered at high-risk for pregnancy-related health complications, the resources and skills needed for healthy pregnancies and to raise healthy children. Common services provided by home visiting programs include the provision of prenatal care and screening, case management, family counseling and support, and parent/guardian skills training. This report will refer to the home visiting programs that meet the evidence-based criteria (21 total programs) set forth by the U.S. Department of Health and Human Services.<sup>101</sup> While these programs share some characteristics, they differ in delivery modality, intensity of services, scope, and target populations.

Given the number and variety of evidence-based home visiting programs, there are several factors for policymakers and program administrators to take into account in order to ensure the delivery of high-quality services. Evidence-based home visiting programs typically include:<sup>102</sup>

- Utilization of trained providers (nurses, social workers, or community health workers) to deliver services;
- Standardization of curricula to ensure fidelity to the evidence-based models;
- Use of standardized screening tools to identify physical and behavioral issues in children and parents;
- Provision of case management services to support program participants' access to medical and social services; and
- Counseling of parents and/or guardians to address their own needs and the specific needs of their child.



While the complete adoption of a specific home visiting program model may work for some localities, some aspects of the model may be too difficult to implement with high fidelity. For example, the Nurse-Family Partnership is recognized as one of the most effective home visiting programs, but the cost of maintaining the program may restrict localities' ability to implement the model. However, across the 21 evidence-based programs promoted by the U.S. Department of Health and Human Services, there are some components that have been shown to be effective across models.<sup>103</sup>

- Teaching sensitive and responsive parenting;
- Teaching positive parenting and behavior management techniques; and
- Teaching problem solving.

## Why are home visiting programs needed?

In 2016, approximately 23 percent of all U.S. women initiated care late in pregnancy (second trimester or later) or did not receive the recommended number of prenatal visits.<sup>104</sup> About 82 percent of white women initiated prenatal care in the first trimester.<sup>105</sup> Yet only 72 percent of Hispanic women, 66.5 percent of Black women, 63 percent of American Indian or Alaska Native women, and 51.9 percent Native Hawaiian or Other Pacific Islander women received care during the first trimester.<sup>106</sup> Use of Medicaid as a payment source (68.1 percent) was also associated with lower receipt of prenatal care during the first trimester compared with women paying with private insurance (87 percent).<sup>107</sup> Home visiting programs, which typically focus on low-income mothers who are Medicaid beneficiaries, can help reduce these disparities and improve maternal and child health in the decades to come with broader implementation.

## What are the health benefits of home visiting programs?

- **Improves mental health:** Women who are recipients of home visiting programs are less likely to show symptoms of depression and report improved mental health as compared with women who do not participate in home visiting.<sup>108</sup> Mothers participating in the Child First home visiting model were 64 percent less likely to have psychological distress one year after participating and 33 percent less likely than control group families to be involved with child protective services three years out.<sup>109</sup> Mothers receiving services from the Family Check-Up home visiting model reported a significantly greater decrease in depressive symptoms than the mothers in the control group.<sup>110</sup>
- **Improves behavioral health for American Indians:** Family Spirit, a home visiting program designed to serve behavioral health disparities for American Indian teen mothers, significantly reduced depression and lowered use of illicit drugs compared with the non-intervention participants.<sup>111</sup>
- **Improves infant health:** The Early Intervention Program for Adolescent Mothers, a program that includes home visits and motherhood classes delivered by a public health nurse, significantly reduced the total number of days for infant re-hospitalization during the first six weeks of life.<sup>112</sup> Family Connects, a shorter home visiting program that extends through the first 12 weeks of infants' lives, showed participants had significantly fewer overnight hospitalizations and emergency medical care episodes from birth to 12 months compared with non-program participants.<sup>113</sup> Health Access Nurturing Development Services (HANDS), a statewide program implemented in Kentucky, significantly reduced low birth weight and preterm births.<sup>114</sup>
- **Increases school readiness:** Home visiting programs are associated with higher language scores at age 6 and improved academic achievement at age 9; kids participating in home visiting programs were 42.5 percent more likely to graduate from high school than children who did not participate in the programs.<sup>115,116,117,118</sup> Some evidence-based home visiting program models have also been shown to help mitigate adverse childhood experiences.<sup>119</sup>
- **Improves well-being throughout life:** Children who participated in the Nurse-Family Partnership home visiting program in Elmira, New York, self-reported having 57 percent fewer lifetime arrests and 66 percent fewer lifetime convictions (as of age 19) compared with children who did not participate in the program.<sup>120</sup> Program participants also had 48 percent fewer verified incidents of child abuse and neglect as of age 15.<sup>121</sup> Parents also reported that their children had fewer behavioral issues related to alcohol or other drug use.<sup>122</sup>
- **Improves family self-sufficiency:** Nurse-Family Partnership participants were twice as likely to be employed when their child reached age 2 and worked 82 percent more hours when their child turned 4 compared with non-program participants.<sup>123</sup> Women participating in the Nurse-Family Partnership were more likely to be in stable relationships following program participation.<sup>124,125</sup> Family stability has been shown to encourage more effective child supervision and parental monitoring, which results in better physical and mental health for children.<sup>126,127</sup>
- **Increases enrollment in school or training:** The Health Families America model implemented in Arizona had 35.2 percent of participating parents enrolled in school or training one year after program initiation compared with 6.8 percent of the control group participants.<sup>128</sup> An analysis of 17 Early Head Start programs found that parents' participating in the program were more likely (60 percent to 51.4 percent) to participate in education or job training activities 26 months following enrollment and had a statistically significant increase in income.<sup>129,130</sup>

## What are the economic benefits of home visiting programs?

- **Yields significant financial benefits to society and government:** An economic evaluation of the Nurse-Family Partnership found that total benefits to society (\$41,419) exceeded costs (\$7,271) by \$34,148 per higher-risk child served. A significant majority of the benefits (\$32,447) were savings yielded by the government.<sup>131</sup> These savings accrued from increases in educational attainment, reductions in delinquency and crime, and reduced outlays for social welfare programs.<sup>132</sup>

## KEY CONSIDERATIONS AND POLICY RECOMMENDATIONS

When creating policies that expand access to home visiting programs, policymakers should consider the following points.

Provide adequate funding and resources for successful implementation of home visiting programs. Policymakers must also consider how to fund home visiting programs. While the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, funded by the U.S. Department of Health Resources and Services Administration, provides federal funding to support home visiting programs, additional state and local dollars are often necessary to ensure effective implementation of the selected home visiting model. States can use a variety of funds to support such efforts, such as Medicaid, Children's Health Insurance Program (CHIP), or public-private pay-for-success models.<sup>133,134</sup>

- Congress should ensure continued and robust annual funding for the MIECHV.

- The Department of Health and Human Services should continue to provide flexibility in the use of Medicaid, CHIP, and Temporary Assistance for Needy Families funds for states to use toward home visiting programs.
- State policymakers should leverage federal funds by providing state funds to support the creation or enhancement of evidence-based home visiting models.
- State policymakers should develop innovative funding strategies, such as pay-for-success models or by utilizing Medicaid funding, to expand the reach of home visiting programs.
- Localities should allocate funding and resources to support home visiting programs. Given the cost savings accrued from home visiting programs occur outside of the healthcare systems, local governments are well positioned to yield positive economic returns on investments in home visiting programs.

### Support community outreach and capacity building.

- Localities should work closely with state government officials to build local capacity and infrastructure to support effective implementation and reach.

### Establish accountability and performance measures.

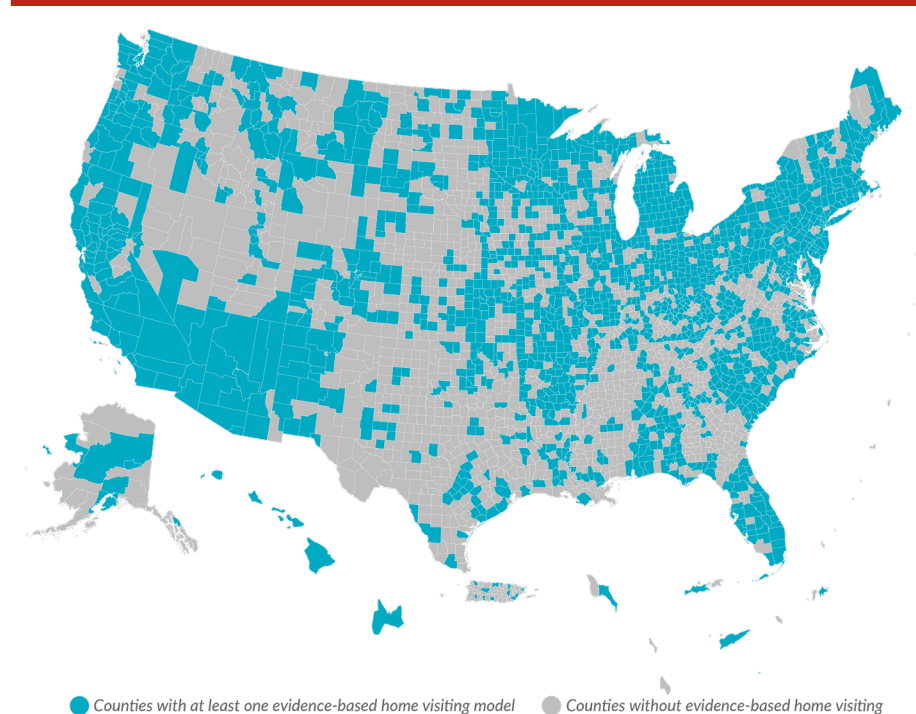
- States should establish accountability and performance measures and reporting requirements to support quality improvement.
- States should align and coordinate early learning and health systems, such as supporting cross-agency data sharing.



### Where have home visiting programs been implemented?

In 2019, MIECHV served 154,000 parents in over 1,000 counties in the United States. Although states are not required to operate home visiting programs, at least 23 states have passed home visiting legislation since

the establishment of the MIECHV to create complementary funding streams and define program standards.<sup>135,136</sup> Eighteen states have evidence-based home visiting agencies in 75 percent or more of their counties, and seven states have agencies in fewer than 25 percent of all counties.<sup>137</sup>



Source: National Home Visiting Resource Center<sup>138</sup>



### EXAMPLE: MICHIGAN

Michigan's Home Visiting Initiative (MHVI) is a statewide cross-agency effort to increase access to evidence-based, prevention-focused home visiting services.<sup>139</sup> In collaboration with partners from across the Michigan Department of Education, Michigan Department of Health and Human Services (MDHHS), and other stakeholders, the initiative increases support for families, avoids duplication of service, and maximizes the impact of investments.<sup>140</sup> MHVI comprises eight evidence-based and promising home visiting models. Each model has specific target populations and outcomes to measure how the community's support for families has improved. Two of

these models, the Maternal Infant Health Program and Nurse-Family Partnership, promote maternal health, child health and development, healthy pregnancies, and other indicators to meet the needs of different families.<sup>141</sup> Michigan's home visiting programs have achieved great outcomes. For instance, nearly 90 percent of mothers did not have a preterm birth, and 82 percent of mothers received a postpartum visit in 2019.<sup>142</sup> MHVI has received funding from federal programs, such as the MIECHV, Child Abuse Prevention and Treatment Act, and Medicaid.<sup>143</sup> Michigan also provides direct support to home visiting services through MDHHS General Fund appropriations and other state funds.<sup>144</sup>



## POLICY: Supporting Increased Use and Training of Community Health Workers

### What are community health workers?

Community health workers (CHWs) are trained public health or lay workers who serve as a connector among the communities they serve, local healthcare systems, social service providers, and health departments.<sup>145,146</sup> CHWs also build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities, such as outreach, community education, informal counseling, social support, and advocacy.<sup>147</sup> CHWs typically share a similar background as the community they are serving. Whether that is a shared language, socioeconomic situation, or life experience, CHWs' ability to directly connect with their community enables them to be a frontline change agent to help reduce health inequities. As of 2010, the U.S. Department of Labor recognized CHWs as a distinct occupation.<sup>148</sup> Despite CHWs being utilized for over 50 years, they are now starting to be recognized as a cost-effective, culturally sensitive approach to improving community health.

### Why are CHWs needed?

Community health workers have the potential to help close many of the long-standing inequities that exist in low-income and vulnerable communities across the country. Multiple studies show a pattern of historical distrust of and ongoing experiences with discrimination in the healthcare system among Black and Hispanic communities.<sup>149,150,151</sup> Separate research has found that mistrust of healthcare institutions is associated with the underutilization of health services.<sup>152</sup> With CHWs being members of the communities they serve, they have the potential to help reduce

the long-standing health inequities, discrimination, and mistrust that low-income and communities of color face across the country by delivering health information in a manner that is culturally and linguistically appropriate.

### What are the health benefits of CHWs?

CHWs have been shown to have a positive health impact on the communities they serve in a number of ways.

- **Improves health outcomes:** High-poverty, publicly insured patients who received a CHW intervention had improvements in managing diabetes, reducing body mass index, and decreasing cigarettes smoked per day.<sup>153</sup> Patients who received CHW services also showed improvements in mental health and self-reported receipt of high-quality, comprehensive primary care than their usual care counterparts.<sup>154</sup>
- **Improves access to care and reductions in hospital readmissions:** CHWs utilizing individualized action plans for recovery increased the likelihood of patients obtaining primary care, increased mental health improvements, and reduced the likelihood of multiple 30-day readmissions among a subgroup of participants by nearly 25 percentage points (40 percent to 15.2 percent).<sup>155</sup>
- **Improves care delivery:** CHWs have been found to be more effective than traditional chronic disease management and care strategies for vulnerable populations, cancer prevention, cardiovascular risk reduction, managing diabetes, and addressing mental health issues.<sup>156,157,158</sup>

## What are the economic benefits of CHWs?

CHWs are one of the most cost-effective interventions to improve health and reduce costs:

- **Robust return on investment:** At the national level, an evaluation of Center for Medicare and Medicaid Innovation’s Health Care Innovation Award grantees found that of the over 100 models utilized in the program, only those using CHWs lowered costs (by \$138 per-beneficiary per-quarter).<sup>159</sup> Kentucky’s Homeplace program found a return on investment of \$11.34 for every \$1 spent on training CHWs.<sup>160</sup> At the local level, an analysis of Denver’s Health Community Voices Program, found that the return on investment of the CHW intervention was \$2.28 for every \$1 spent, resulting in total annual program savings of \$95,941.<sup>161</sup>
- **Provides near- and long-term savings:** In Nevada, three CHWs working with 37 patients each for 30 to 60 days resulted in approximately \$300 savings in average medical costs per patient.<sup>162</sup> In New Mexico, CHWs provided services to 448 high-utilizers in Medicaid Managed Care plans over six months and reduced utilization costs by over \$2 million compared with pre-intervention.<sup>163</sup>

## KEY CONSIDERATIONS AND POLICY RECOMMENDATIONS

The CDC evaluated various components of CHW policy to determine which had the most supporting evidence. They evaluated the quality and level of evidence of the public health impact of each component.<sup>164</sup> Included here are CDC’s eight “best” components followed by our own policy recommendations, where applicable.

**CHWs provide chronic disease care services.** Refers to CHW services to help prevent and control chronic diseases.

- States should authorize CHWs to provide services to help prevent chronic diseases, such as hypertension and diabetes.
- **Inclusion of CHWs in team-based care models.** Refers to inclusion of CHWs in multidisciplinary healthcare teams.
- The Centers for Medicare and Medicaid Services should continue to support the adoption of value-based contracting and the inclusion of CHWs in healthcare teams.
- Congress should build off of the American Rescue Plan Act’s \$330 million investment in community health workers and provide sustainable, long-term funding to further support the development of the CHW workforce.<sup>165</sup>

**Core competency CHW certification.**

Refers to the establishment of a certification process of core competencies to establish professional standards for the field.

- States should establish professional standards through a CHW certification process. The certification process should be designed to avoid the exclusion of those without formal educational training.
- States should provide financial assistance and incentivize CHW employers to cover the costs of certification.



- Localities should establish partnerships with local colleges or educational institutions to support the bolstering of the CHW workforce through training, continuing education credits, and certification.

**CHWs supervised by healthcare professionals.**

**Standardized core CHW curriculum.**

Refers to promotion of a common base of knowledge among CHWs through the creation of a standardized core curriculum.

**Medicaid payment for CHW services.**

- The Centers for Medicare and Medicaid Services should continue to provide waiver flexibilities to states for CHWs to bill for services directly.
- States should secure Medicaid funding for CHWs. This can be done through direct fee-for-service initiatives, incentives included in Medicaid managed care contracts, and amendments to states' Medicaid State Plans.
- Localities should utilize general funds to employ or reimburse CHW services directly.

**Specialty area CHW certification.**

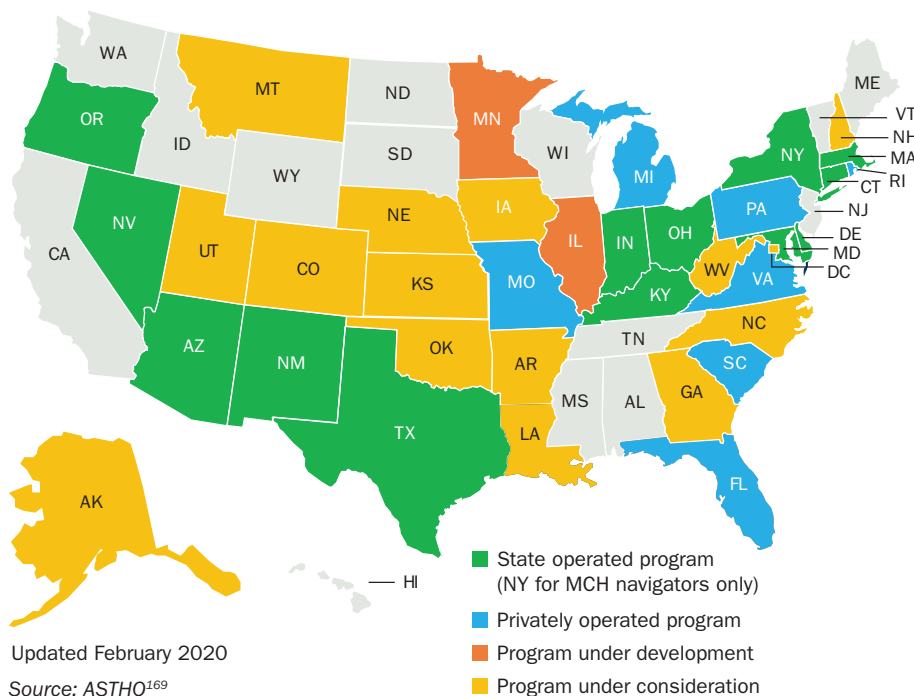
Refers to the use of CHW certification to establish standards for providing specialty care services (e.g., specifically addressing hypertension).

**Inclusion of CHWs in development of their certification process.**

- States should engage with current CHWs when establishing new credentialing programs to avoid creating barriers to entry related to financial resources, educational attainment, language preference/proficiency, race/ethnicity, culture, or immigration status.<sup>166</sup>

**Where have CHW-related policies been implemented?**

As of July 2020, 19 states have a voluntary or mandatory certification process for CHWs.<sup>167</sup> While standardization of credentials are important, some states have chosen not to require licensure as they found it to be a barrier to entry.<sup>168</sup>



**EXAMPLE: ARKANSAS**

In October 2012, the Arkansas Department of Health, the University of Arkansas for Medical Sciences College of Public Health, CHW employer groups, and other stakeholders established a collaborative CHW interest group.<sup>170</sup> This interest group developed the Arkansas Community Health Worker Association in 2015, a 501(c)(3) nonprofit membership-based organization with the mission of supporting Arkansas CHWs in promoting improvements in health and healthcare.<sup>171</sup> Data show that CHWs have a positive financial impact in Arkansas. The most notable evidence-based example of this impact is the Tri-County Rural Health Network Community Connector Program, which utilizes CHWs to link elderly residents and adults with disabilities to services so that they can stay in their homes rather than enter a nursing home.<sup>172</sup> A three-year study investigating the impact of this program found total estimated savings of \$3.5 million in Arkansas Medicaid expenditures for 919 program participants.<sup>173</sup> Additionally, the Community Connector Program produced a return on investment of \$2.92 per dollar invested in the program.<sup>174</sup>

## Promoting Economic Mobility

The connections between health and income are well documented and associated with differences in access to resources that affect health status.<sup>175</sup> The relationship between income and health is unique in that one affects the other. A person's economic well-being can be a driver of one's health outcomes, while an individual's overall health status can also affect their income and economic well-being.



The COVID-19 pandemic is one example of how overall health and economic well-being are connected, as people in the United States simultaneously experienced health and economic crises. As a result of the pandemic, the United States has seen the highest rate of unemployment since the Great Recession.<sup>176</sup> The economic crisis has also left many people struggling to cover their basic needs during a prolonged public health emergency.

Prior to the pandemic, there were approximately 34 million people living in poverty in the United States as well as longstanding racial and ethnic wealth disparities.<sup>177</sup> For example, Black and Latino households had an average net worth of white households that was six to seven times lower than white households, and while on average white households held more debt compared with Black and Latinx households, white households were more likely to have the resources to pay down their debt.<sup>178</sup>

Families across the United States have been severely affected by the economic impacts of COVID-19, pushing more people into poverty and putting low-income families at greater risk of falling into deep poverty.<sup>179,180</sup> Although poverty rates were falling steadily prior to the pandemic, one study estimates the monthly poverty rate increased from 15 percent to 16.7 percent from February to September 2020, despite temporary relief sent to communities through the Coronavirus Aid, Relief, and Economic Security (CARES) Act.<sup>181</sup> Rather than measuring poverty based on a family's annual resources, the aforementioned study estimated monthly poverty rates based on a family's resources before and throughout the COVID-19 pandemic.<sup>182</sup> The same study found that Black and Hispanic individuals faced high rates of monthly poverty compared with white individuals before the pandemic, but these differences were exacerbated after the crisis. By September 2020, the monthly poverty rate for Blacks and Hispanics was 25.2 and 25.8 percent, respectively, compared with 12 percent for whites.<sup>183</sup>

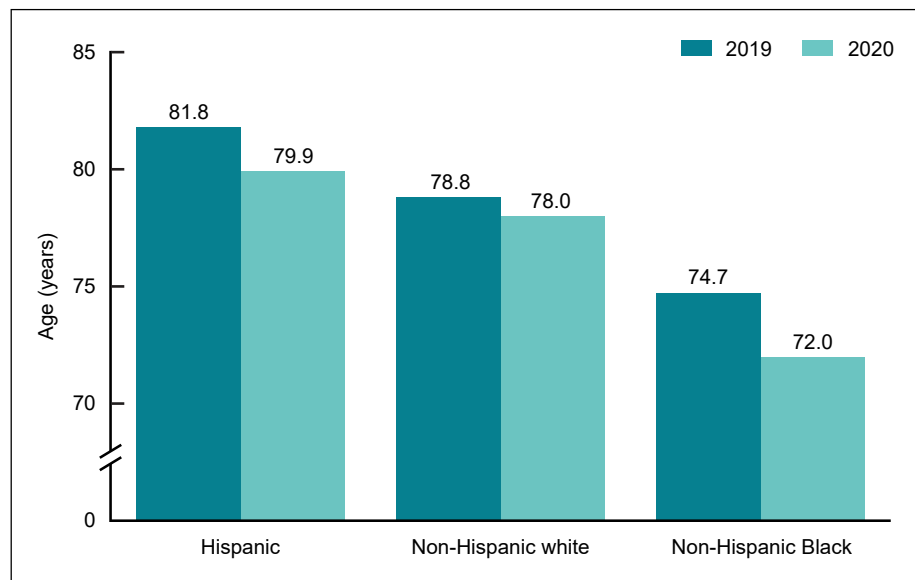


Given the fact that health and economic well-being are interrelated, it is not a surprise that the economic and wealth disparities that existed prior to the pandemic translated into poorer health outcomes for those already living in poverty. The racial and ethnic disparities in income and wealth prior to the pandemic are largely due to systemic racism and discriminatory practices. The pandemic has more severely affected people of color and exacerbated health and economic disparities. For example, in 2019 the life expectancy for non-Hispanic Black Americans was 74.7 years compared with 78.8 for non-Hispanic whites, about a four-year difference [see figure below]. Provisional data from

the first half of 2020 found that while the COVID-19 pandemic decreased the overall life-expectancy among Americans, the disparity between white and Black Americans worsened. For non-Hispanic whites, the life expectancy had fallen to 78 years compared with 72 years for non-Hispanic Black Americans.

Policymakers have an opportunity to support evidence-based policies to address the economic needs of communities, improve their economic stability and promote their health and well-being. These policies would not only help families recover from the current health and economic crises but would have lasting impacts after the pandemic.

**Life expectancy at birth, by Hispanic origin and race; United States, 2019 and 2020**



NOTES: Life expectancies for 2019 by Hispanic origin and race are not final estimates; see Technical Notes. Estimates are based on provisional data from January 2020 through June 2020.  
SOURCE: National Center for Health Statistics, National Vital Statistics System, Mortality data.

Source: Centers for Disease Control and Prevention<sup>184</sup>



## POLICY: Earned Income Tax Credit

### What Are Earned Income Tax Credits?

The Earned Income Tax Credit (EITC) is a tax credit offered to eligible low-income workers to enhance their economic security. The EITC assists working families by reducing the tax liability of qualifying taxpayers by an amount based on the taxpayer's income level, marital status, and number of dependent children.<sup>185</sup>

The federal EITC was first enacted in 1975 to provide financial assistance to low-income, working families with children.<sup>186</sup> Workers typically receive a credit equal to a percentage of their earnings up to a maximum amount, which is dependent on family size.

Larger credits are available to families with more dependent children.<sup>187</sup>

Workers without dependent children must be 25 years or older and less than 65 years old, live in the United States for more than six months, and are not a dependent of another person.<sup>188</sup>

The amount of the federal tax credit changes from year to year. One key component of the EITC policy is refundability. These tax credits can be refundable, meaning individuals can receive the full value of the credit, regardless of the tax liability.

In addition to the federal EITC, states can offer a supplemental state-level EITC to eligible workers. Most state EITC policies are modeled after the federal credit but may vary in eligibility, credit amount, refundability, and other requirements.

### Why are EITCs important?

The federal EITC is one method of directly addressing poverty in the United States: supplementing the earnings of low-income working families. Each year, EITC policies help lift millions of families out of poverty and reduce the severity of poverty for millions more.<sup>189</sup>

Given the economic impacts of COVID-19, scores of working adults and underemployed workers experiencing financial hardship would benefit from refundable EITC policies to provide temporary financial relief. Prior to the pandemic, 39 percent of Americans would have had to borrow, sell something, or be unable to cover a \$400 emergency, even fewer had enough savings to weather unemployment or underemployment for months at a time.<sup>190</sup> Because so many low-wage workers are experiencing economic hardship during the COVID-19 pandemic, economic relief policies such as the EITC can serve as a mechanism to provide direct financial support for eligible workers. Receiving an EITC refund to supplement earnings can help workers pay off any debts accumulated during the pandemic, secure basic needs, or pay for other expenses.

### What are the health benefits of EITCs?

There is strong evidence that EITC policies can positively impact families, with benefits following children into adulthood.<sup>191,192,193,194,195,196,197,198,199</sup>

- **Improves maternal and child**

**health:** For mothers who receive the EITC, there is a correlation of improved maternal and child health, reduced infant mortality, and higher breastfeeding rates.<sup>200,201,202,203</sup> A study of the 1990 expansion of the federal EITC found that increasing the EITC may improve mental health for mothers who are married, specifically self-reported symptoms of depression.<sup>204</sup> One study found that every 10 percent increase in a state-level EITC is associated with a drop in the infant mortality rate by 23.2 per 100,000.<sup>205</sup> Mothers living in a state that recently enacted or increased a state EITC reported having less

mental stress and lower smoking rates during pregnancy, both of which also contribute to improvements in birthweight.<sup>206,207,208</sup>

- Decreases incidence of low-birthweight births:** A number of studies have demonstrated decreased incidence of low-birthweight births, particularly among Black mothers.<sup>209,210,211,212</sup> States with refundable EITCs had the largest increases in birthweights and reductions in prevalence of low-weight births, with larger effects seen among states with more generous EITCs.<sup>213</sup>

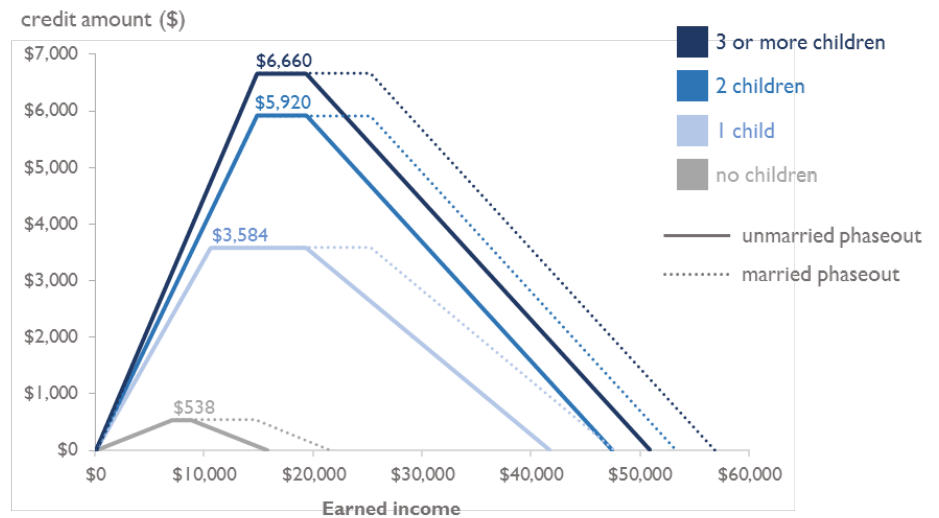
- Improves child well-being and academic achievement:** Receipt of the EITC is associated with improved behavior among children, better home environments, less incidence of child neglect and maltreatment, and decreased entry into foster care.<sup>214,215,216,217</sup> There is also evidence that increasing family income through employment and earning supplements has positive effects on children’s academic achievement.<sup>218</sup> Children from households that received larger state or federal EITCs scored better in reading and math, and were more likely to finish high school and go to college.<sup>219</sup> The effects of larger EITC benefits extend to children of all racial and ethnic groups, especially children of color, boys, and younger children.<sup>220</sup>

### What are the economic benefits of EITCs?

There is strong evidence that EITC policies increase employment and income for families:

- Increases employment:** Evidence suggests that EITC policies increase employment for single-parent households due to increased incentives to participate in the workforce, especially among single mothers.<sup>221,222,223, 224,225,226,227,228</sup> This

**EITC Amount by Number of Qualifying Children, Marital Status, and Income, 2020**



Source: Congressional Research Service<sup>232</sup>

extra time spent in the workforce can lead to better job opportunities and higher pay over time.<sup>229</sup> Another study showed that a \$1,000 increase in the federal EITC led to a 7.3 percentage point increase in employment.<sup>230</sup> In addition to increasing employment and income among working-age parents, the federal EITC also increases their Social Security retirement benefits, thereby reducing poverty among older adults.<sup>231</sup>

- Lifts families and individuals out of poverty:** In 2018, the federal EITC lifted about 5.6 million individuals out of poverty, including about 3 million children.<sup>233</sup> The federal credit also reduced the severity of poverty for another 16.5 million people, including 6.1 million children.<sup>234</sup> In 2019, 25 million eligible workers and families received about \$63 billion in federal EITC payments, where the average payment was \$2,476.<sup>235</sup>

- Serves as a short-term safety net:** Research shows that families receiving an EITC benefit mostly use the supplemental income to pay for necessities, repay debts, repair

their homes or vehicles, or obtain additional education to increase their employability and earnings.<sup>236,237</sup> Refundable EITC benefits help families meet short-term and medium-term needs.<sup>238</sup> One study found that one-half of surveyed individuals receiving an EITC benefit rated paying a bill as their first priority.<sup>239</sup>

- An effective and relatively low-cost tax credit:** State EITC policies are cost effective and may be less expensive compared with other tax credits, increasing quality of life and longevity among recipients.<sup>240</sup> In states with an income tax and refundable EITC policy, the EITC costs less than 2 percent of the tax revenue each year.<sup>241</sup> While a state may have a sizable number of low-income households, they make up a smaller share of tax revenue. A refund for eligible families can have a major economic impact without being a large cost to the state.<sup>242</sup> California’s EITC has been shown to have a positive impact on the state and local economies through increased sales and jobs.<sup>243</sup>

## KEY CONSIDERATIONS AND POLICY RECOMMENDATIONS

Federal and state level EITC laws differ in their eligibility requirements, amount, and whether the credit is refundable. When creating EITC policies, policymakers should consider the following points.

**States should increase the value of the EITC.** The federal tax credit changes from year to year. State EITC policies set their credit amount as a percentage of the federal EITC. As of August 2020, nine states have a credit that is 10 percent or less.<sup>244</sup> Increasing the amount would help offset more of a worker's tax liability and increase their refund, if refundable.

- In states that offer a refundable EITC, policymakers should increase the current benefit amount to be at least 10 percent or higher of the federal EITC rate to maximize the impact and the health and economic benefits associated with the policy.

**Make the EITC refundable.** A refundable EITC allows eligible taxpayers to keep the full value of their credit even if it exceeds their income tax liability, meaning the credit can offset taxes they owe and the remaining amount is refunded to them.

- If a state does not already offer an EITC benefit, policymakers should work to establish an EITC policy that is right for their state and budget.
- In states that offer an EITC that is not refundable, policymakers should expand their current policy to offer a refundable tax credit to eligible workers.

**Expand EITC eligibility.** Expanding eligibility would help lift more people out of poverty, increase employment rates, and help narrow the income gap for low-income workers. Currently,

childless workers under the age of 25 are not eligible to claim the federal EITC; some of these 5.8 million workers are then taxed into poverty or deeper poverty each year because their federal EITC benefits are not enough to offset their tax liability.<sup>245,246</sup> Expanding the federal EITC for childless workers would generate \$1.20 in economic activity per dollar spent.<sup>247</sup> States can also expand the EITC for low-income workers without children.

- Congress should permanently expand the eligibility requirements to include childless workers and people under the age of 25 years to receive the federal EITC. The American Rescue Plan Act of 2021 temporarily lowered the EITC eligibility for childless workers ages 19 to 24 and eliminated the upper age limit to include childless workers ages 65 years and older to qualify for the tax credit.<sup>248</sup> Prior to the temporary changes of the ARPA, the EITC was only available to childless individuals ages 25-64.
- Congress and states should expand eligibility requirements to filers with an Individual Taxpayer Identification Number (ITIN) and children without a Social Security number. The American Rescue Plan Act allows individuals who have children without a Social Security number to claim the federal childless EITC.<sup>249</sup>
- States should also expand their eligibility requirements to include childless workers and lower the age limit of EITC eligibility.

**Allocate resources to increase outreach and awareness.** Some people may not know that they are eligible for a federal or state EITC and may miss out on much-needed economic support.

The Internal Revenue Service (IRS) currently holds an Awareness Day outreach campaign for the federal EITC; however, the IRS estimates one out of five eligible tax filers do not claim the EITC.<sup>250</sup>

- Federal, state, and local policymakers should allocate additional resources to increase awareness of state and federal EITCs and who is eligible to receive the benefit.
- States should allocate resources to increase outreach and awareness of their EITC benefit or charge state agencies to lead outreach efforts.
- State policymakers should mandate that beneficiaries of certain assistance programs be notified of the EITC benefits.
- Localities can allocate resources to increase outreach and awareness of the state and local EITC benefits available to eligible residents by partnering with community organizations and IRS Volunteer Income Tax Assistance sites.

### Where have EITCs been implemented?

In addition to the federal EITC, 29 states and the District of Columbia have an EITC policy in place as of August 2020.<sup>251</sup> The federal EITC has been in place since 1975, and Rhode Island enacted the first statewide EITC in 1986.<sup>252</sup> There is variation in EITC laws across states in terms of refundability, percentage of the federal EITC, and eligibility. All states set their credits based as a percentage of the federal credit, except for Minnesota.<sup>253</sup> However, the percentages used vary greatly from state to state, ranging from 3 percent to 125 percent. There is also variation across states as to whether the EITC operates as a refund or as a reduction. In 23 states and the District of Columbia, credits are fully or partially refundable if the amount is greater than the taxes owed.<sup>254</sup> In six states, the EITC can only reduce a person's tax liability, not provide a refund.<sup>255</sup> Eligibility can differ based on family size, particularly the number of dependent children, and the marriage status of the taxpayer, adding greater variation to the policies.



#### EXAMPLE: WASHINGTON, DC

The District of Columbia offers a fully refundable earned income tax credit set at 40 percent of the federal EITC amount for working families with children. In 2014, the District expanded income eligibility to include childless workers and matched their federal EITC amount from 40 percent to 100 percent.<sup>256</sup> As a result, taxpayers in DC ages 18 to 30 can now claim the credit even if they do not qualify for the federal EITC. Taxpayers who do not have dependent children can also qualify for the DC EITC benefit by using a separate worksheet for filers without a qualifying child. Following the eligibility changes to include childless workers, the number of District tax filers increased from 41,391 in 2014 to 53,839 in 2015. A report on the District's EITC found that many full-time childless workers claimed the expanded EITC. Those workers tended to be younger, between ages 25 to 30, and male.<sup>257</sup>

## POLICY: Living Wage

### What is a living wage?

A living wage is the hourly wage necessary to meet a person or family's basic needs given the local cost of living. The living wage draws upon geographic location and the cost of basic necessities, such as the minimum food, childcare, health insurance, housing, transportation, and other basic necessities and the minimum employment earnings necessary to meet basic needs while maintaining self-sufficiency.<sup>258</sup>

### Why are living wages important?

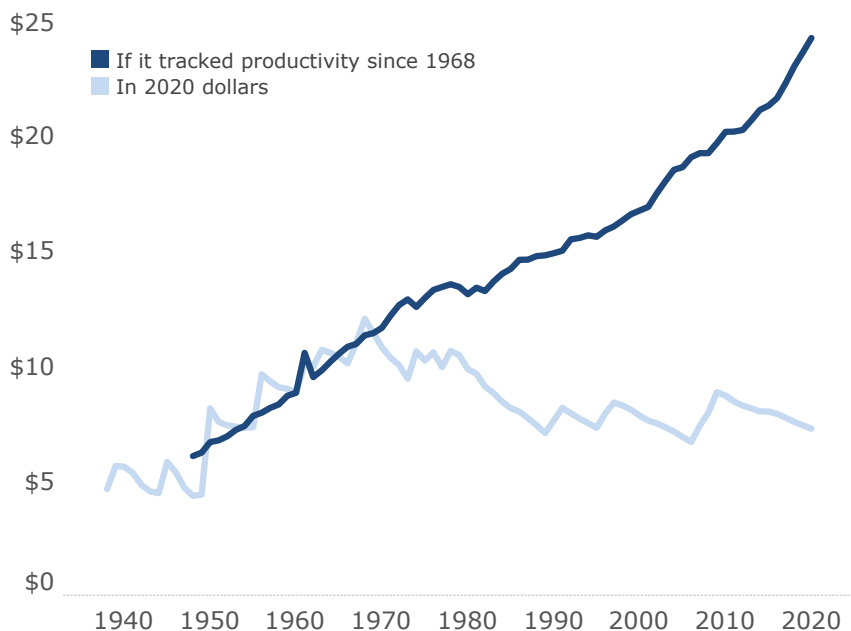
The living wage model accounts for living expenses that are not included in the federal minimum wage calculation. The federal minimum wage differs

from a living wage in that the minimum wage is set by an act of Congress but does not consider the average cost of living expenses other than food. Researchers have developed different tools: using publicly available data, adjusting wages by geography, and constructing an hourly wage needed to cover basic expenses for different family sizes.<sup>259</sup> For example, the MIT Living Wage Calculator tool takes into account the cost of childcare, health insurance, housing, transportation, and other basic necessities, but it does not include funds to enable savings or investments (e.g., retirement, home purchase, etc.).<sup>260</sup> Currently, the federal minimum wage is set at \$7.25 an hour. A full-time worker earning minimum wage earns \$15,080 per year before tax deductions—an annual income that sits below the federal poverty level for a family of two.<sup>261</sup> Following an executive order signed by President Biden, the minimum wage for federal contractors will be raised to \$15 an hour starting in 2022.<sup>262</sup> Efforts to establish a living wage may overlap with efforts to increase the minimum wage.

The federal minimum wage was originally intended to serve as a living wage and account for changes in cost of living and productivity.<sup>263</sup> However, the law contains no formula for setting the wage level and has not been updated frequently enough to keep pace with rising costs and inflation.<sup>264</sup> As a result, each year, the purchasing power decreases until the next increase is enacted by Congress.<sup>265</sup> If the federal minimum wage had kept up with the rise of productivity, the inflation-adjusted minimum wage would be over \$24 an hour (in 2020 dollars).<sup>266</sup>

### Trends in the Minimum Wage

Minimum Wage, in 2020 dollars and if it had kept pace with productivity, 1938–2020



Source: Center for Economic and Policy Research<sup>267</sup>



It is important to note that there is geographic variation in cost-of-living expenses, making some cities and counties more affordable to live in than others. However, even in places where there are lower living expenses, it can be difficult to live off the current federal or state minimum wage. For example, a living wage in New York City for a childless worker is \$20 per hour, using MIT's Living Wage Calculator, while the local minimum wage is \$15.<sup>268,269</sup> A living wage in McAllen, Texas, for a childless worker is \$12.63 per hour while the state minimum wage is \$7.25.<sup>270,271</sup> Despite differences in living expenses like housing and transportation, neither minimum wage amounts are enough to be considered a living wage.

Passing living wage policies at the state or local level can help lift people currently experiencing poverty and those working in industries and occupations hardest hit by the pandemic. In addition to low wages, these workers, especially workers of color, were also less likely to have access to paid sick leave or paid family leave, savings, or additional resources to help them during the pandemic.<sup>272</sup> In 2020, of the 1.1 million workers ages 16 and older who were paid at or below the federal minimum wage, approximately 52 percent were adults over the age of 25 and over 66 percent were women.<sup>273</sup> Service occupations were more likely to have hourly wage workers earning at or below the federal minimum wage. Approximately seven in 10 workers earning minimum wage or less in 2020 were in service occupations, mostly food preparation and serving-related jobs.<sup>274</sup>

### What are the health benefits of living wage policies?

Research suggests that income and health are related, where higher incomes correspond to better health outcomes. Workers who are paid lower incomes or those who experience unstable or flexible employment may experience worse health.<sup>275</sup>

- **Improves physical and behavioral health:** Implementation of a living wage policy in London found that service-sector employees who worked for a living wage employer experienced better psychological well-being compared with those who did not.<sup>276</sup> Research to date suggests that living wage policies are associated with better health outcomes.<sup>277</sup> Preliminary findings have shown that among low-wage workers, living wage policies on average decreased depressive symptoms by 14 percent, unmet medical needs by 15 percent, and increased attempted smoking cessation by 15 percent.<sup>278</sup> Studies also suggest associations between increased wage rates and decreases in suicide mortality, hypertension, better birth outcomes, and lower rates of sexually transmitted infections among women.<sup>279,280,281,282</sup> However, additional research is needed to confirm these effects across all populations.
- **Expands access to healthcare:** Enacting living wage policies that require a healthcare differential, a wage that requires employers to provide health insurance for workers, can help make health coverage more affordable for employees.<sup>283</sup> An analysis of San Francisco's living wage policy found that, due to the policy, the hourly wages of homecare workers nearly doubled.<sup>284</sup>

### What are the economic impacts of living wage policies?

- **Reduces poverty rates:** Research suggests that living wage laws increase wages for workers and can reduce poverty rates, although additional research is needed to confirm long-term effects.<sup>285,286,287</sup> Workers just above and below the poverty line are most impacted by living wage laws.<sup>288</sup> Living wage laws that mandated moderate living wage requirements for local government workers, contractors, and grantee employees funded by a local government were most likely to see reduced poverty rates compared to economic development subsidies.<sup>289</sup>
- **Reduces productivity losses:** Evidence suggests that living wage laws can save employers the costs associated with replacing employees and productivity losses due to absenteeism.<sup>290</sup> Employers covered by Los Angeles's living wage ordinance found that they experienced reduced employee turnover, a drop in absenteeism, fewer overtime hours, and reduced job training compared with other businesses.<sup>291</sup> San Francisco's living wage ordinance, which applied to the San Francisco airport, resulted in the annual turnover rate among security screeners falling from 95 percent to 19 percent and their hourly wage rising from \$6.45 to \$10 per hour in 2001.<sup>292,293</sup> Establishing living wage laws can also benefit employers because offering higher wages can attract higher-skilled workers.

## KEY CONSIDERATIONS AND POLICY RECOMMENDATIONS

For effective implementation, states and localities should consider the following points when crafting and implementing living wage policies. Living wage policies can include different provisions, such as automatic increases linked to the cost of living, a healthcare differential, and paid leave for workers.

**Set wage levels that reflect the local cost of living.** Conducting a local economic analysis and utilizing cost-of-living calculator tools, such as those developed by the Economic Policy Institute or MIT, can assist policymakers in determining a living wage for workers.<sup>294,295</sup>

- Congress should pass legislation to increase the federal minimum wage to an amount that better reflects the current cost of living.
- States can establish a living wage law and cover workers or sectors not covered by the federal minimum wage, including domestic service workers and tipped workers.
- States should repeal preemption laws that currently prohibit cities from setting local living wage policies.

**Account for cost-of-living increases.**

- Federal, state, and local policymakers should consider including a mechanism in their living wage calculation for regular cost-of-living increases, such as tying the wage to inflation.

**Define which employers will be required to provide their workers a living wage.**

Living wage policies can apply to all businesses in a jurisdiction, businesses

that contract with local governments, and businesses that receive economic development subsidies; it can also target certain industries. Living wage policies can also be applied to cover private businesses working on city-owned land, such as convention centers, or be included as provisions of a community benefits agreement.

- Localities can set a living wage policy that applies to employers within the local jurisdiction. The policy can also target specific sectors, contracts, or grantees funded by local government.
- Localities should support efforts to bring together communities and developers to design a community benefits agreement that requires a living wage be paid to employees for development projects.<sup>296</sup>

**Consider employee benefits such as offering a healthcare differential and paid leave for workers.**

- Federal, state, and local policymakers should consider setting different wage rates (healthcare differential) depending on whether an employer provides employee health insurance.
- Federal, state, and local policymakers should also consider requiring employers to provide paid leave to employees should they fall ill or need to take time off.

**Allocate resources to ensure compliance and enforcement of living wage standards.**

- Federal, state, and local policymakers should create a mechanism to receive and investigate employee complaints, and they should audit employers.



### Where have living wage policies been implemented?

While assessments of minimum wage policies at the local and state level have been regularly updated, there has not been an analysis of living wage ordinances in over a decade. The most recent data (2008) shows that at least 140 jurisdictions across the country have enacted living wage policies.<sup>297</sup> As of May 2021, 30 states and the District of Columbia have a minimum wage that is greater than the federal

minimum wage. There are 15 states that have a minimum wage that is equal to the federal minimum wage, and five states that do not require a minimum wage, which means the current federal minimum wage applies to them.<sup>298</sup>

As of 2020, 26 states have preemption laws in place prohibiting local governments from setting a minimum wage that is higher than the state minimum wage.<sup>299</sup> These laws prohibit mandatory living wage ordinances and local minimum wage laws.



### EXAMPLE: HARTFORD, CONNECTICUT <sup>300</sup>

In Connecticut, the city of Hartford's living wage ordinance sets the hourly wage rate at \$15.12 with employer-offered health insurance coverage and at \$21.77 without employer-offered health insurance coverage for all eligible employees.<sup>301</sup> The ordinance applies to all eligible workers employed to perform work associated with the specified contracts and development projects with the city. The living wage rates are updated annually according to the cost of living in the region and take effect on July 1 of each fiscal year. Covered employers include any person or entity awarded a city contract and includes all subcontractors who perform work within the boundaries of the city or on city-owned property. Employers included in the ordinance are prohibited from using the living wage requirement to reduce the compensation paid to any of its eligible employees.

## POLICY: Paid Sick & Family Leave

### What are paid leave policies?

Paid sick leave and paid family leave policies allow workers to take time off from work to address a personal or family health condition or bond with a new child without fear of lost wages or termination. Paid leave laws allow workers to address their own health and family needs without compromising their own economic security. Yet, many employers do not offer paid leave as a workplace benefit to their workers and disparities in access to paid leave remain.

### Paid Sick Leave

There is currently no federal law requiring employers to provide workers with paid sick leave. Some states and localities have implemented their own paid sick leave laws and some businesses offer paid sick leave through employee benefits packages. Data from the Bureau of Labor Statistics shows that approximately 25 percent of private-industry workers do not have access to paid sick leave, including about 70 percent of the lowest-income workers.<sup>302</sup> Workers in public-facing occupations are less likely to have paid sick days compared with those in management or professional jobs. Only 59 percent of service workers have access to sick leave compared with 92 percent of professional workers.<sup>303</sup> This means that workers without paid sick leave may go to work while they are ill and risk exposing their workplace and others to infectious diseases due to fear of losing pay or their job.

Paid sick leave is not provided equitably and some populations are less likely to have sick leave including, low-wage workers, working women, some racial and ethnic minorities, and employees with lower educational attainment. Disparities in access to paid sick leave

disproportionately exposes Black and Latino workers to increased risk of illness.<sup>304</sup> About 48 percent of Latino workers and 36 percent of Black workers reported having no access to paid leave in 2017-18.<sup>305</sup> Lack of access to paid sick leave can exacerbate existing health disparities by disproportionately exposing workers to illness and not allowing workers time off to recover if they do fall ill. Employees may go to work while they are sick because they fear workplace discipline or losing their job. Approximately one in four workers has reported losing their job or being threatened with job loss for needing to take a sick day.<sup>306</sup>

### Paid Family Leave

Currently, the United States is the only country in the Organisation for Economic Co-operation and Development that does not guarantee paid family leave to new parents.<sup>307</sup> The federal Family and Medical Leave Act (FMLA) provides eligible workers up to 12 weeks of unpaid leave to new parents, but no federal law requires private-sector employers to provide paid leave of any kind.<sup>308,309</sup> Even with FMLA, 44 percent of the workforce were not covered by the law in 2012, and part-time workers are excluded.<sup>310</sup> In 2020, only 20 percent of private-sector workers had access to paid family leave to care for a new child or a family member.<sup>311</sup> Working mothers who have little or no access to paid family leave must either take unpaid leave, quit their jobs, or return to work shortly after childbirth.<sup>312</sup>

Certain populations and types of workers are less likely to have access to paid family leave and significant disparities remain. For example, part-time and low-wage workers are less



likely to have access to paid family leave. Only 8 percent of the low-wage workers had access to paid family leave in 2020.<sup>313</sup> Research shows that even when family and medical leave is available, low-wage workers are less likely to take leave if it is unpaid.<sup>314</sup> Additionally, racial and ethnic disparities in access to paid family leave persist. Black and Hispanic workers are less likely than white, non-Hispanic workers to have access to paid family and medical leave.<sup>315</sup> Black and Latina women also are more likely to report being fired for taking leave after childbirth.<sup>316</sup> Overall, only 42 percent of private-sector workers had access to short-term disability insurance in 2020 to recover from an illness or injury.<sup>317</sup> Women can qualify for short-term disability as part of maternity leave to cover some wages.<sup>318</sup>

### Why are paid sick and family leave policies important?

As the number of COVID-19 cases increased at the start of the pandemic, Americans were urged to stay home if they or a loved one became ill. However, for too many Americans, this was not possible due to lack of access to paid leave. Without paid leave, workers were forced to choose between protecting their own health and their family's health or earning a paycheck to pay for necessities like food and housing during the pandemic. Inequitable access to paid sick leave and paid family leave meant workers employed in certain sectors were even more vulnerable to contracting the virus. In the case that workers did fall ill, without access to any paid leave, they were forced to choose between going to work sick or risk losing their job or pay. Even before the pandemic, about three in 10 adults were either unable to pay their bills or one modest



financial setback away from hardship, making it unrealistic for many workers to take unpaid leave to quarantine or take time to care for a loved one during an emergency.<sup>319</sup>

In response to the coronavirus pandemic, Congress passed the Families First Coronavirus Response Act (FFCRA) and the CARES Act, which provided some workers with short-term emergency paid leave.<sup>320</sup> The American Rescue Plan Act extended the paid sick leave and paid family leave tax credits created under the FFCRA, allowing employers to continue offering workers paid leave to care for themselves or a loved one.<sup>321</sup> Enacting federal emergency paid sick and family leave at the start of the COVID-19 emergency was a step forward in expanding access to leave for more workers to isolate and quarantine when necessary. However, Americans still need a permanent paid leave solution to protect against future public health emergencies and to address their own family and medical needs.

### What are the health benefits of paid sick and family leave policies?

#### Paid Family Leave

- **Improves infant health:** Paid family leave policies reduce the likelihood of having low-birthweight babies and pre-term births.<sup>322</sup> Evidence from other developed nations shows that paid parental leave policies are associated with lower infant and child mortality, with longer leave associated with lower mortality.<sup>323,324,325</sup> It is estimated that providing 12 weeks of job-protected paid leave in the United States would result in nearly 600 fewer infant and post-neonatal deaths per year.<sup>326</sup> Paid family leave can also contribute to longer periods of breastfeeding. In New Jersey, new mothers who used the state paid leave program, on average, breastfed one month longer than those who did not use the program.<sup>327</sup> When new parents take paid family leave, they can take time to breastfeed their new child, attend well-child medical visits, and ensure children are vaccinated.



- **Improves maternal health:** Paid family leave can also positively impact parental health by lowering prenatal and postpartum stress, allowing parents time to bond with their new child and mothers to physically recover from childbirth.<sup>328</sup> Access to paid family leave can lead to better maternal mental health outcomes. Mothers who have a longer delay returning to work after giving birth may have fewer depressive symptoms and better mental health compared with mothers who return to work earlier.<sup>329,330</sup> Each week of paid leave up to 12 weeks can help reduce the odds of a new mother experiencing symptoms of postpartum depression.<sup>331</sup>

#### **Paid Sick Leave**

- **Decreases spread of infectious disease:** Access to paid sick leave can decrease the spread of infectious diseases in the workplace because fewer people attend work while sick.<sup>332</sup> People without paid sick days (55%) are more likely to go to work with a contagious illness like the flu or a viral infection compared with workers with paid sick leave (37%).<sup>333</sup>
- **Improves access to care:** Workers without paid sick days are also more likely to delay or forgo medical care, meaning minor health problems can lead to more serious cases and more costly visits.<sup>334</sup> When workers do not have access to paid sick leave, they are less likely to use preventive healthcare services like cancer screenings, annual physicals, and flu shots.<sup>335,336</sup> In jurisdictions with paid sick days the flu rate decreased by 5.5 to 6.5 percent after implementation.<sup>337</sup>

## **What are the economic benefits of paid leave policies?**

### **Paid Family Leave**

Because the United States does not have a comprehensive paid family leave law, many new parents must choose between caring for a new child and economic security. Access to paid leave gives new parents and caregivers time to search for childcare accommodations that meet their family needs, facilitating greater productivity when they return to their jobs. Paid family leave also gives parents time to address their child's early medical needs, further reducing the likelihood of infant mortality and childhood illness, resulting in lower health expenditures.<sup>338</sup>

- **Increases employee retention:** Offering employees paid family leave can benefit businesses by increasing employee retention and saving employers money through reduced turnover costs.<sup>339</sup> Replacing workers costs approximately 20 percent of an employee's annual salary.<sup>340</sup> Among new mothers, the likelihood of being employed nine to 12 months post-partum was higher among new mothers who had taken paid leave compared with mothers who did not take any leave.<sup>341</sup> This may suggest that paid family leave strengthens women's workforce attachment and workforce stability, because they remain employed before and after birth.<sup>342</sup> Additionally, first time mothers who take paid leave are more likely to return to the same employer compared with those who took unpaid leave or no leave at all.<sup>343</sup>
- **Increases employee productivity:** Offering employees paid leave can also increase worker productivity.<sup>344</sup> An evaluation of California's paid leave

program found that nearly 90 percent of businesses surveyed found the program had either a positive or no noticeable effect on productivity.<sup>345</sup>

### **Paid Sick Leave**

- **Improves financial stability for workers:** Paid sick leave policies allow employees to recover from illness without jeopardizing their financial stability, and the cost to employers is minimal. Without paid sick leave, on average, 2.7 days of pay lost due to illness are equivalent to a family's entire grocery budget for the month.<sup>346</sup>
- **Reduces absenteeism and presenteeism:** Allowing employees to take paid sick leave also saves employers the cost of replacing an employee and lost productivity due to presenteeism. Presenteeism, or going to work sick, costs the national economy an estimated \$160 billion annually, or \$234 billion (adjusted for inflation).<sup>347</sup> After implementing paid sick leave laws, employers have reported no impact on their profitability or increased growth. When Connecticut enacted its paid sick leave law, the majority of employers saw minimal effects on costs and made no changes such as increased prices or a reduction in employee hours.<sup>348</sup>

### **Where have paid leave policies been implemented?**

#### **Paid Family Leave**

The United States has yet to adopt a national paid family leave policy, however some progress has been made to expand access for some federal workers. The Federal Employee Paid Leave Act, which took effect in October 2020, grants eligible employees 12 weeks of paid parental leave following the birth, fostering, or adoption of a child.<sup>349</sup>

As of January 2021, nine states and the District of Columbia have paid family leave laws.<sup>350</sup> Across states, policies differ in the length of time workers can take, generally ranging from four to 12 weeks of leave.<sup>351</sup> The funding methods for the state paid leave policy via employer and/or employee contributions also differ among states, as do details on the size of the employer covered by the policy.<sup>352,353</sup> There is also variation in the definition of a family member, which affects workers ability to use paid family leave for caregiving responsibilities for parents or other relatives.<sup>354</sup>

Additionally, some states protect a worker's job during their paid family leave, while other states do no more than the FMLA requires.<sup>355</sup>

#### **Paid Sick Leave**

Currently, there is no federal paid sick leave law in place. As of March 2021, 14 states and the District of Columbia have implemented paid sick leave laws.<sup>356</sup> Across states, eligibility requirements, employer size, how and when an employee may use their time, and rate of leave accrual all vary. At the local level, 19 cities and three counties have enacted paid sick days (as of March 2021).<sup>357</sup> While these cities and municipalities enacted their own paid sick leave laws, many are not able to do so due to state preemption policies. Currently, 22 states have laws in place that prohibit local governments from requiring employers to provide earned sick leave for workers.<sup>358</sup>

There is a high degree of variation across state and local paid sick leave laws. Policies differ in the maximum length of paid sick leave, generally ranging between 40 and 50 hours per year, the eligibility requirements for the program, who is covered by the policy, rate of accrual, and waiting periods.<sup>359</sup>

## KEY CONSIDERATIONS AND POLICY RECOMMENDATIONS<sup>360,361,362</sup>

The current patchwork of federal, state, and local laws along with voluntary employer policies creates a high degree of variation in paid leave policies.

Paid sick leave and paid family leave policies differ in terms of eligibility requirements, employer size, how and when an employee may use their time, and rate of leave accrual.

### All Paid Leave Laws

**Provide flexibility to employers** to use existing policies as long as they meet the minimum requirements as required by law.

**Allocate resources to conduct outreach and increase awareness activities.** Allocate funding to conduct outreach and awareness activities to inform workers of their rights. Ensure that activities are culturally and linguistically appropriate, focused on low-income workers, people of color, and other populations that are less likely to utilize leave when available for fear of retaliation.<sup>363</sup>

### Paid Family Leave

**Offer workers 12 weeks of paid leave** to care for a new child, care for a family member with a serious health condition, or to care for their own health condition or disability.

- Congress should pass a comprehensive national paid family leave law, such as the FAMILY Act, to allow workers to take time off to care for a new child or to address their own serious medical condition or that of a family member.
- In absence of a national paid family leave law, states can pass their own paid family leave legislation.
- States should repeal preemption laws that current prohibit localities from adopting their own paid leave laws.

- States and localities can also offer protections for employees with school-age children to enable them to attend parent-teacher conferences and school-related activities.<sup>364,365</sup>
- Localities should adopt their own paid leave laws if a state law is not already in place and they are not preempted from doing so.

**Include nondiscrimination provisions** in paid family leave and job-protection laws, beyond what is required in FMLA, to ensure employees do not face retaliation or job loss for taking paid family leave.

- If a state already has a paid family leave law in place, the law can be further strengthened by adopting stricter nondiscrimination and job-protection laws.

### Define eligibility requirements.

- Federal policymakers should broaden the definition of “family members” to include domestic partners, siblings, grandparents, grandchildren, or parent-in-laws to reflect caregiving needs and responsibilities.
- States can also adopt a broad definition of “family members,” beyond what is included in the FMLA, and expand eligibility to part-time and low-income workers to make paid family leave more accessible to workers.

**Support a high-wage replacement rate,** or the amount of wages replaced while a worker is on leave.

- Federal and state policymakers should consider workers’ income compared with the average weekly wage and adjust wage replacement rates as needed. Higher wage replacement rates would provide greater supports

to low-income workers, who may be unable to take paid leave if the wage replacement rate is too low.

### **Paid Sick Leave**

**Encourage all employers to offer at least 7 days of voluntary job-protected paid sick leave**, regardless of size and number of employees. During public health emergencies, employers should provide more leave to comply with public health guidance.

- Congress should pass a comprehensive national paid sick leave law, such as the Healthy Families Act, to allow workers to address their own medical needs or to care for a sick family member.
- In absence of a national paid sick leave law, states can pass their own legislation.
- States should allow localities to adopt their own paid sick leave laws if they are currently preempted from doing so by state law.

**Include nondiscrimination provisions** in paid sick leave and job-protection laws to ensure employees do not face retaliation or job loss for taking paid sick leave.

- If a state already has a paid sick leave law in place, the law can be further strengthened by expanding employee eligibility and adopting stricter nondiscrimination and job-protection laws.

**Define eligibility requirements.** Define which types of employers are required to provide paid sick leave. Also consider how, when, and what type of employees will be eligible for sick leave benefits. Consider financial eligibility requirements, wages earned, and hours worked when accruing leave.

- States can adopt a broad definition of “family members” and expand eligibility to part time and low-income workers can make paid leave more accessible to workers.
- If certain businesses or workers are exempt, consider allowing employees working for exempt businesses (for example, those below the minimum number-of-workers threshold) to earn job-protected, unpaid sick time, unless their employers choose to offer paid sick days.



### **EXAMPLE: NEW YORK**

New York has enacted one of the most generous paid sick leave policies in response to COVID-19. On March 18, 2020, New York state enacted legislation authorizing sick leave for employees subject to mandatory or precautionary order of quarantine or isolation.<sup>366</sup> The law provides paid and unpaid sick leave with access to temporary disability and full job protection upon return from leave.<sup>367</sup> Eligible employees began accruing sick leave as of September 20, 2020, and were able to access their accrued sick leave on January 1, 2021.<sup>368</sup> The amount of sick leave is determined by an employer’s size and net income in a given year. The law requires employers with five or

more employees—or net income of more than \$1 million—to provide at least five days of job-protected paid sick leave.<sup>369</sup> Employers with four or fewer employees and a net income less than \$1 million must provide up to 40 hours of unpaid sick leave.<sup>370</sup> Large employers, those with 100 or more employees, must provide at least 56 hours of job-protected paid sick leave.<sup>371</sup> All private-sector workers in New York state are now covered under the state’s new Paid Sick and Safe Leave law, regardless of industry, occupation, part-time status, overtime exempt status, and seasonal status. The robust law is one example of how states can increase access to paid sick leave and protect workers against infectious diseases.

## 4

## Ensuring Access to Affordable Housing

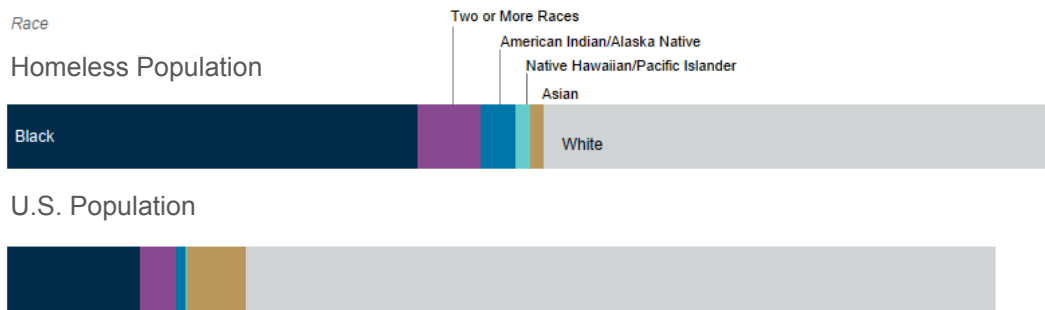
Despite a growing economy, far too many people in the United States do not have access to safe and affordable housing. Decades of research has firmly established the connection between health and housing.<sup>372</sup> When people have access to safe, quality, affordable housing, they tend to have better health outcomes.

When the COVID-19 pandemic hit, the virus posed a new threat to an already vulnerable population. States and localities issued stay-at-home orders to slow the spread of the novel coronavirus, but following these orders was nearly impossible for people experiencing homelessness or housing insecurity. Housing insecurity involves various challenges, including overcrowding, trouble paying rent, housing cost burden, evictions, and other circumstances that contribute to unstable housing.<sup>373</sup> Homelessness is defined as lacking a regular nighttime residence or having a primary nighttime residence that is a temporary shelter or other place not designed for sleeping.<sup>374</sup> According

to the U.S. Department of Housing and Urban Development's Annual Point-in-Time count, there were approximately 580,466 individuals experiencing homelessness on a single night in 2020.<sup>375</sup> People of color make up a larger share of the homeless population compared with their share of the general population.<sup>376</sup> For example, African Americans represent 13 percent of the general population, but are 39 percent of people experiencing homelessness.<sup>377</sup> Even worse, a viral infection like COVID-19 can spread rapidly among people living in group settings such as homeless shelters. If infected, homeless individuals are left with few options to self-isolate to recover and avoid infecting others.

### Most Minority Groups Make up a Larger Share of the Homeless Population than They Do of the General Population

Race and ethnicity of those experiencing homelessness as compared with the general population



Homeless population data are for a given night in 2020.  
Source: Annual Homeless Assessment Report to Congress, Part 1, 2021.

Source: National Alliance to End Homelessness<sup>378</sup>

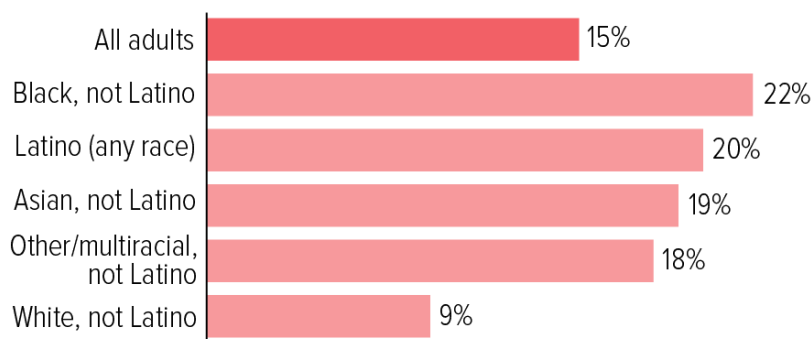


Further compounding housing issues is the unemployment rate; more people are experiencing financial hardship as a result of the public health emergency. This has put some households in a position where they

are unable to pay their rent or other bills, putting them at risk of getting evicted and entering homelessness. Low-income workers were more likely to lose income during the pandemic and fall behind on rent.<sup>379</sup>

### Over 1 in 7 Renters Not Caught Up on Rent During Pandemic With Renters of Color Facing Greatest Hardship

Share of adult renters saying their household is not caught up on rent



Note: Other/multiracial, not Latino = people identifying as American Indian, Alaska Native, Native Hawaiian or Pacific Islander, or more than one race. Chart excludes renters who did not respond to the question.

Source: CBPP analysis of Census Bureau Household Pulse Survey tables for March 17-29, 2021

Source: Center on Budget and Policy Priorities<sup>380</sup>

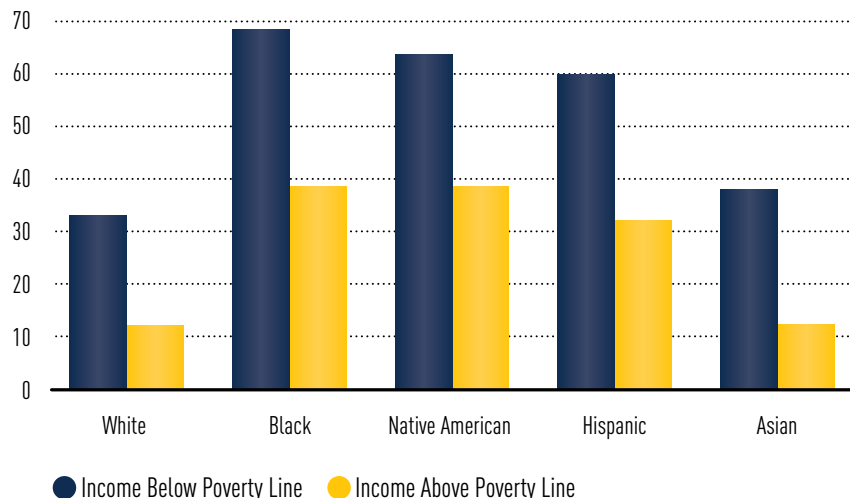
A federal evictions moratorium has been in effect since March 2020. The CARES Act established a narrow set of eviction protections, and the CDC imposed a nationwide temporary moratorium on residential evictions for nonpayment of rent.<sup>381</sup> Some states and local governments placed additional moratoriums on evictions and foreclosures.<sup>382</sup> However, rent and mortgage payments are still due, and once protections are lifted, people will need to pay their missed rent and mortgages.

Prior to the pandemic, lack of access to affordable housing, rising housing costs, and stagnant wages increased the financial burden for families, especially low-income workers.<sup>383</sup> Additionally, poor-quality housing conditions, such as poor insulation, lead paint,

or mold pose safety hazards that can impact health.<sup>384,385</sup> Lower-income families are especially vulnerable to unhealthy housing conditions.<sup>386,387,388</sup> Approximately 20.4 million renters were already cost-burdened and paying over 30 percent of their income for housing before the pandemic.<sup>389</sup> People of color and low-income families were particularly rent-burdened and faced housing instability.<sup>390,391</sup> About 54 percent of Black renters and 52 percent of Hispanic renters were cost-burdened, more than 10 percentage points higher than that of white renters.<sup>392</sup> These disparities were made worse by the economic impact of the pandemic. In September 2020, 23 percent of Black, 20 percent of Hispanic, and 19 percent of Asian renters were behind on their rents, or about twice the 10 percent share of white renters.<sup>393</sup>

## People of Color Are More Concentrated in High-Poverty Neighborhoods than White People with Similar Incomes

Share of Population Living in Census Tracts with 20% or Higher Poverty (Percent)



Source: Joint Center for Housing Studies of Harvard University<sup>394</sup>

Structural racism and discrimination in housing and lending practices have shaped current housing and neighborhood characteristics, which affect health outcomes.<sup>395,396</sup> For example, redlining practices and racial covenants that barred certain racial and ethnic groups from buying property in particular neighborhoods contributed to contemporary patterns of racial segregation.<sup>397,398</sup> While discriminatory redlining practices and covenants are no longer enforceable, the impact of such policies helped shape current racial wealth and health disparities. Research shows that residential segregation is a cause of racial disparities in health.<sup>399</sup> Evidence also suggests that segregation is a primary cause of racial differences in

socioeconomic status by determining access to education, employment, and affordable housing opportunities.<sup>400,401</sup>

Policymakers should support policies and programs that help reduce residential segregation, increase housing affordability, and reverse the negative health impacts of structural racism and discrimination in the housing market. The three policies identified in this report support access to affordable housing by increasing the supply of affordable housing units, providing financial supports to families to reduce their housing cost burden, and providing essential tenant protections to help families stay in affordable housing after they have found it.

## POLICY: Low-Income Housing Tax Credits

### What are Low-Income Housing Tax Credits?

The Low-Income Housing Tax Credit (LIHTC) program was created by the Tax Reform Act of 1986 and is the largest driver of new affordable housing units in the United States.<sup>402</sup> The LIHTC program was created to provide tax incentives to encourage developers to build affordable housing. The LIHTC program provides state and local LIHTC-allocating agencies about \$8 billion in annual budget authority to issue tax credits to support the acquisition, rehabilitation, or new construction of rental housing for lower-income households.<sup>403</sup>

States utilize Qualified Allocation Plans (QAP) to distribute LIHTC funds to developers. The QAP is a document that the state and some local agencies must develop that outlines their housing finance agency's priorities and the criteria it will use to select projects competing for tax credits.<sup>404</sup> The QAP must give preference to projects that serve residents with the lowest income for the longest period of time.<sup>405</sup>

Developers who are awarded the LIHTCs sell the credits to investors to create cash equity, which provides a portion of the funds needed to build affordable housing.<sup>406</sup> Developers building housing agree to rent a certain percentage of units at an affordable rate below the market standard, called a use restriction. Developers can choose among the following use restrictions:<sup>407,408</sup>

- At least 20 percent of occupied units are to be occupied by tenants at less than 50 percent of the Area Median Income (AMI); or

- At least 40 percent of units are occupied by tenants at less than 60 percent AMI.
- At least 40 percent of the units are occupied by tenants with income averaging no more than 60 percent of AMI, and no units are occupied by tenants with income greater than 80 percent of AMI.

Units typically must remain affordable for at least 30 years. Once the housing project is complete and in use, the investors can claim the LIHTC over a 10-year period.<sup>409</sup>

### Why are LIHTCs important?

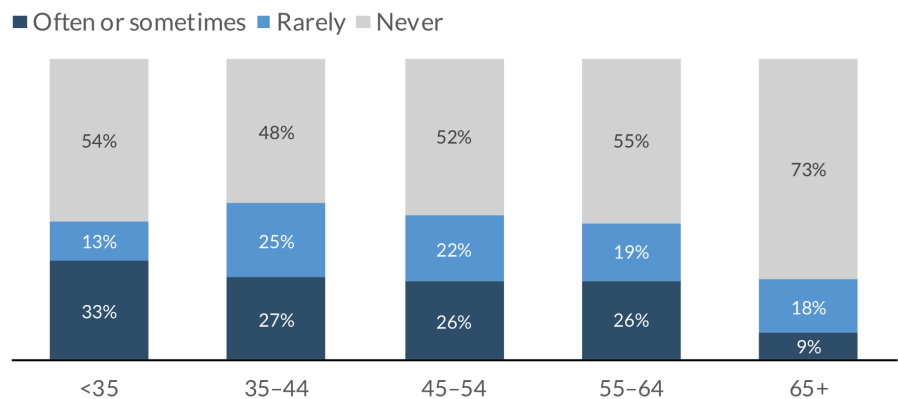
Since the LIHTC program started, approximately 3 million quality homes have been developed to serve working families, older adults, people with disabilities, and people at risk of homelessness.<sup>410</sup> Each year about 110,000 rental units have been constructed or rehabilitated to create more affordable housing in communities.<sup>411</sup> Despite this

progress, the demand for affordable housing remains high.

Prior to the COVID-19 pandemic, low-income renters were already cost-burdened. Before the pandemic, people of color were already disproportionately renters and reported more difficulty paying rent compared with their white counterparts. One-third of Black households reported they often or sometimes had trouble paying rent, which was 8 percentage points higher than white households.<sup>412</sup> It is estimated that only 57 rental units are affordable and available for every 100 very low-income renters. For extremely low-income renters (earning less than 30 percent of area median), only 36 units are affordable and available for every 100 households.<sup>413</sup> Shutdowns and layoffs stemming from the coronavirus pandemic created more economic hardship for low-income families. Low incomes, lack of affordable housing options, and economic insecurity put these families at higher risk of losing their homes.

### Young People Across the Country Have More Difficulty Paying Rent (2019)

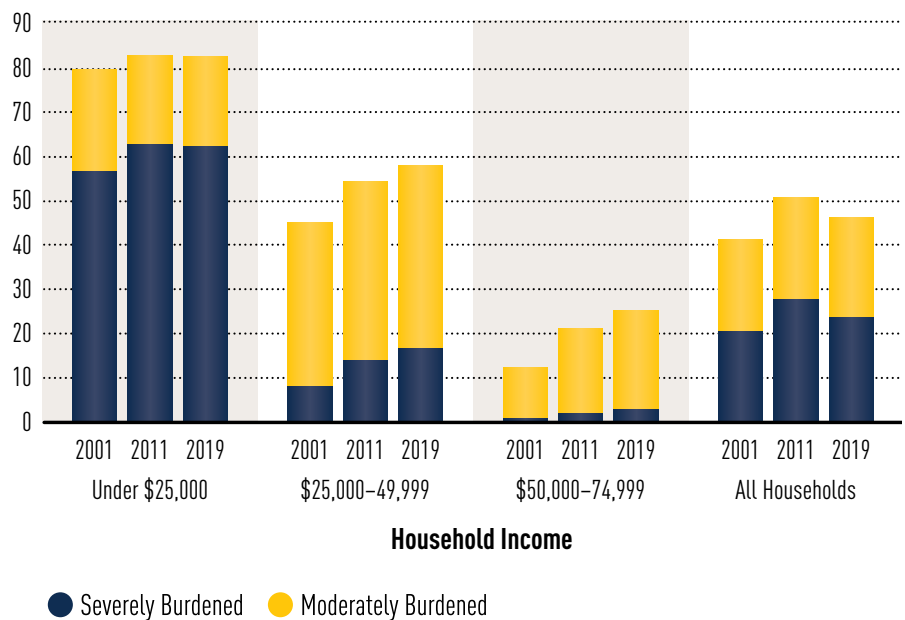
By Age



Source: Urban Institute<sup>414</sup>

## Heading Into the Pandemic, Renter Cost Burden Rates Were Already High and Moving Up the Income Scale

Share of Renter Households with Cost Burdens (Percent)



Source: Joint Center for Housing Studies of Harvard University<sup>415</sup>

### What are the health benefits of LIHTCs?

Housing is deemed affordable when a family spends less than 30 percent of their income to rent or buy their housing.<sup>416</sup> Lack of affordable housing options can create serious financial strain for families and inhibit their ability to meet other essential expenses, like food and medications.<sup>417</sup> Low-income families who face difficulty in paying their rent or mortgage are less likely to have a usual source for medical care and are more likely to postpone needed medical treatment or use the emergency room for treatment compared with those who are less cost-burdened.<sup>418,419</sup>

**Increases discretionary income for low-income families:** New York City families living in affordable housing financed by LIHTCs had double the discretionary income of their neighbors living in high-cost housing, allowing them to spend on health insurance, education, or save to buy a home.<sup>420</sup>

**Increases access to quality, affordable housing:** Low-income housing tax credits, in addition to housing vouchers, can help increase access to quality, affordable housing for families with low and moderate incomes.<sup>421,422,423</sup> LIHTCs are a strategy that can be used to incentivize the development of affordable housing options to minimize the displacement of low-income residents in areas experiencing recent improvements and gentrification.<sup>424</sup> Additional research is needed to confirm the long-term effects of successful LIHTC efforts.

### What are the economic benefits of LIHTCs?

**Promotes economic mobility:** A survey of LIHTC recipients in California found that 90 percent of residents interviewed said they could easily access public transportation, which improved their proximity to jobs. Approximately 58 percent of respondents were employed, and

among those who were unemployed the majority were either retired, disabled, a stay-at-home parent, or a student.<sup>425</sup> Only 17 percent reported being unable to find a job.<sup>426</sup> Over one-third of respondents had an economic mobility strategy, such as learning English or going back to school, and attributed their ability to develop plans to their rent stability.<sup>427</sup> Instead, employed residents noted the inability to find jobs that pay a living wage was a barrier to finding affordable housing in the private market despite earning above the national poverty rate.<sup>428</sup>

**Increases access to affordable housing for low-income households:** Reducing the rent burden for low-income residents allows them to spend their income on other necessities or save for educational expenses or homeownership.<sup>429</sup> Approximately 45 percent of tenants in LIHTCs have extremely low incomes, and LIHTCs can be modified to more adequately meet the needs of low-income households.<sup>430,431</sup>

**Promotes local economic activity:** LIHTCs can promote economic activity at the local level, including new income and jobs for residents, and revenue for local governments. The economic impacts continue beyond the construction of new housing units as residents pay taxes and purchase goods and services in the community. An economic impact analysis of LIHTCs in Denver estimated that the impact of building 615 LIHTC apartments would result in \$57.6 million in local income, \$5 million in taxes and revenue for local governments, and 732 local jobs in the first year. Annual recurring impacts would include \$16.7 million in local income, \$2.3 in taxes and local revenue, and 192 local jobs.<sup>432</sup>

## KEY CONSIDERATIONS AND POLICY RECOMMENDATIONS<sup>433,434,435</sup>

### Increase the supply of affordable housing and maintain access to existing affordable housing.

- Congress should pass legislation that supports financing of LIHTCs, such as the Affordable Housing Credit Improvement Act, to ensure long-term housing affordability for homeless and low-income families, encourage development in tribal communities, and facilitate development in rural America.<sup>436</sup>
- Federal policymakers should increase LIHTC allocations by 50 percent, phased in over five years, to help meet the growing need for affordable housing.<sup>437</sup> Special considerations should be taken for hard-to-reach communities, including rural, Native American, high-poverty/high-cost communities, and extremely low-income tenants.
- Federal policymakers should increase funding for and expand access to rental-assistance programs to help low-income families afford LIHTC housing in places where the median income is high. LIHTC developments are required to set rents at levels according to the median income; however, for families with income at or below the poverty line, the rents for LIHTC units may still require families to spend high shares of their income.<sup>438</sup>
- States should repeal policies that preempt cities and localities from building affordable housing units to increase the supply of affordable units and meet the needs of low-income and working families.<sup>439</sup>

**Prioritize projects that offer renters more affordable housing.** For LIHTCs, developers are required to adopt use restrictions and agree to rent units at an affordable rate. State housing finance agencies can require or give preference to projects with deeper subsidies.

**Require long-term housing affordability.** Most LIHTC properties must keep their use restriction in place for at least 30 years, guaranteeing their units will remain affordable for tenants. States may require the developments maintain the use agreements beyond 30 years.<sup>440</sup>

**Incentivize projects that reflect community needs.** Each state housing finance agency must review and revise their QAPs, which outline criteria and eligibility requirements to evaluate projects and priorities. During the revision process, the public may advocate for the inclusion of specific criteria. These criteria help to determine tax credit allocations that incentivize housing developers to create housing.

- State housing finance agencies can target tax credits through the QAP selection process to give preferences to projects that serve particular populations or locations. They can also establish a set-aside, reserving a percentage or dollar amount of any year's tax credit allocation for projects intended to serve a population or location, such as allocating funding for projects in rural communities.<sup>441</sup>



- Localities, advocates, and the public should use the QAP public hearing and comment requirements to convince their state housing finance agency to target tax credits and encourage LIHTC developments in high-opportunity areas. The QAP can mitigate the concentration of poverty by prioritizing projects that propose building developments in low-poverty areas, close to high-performing schools, or access to jobs.<sup>442 443</sup>

**Prioritize health-promoting projects.**

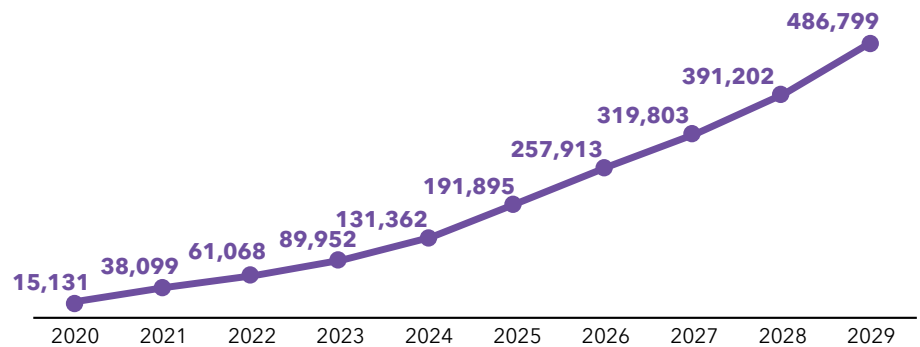
LIHTCs properties can prioritize health by being built near specific health-

promoting resource and services, in low-poverty or higher-opportunity communities, or by using construction materials that are nontoxic and/or environmentally friendly.<sup>444</sup>

**Where have LIHTCs been implemented?**

LIHTCs have been implemented in all 50 states and the District of Columbia.<sup>445</sup> However, over the coming years, a number of LIHTC units will lose their affordability restrictions and potentially push out low-income renters out of their homes.<sup>446</sup>

**Cumulative Count of LIHTC Units Losing All Affordability Restrictions (2020-2029)**



Source: NLIHC and PAHRC<sup>447</sup>



**EXAMPLE: ANNAPOLIS, MARYLAND**

The Residences at Wiley H. Bates Heritage Park in Annapolis, Maryland, is now a multi-use complex that was converted from a previously vacant high school.<sup>448</sup> In 2005, developers created a 71-unit independent living facility for older adults out of the former classroom buildings. The developers used private and public funding sources to finance the project, including the 9 percent LIHTC.<sup>449</sup> The project was also supported by a Section 8 contract for all 71 apartment units and included 36 units restricted for individuals earning up to 40 percent of the area median income.<sup>450</sup> An additional 35 units are restricted to residents earning 50 percent of the area median income.<sup>451</sup>

## POLICY: Housing Choice Vouchers

### What are housing choice vouchers?

The Housing Choice Voucher Program is a federal government program that assists very low-income families, older adults, and people with disabilities to afford safe, decent housing in the private market.<sup>452</sup> Program participants can choose any housing that meets the requirements of the program and are not limited to subsidized housing units.

### Why are housing choice vouchers important?

The Housing Choice Voucher Program is the nation's largest rental-assistance program, helping more than 5 million people in 2.2 million households afford housing.<sup>453</sup> Approximately 70 percent of voucher recipients are families, helping 1 million families with 2.2 million children afford housing. Despite helping millions, seven in 10 low-income U.S. households still pay too much of their income in rent and do not receive a voucher to assist with the cost of housing.<sup>454</sup>

The health and economic impacts of COVID-19 have magnified the housing affordability crisis. Data from the September 2020 Census Bureau's Household Pulse Survey found that since the March 2020 COVID-19 shutdown, renters earning less than \$25,000 a year were much more likely to report lost employment income.<sup>455</sup> Fifty-two percent of the lowest-income renters lost wages compared with 41 percent of all households.<sup>456</sup> About one in five renters earning less than \$25,000 a year reported that they were behind on rent, compared with 15 percent of all renters and 7 percent of renters earning more than \$75,000.<sup>457</sup> While the economic impact payments helped provide some temporary relief, the drop in employment income disproportionately affected Hispanic, Black, and Asian



households. Approximately, 54 percent of Hispanic households, 48 percent of Black households, and 42 percent of Asian households reported income losses compared with 37 percent of white households.<sup>458</sup>

### What are the health benefits of the Housing Choice Voucher Program?

- **Neighborhood improvements:** There is evidence that the Housing Choice Voucher Program can help families move to higher-quality neighborhoods, improve neighborhood socioeconomic diversity, and reduce homelessness, family separations, and exposure to crime.<sup>459,460,461,462</sup> Additional research is needed to confirm the long-term effects of the program.
- **Improves behavioral health:** In the short term, participation in the Housing Choice Voucher Program can reduce psychological distress as well as alcohol and drug use among adults. Participation was also associated with reduced intimate partner violence.<sup>463</sup>
- **Reduces concentrated poverty:** Studies suggest that participation in the Housing Choice Voucher Program can help reduce concentrated poverty and overcrowding.<sup>464</sup> Recipients can

move to neighborhoods where fewer people live in poverty, fewer households receive public assistance, more people have higher rates of employment, and more residents have higher educational attainment.<sup>465,466</sup> Some studies suggest that recipients may also move to neighborhoods with better quality schools for their children.<sup>467,468</sup>

- **Improves educational outcomes for children:** For children participating in the program, there were reductions in school absences and behavioral issues.<sup>469</sup> There is also evidence suggesting that among Housing Choice Voucher Program recipients, children who move before the age of 13 are more likely to attend college and reside in better neighborhoods as adults and less likely to become single parents compared with children who move after age 13.<sup>470</sup>

### What are the economic benefits of housing choice vouchers?

- **Reduces healthcare and housing costs:** Housing vouchers can reduce healthcare spending.<sup>471</sup> Vouchers can provide recipients with fixed housing costs, eviction protections, and better-quality housing.<sup>472</sup> Policies that provide recipients with housing search assistance may also reduce residential segregation and increase upward mobility.<sup>473,474</sup> Offering counseling to recipients before and after their move, housing search assistance, landlord engagement, and short-term financial assistance can all help voucher recipients adjust to their new neighborhoods.<sup>475,476,477</sup> The Housing Choice Voucher Program can also reduce costs to emergency shelters, promote child welfare, and reduce the use of care facilities for older adults or people with disabilities.<sup>478</sup>

## KEY CONSIDERATIONS AND POLICY RECOMMENDATIONS<sup>479</sup>

**Increase access to meet the current need of eligible applicants.** Eligibility is currently determined by the public housing agencies based on the total annual gross income and family size and is limited to U.S. citizens and those with an eligible immigration status. The demand for housing assistance often exceeds resources and long waiting periods and waiting lists are common.<sup>480</sup>

- Congress should increase funding for the Housing Choice Voucher Program and make rental assistance available to all income-eligible households in need.<sup>481</sup> More funding would increase the number of available vouchers for applicants, some of which have been on long waiting lists.<sup>482</sup> Expanding vouchers to all who are eligible would benefit the 24 million people in low-income renter households, including 8 million children, 3 million older adults, and 4 million people with disabilities.<sup>483</sup>
- States and cities can create or expand their own emergency rental assistance programs.
- States and cities can establish housing trust funds, a flexible source of funding to support affordable housing activities, like providing rental assistance, constructing affordable housing, or repairing homes for older adults.<sup>484</sup> By further incentivizing the development of affordable housing, states and cities can increase the housing stock of units affordable to individuals and families using housing choice vouchers.

- States should implement strategies to improve the availability and location of housing stock for use in voucher programs. Expanding participation of landlords in high-opportunity areas via tax incentives can improve educational outcomes and future earnings for children whose families participate in housing voucher programs.

- Local housing programs should recruit landlords continuously, regardless of their current housing needs, to ensure future availability.

### **Provide additional housing-related supports and services.**

- States should allocate funds for rent and move-in assistance to help individuals secure a place to live. Medicaid funds can also be used to support housing-related services and supports for people with complex needs, including assisting individuals with preparing and transitioning into housing.<sup>485</sup>

- Case management should be provided to help individuals secure and maintain housing.

**Incentivize use of housing vouchers in high-opportunity areas.** Median income levels vary by location and the public housing authority calculates the maximum amount of assistance allowable—generally the lesser of the payment standard minus 30 percent of the family’s monthly adjusted income or the gross rent minus 30 percent of monthly adjusted income.

- Federal policymakers should create incentives to achieve better location outcomes. Federal policy should provide incentives for agencies to reduce the share of families using vouchers in extreme-poverty areas and increase the share residing in low-poverty, high-opportunity areas. This can be done by rewarding agencies that help families move to high-opportunity areas or adding weight to location outcomes when measuring agency performance.
- The U.S. Department of Housing and Urban Development should require agencies to identify available units in higher-opportunity areas with less poverty, extend the search period for families, and set caps on rental subsidy amounts for smaller geographic areas to more accurately reflect fair market rates of rent.

**Prohibit source-of-income discrimination.** Source-of-income nondiscrimination policies protect tenants against discrimination based on being a housing voucher holder.

- States and localities should adopt tax incentives and laws prohibiting discrimination against housing voucher holders.

### Where have housing choice vouchers been implemented?

At the federal level, the U.S. Department of Housing and Urban Development provides funds to each state for the Housing Choice Voucher Program. The vouchers are then administered locally by public housing agencies.<sup>486</sup>

Some states and localities have adopted antidiscrimination laws that prevent landlords from engaging in source of income discrimination, which includes discrimination against Housing Choice Voucher Program recipients. As of December 2019, 12 states and 87 cities or counties had laws in effect that protect voucher holders from discrimination by landlords.<sup>487</sup>



### EXAMPLE: BALTIMORE, MARYLAND

Local programs may offer recipients additional support and assistance trying to move to a higher-opportunity neighborhood. The Baltimore Housing Mobility Program (BMP) offers voucher recipients a higher payment standard, an intensive counseling process, and security deposit assistance; it also requires that participants move to a low-poverty, mixed-race neighborhood for at least one year.<sup>488</sup> BMP has served over 5,200 families, with 72 percent living in high-opportunity areas.<sup>489</sup>

## **POLICY: Legal supports for tenants in eviction proceedings**

### **What are legal supports for tenants in eviction proceedings?**

Unlike criminal defendants, tenants do not have a constitutional right to counsel in housing court or rent court where landlords and tenants resolve disputes.<sup>490</sup> Policymakers can adopt policies to ensure that low-income tenants have full legal representation or receive some legal assistance from an attorney or paralegal in eviction proceedings.<sup>491</sup> Legal assistance can include instruction on the summary eviction process, assistance in completing and filing paperwork, and assistance in preparing tenants to represent themselves in court.<sup>492</sup>

### **Why are legal supports for tenants important?**

The causes of homelessness are multifaceted, but one contributing factor is loss of tenancy, or eviction.<sup>493</sup> For those facing eviction, data suggest that up to 80 percent of tenants do not have legal representation for eviction proceedings.<sup>494</sup> On the other hand, in some housing courts, 85 to 90 percent of landlords arrive with legal counsel.<sup>495</sup>

When both tenants and the landlord have legal counsel, there is a more equitable opportunity for both parties to reach an agreement where tenants can stay in their homes and avoid having an eviction on their record. Evictions are difficult for both landlords and tenants. Having an eviction on record can make it more difficult for a tenant to acquire future housing. Sometimes, landlords and tenants can reach an agreement before ending up in court. Evictions can be expensive for landlords who may go at least a month without rent payments, and even longer depending on how

long it takes to screen new tenants.

The lack of legal services for tenants with low incomes facing evictions disproportionately impacts racial and ethnic minorities, women, and immigrants.<sup>496,497</sup> A study on discrimination in evictions found that among tenants at risk of eviction, Hispanic tenants in predominantly white neighborhoods were twice as likely to be evicted compared with Hispanic tenants in non-white neighborhoods. Hispanic tenants were also more likely to get evicted when they had a non-Hispanic landlord.<sup>498</sup> Another study found that filing and eviction rates were higher for Black renters than for white renters. In their sample, Black renters made up 19.9 percent of all adult renters and 32.7 percent of all eviction filings, whereas white renters were 51.5 percent of adult renters but received 42.7 percent of eviction filings.<sup>499</sup> Providing legal support to tenants can help prevent evictions, especially for populations that have been historically marginalized and are disproportionately affected.<sup>500</sup>

During the coronavirus pandemic, renters were faced with both health and economic challenges. As people lost their jobs, renters were left with the challenge of paying rent and an increased risk of being evicted from their home during the pandemic. Some states and localities, in addition to the federal government, took steps to keep people experiencing financial stress in their homes by placing moratoria on evictions and foreclosures. However, a patchwork of responses at the state and local levels, coupled with uncertainty of the legality of the federal moratorium, left renters vulnerable depending on what laws applied to them. Initially,



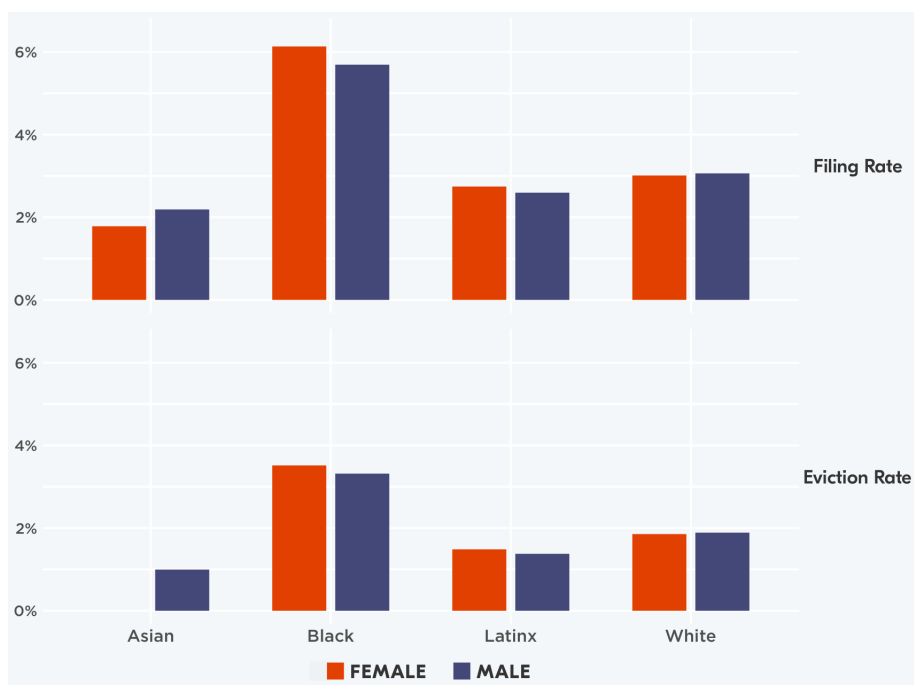
federal actions to halt evictions only applied to some tenants and were eventually extended to cover more households. However, rent is still accumulating, and households are still at risk of being evicted from their homes when the moratoria are lifted.

### How do legal supports for tenants in eviction proceedings impact health?

- **Reduces negative health impacts**

**of evictions:** Tenant evictions are a contributor to homelessness, which can negatively impact a person’s physical and mental health.<sup>501</sup> Evictions are associated with higher rates of suicide and job loss.<sup>502,503</sup> For example, renters in Milwaukee who lost their home due to eviction were 11 to 22 percentage points more likely to lose their job.<sup>504</sup> Low-income workers without paid or unpaid leave face more difficulty taking time off of work to address the eviction process and find new housing without impacting their job performance or losing wages.<sup>505</sup> When families are evicted, children’s health and well-being are also affected. These children are more likely to be placed in out-of-home care, which is associated with poor short- and long-term mental health and physical health outcomes.<sup>506,507,508</sup> Black and Latino renters, and women in particular, are disproportionately threatened with eviction or evicted from their homes.<sup>509</sup> As a result, these renters also face a higher risk of negative consequences associated with eviction, including homelessness, material hardship, job loss, and depression.<sup>510</sup> Providing legal representation for tenants during eviction proceedings is one strategy to improve health equity, reduce disparities in housing status, and reduce the negative impacts of evictions.

**Median Eviction Filing Rates and Eviction Rates by Sex and Race/Ethnicity**



Source: Eviction Lab<sup>511</sup>

- **Improves tenants’ housing stability:**

Providing legal support to tenants in eviction proceedings can lead to fewer evictions among low-income tenants.<sup>512,513,514,515</sup> Among tenants who received legal support, those who received full legal representation in court had better outcomes compared with tenants who received limited legal assistance.<sup>516,517</sup> A study found that two-thirds of tenants who had legal representation in court were able to remain in their homes compared with one-third of tenants who represented themselves. Among those who had legal representation, tenants who were unable to stay in their homes were still able to move out on their own terms or more favorable timelines compared

with tenants who had to represent themselves.<sup>518</sup> In the same study, tenants received payments or rent waivers worth 9.4 months of rent per case compared with 1.9 months of rent among tenants representing themselves.<sup>519</sup> Beyond providing legal counsel, providing limited legal assistance from trained individuals can help expand support to tenants facing eviction. A pilot study of New York City’s Court Navigators Program found that trained individuals without formal legal training could provide legal assistance to tenants and reduce evictions.<sup>520</sup>

## KEY CONSIDERATIONS AND POLICY RECOMMENDATIONS<sup>521,522</sup>

State and local policymakers can adopt policies to provide tenants at risk of eviction with legal assistance and/or legal counsel for eviction proceedings. When creating and implementing such policies, policymakers should consider the following points.

### **Provide legal counsel and/or legal assistance in eviction proceedings.**

- The U.S. government can create a right-to-counsel fund administered by the U.S. Department of Housing and Urban Development for states or localities to provide free legal representation for tenants.
- Congress should establish national right-to-counsel and “just cause” protections for renters to ensure greater housing stability.<sup>523</sup>
- State and local policymakers should enact and fund legislation that makes legal representation in eviction proceedings a right and guarantee legal counsel.

### **Identify the scale and scope of evictions in a defined jurisdiction.**

Collect data from courts and administrative proceedings and include demographic information that can be disaggregated, including, but not limited to, race and ethnicity, age, disability status, income, household size, prior eviction or homelessness, and type of landlord. Additional data points can be collected to assess the need for legal assistance, such as the reason the eviction was entered, whether

the landlord or tenant had legal representation, and the case outcome.

- State and localities should collect evictions data from courts and administrative proceedings to identify the scope and extent of eviction problems in their jurisdiction and identify patterns and trends in who is being most affected.

### **Identify tenant groups to provide legal assistance or legal counsel for eviction proceedings.**

Data collection can inform which tenant groups to include or prioritize, such as those below a specified income threshold. Special attention should be given to existing disparities and be inclusive of marginalized tenant groups.

- State policymakers should launch pilot programs that provide representation for a set period of time and assess the outcomes.

### **Legal support should prioritize neighborhoods with high displacement.**

Indicators can include neighborhoods with a high number of evictions, the amount of rent stabilized housing and the number of people entering homeless shelters.

- Localities that already collect eviction data can provide specific tenant groups with free legal counsel in housing court to avoid evictions. This can include tenants who are below a specific income threshold, participate in state or local rental assistance programs, or other criteria.

### Meet the demand and need for legal support in eviction proceedings.

Some communities may experience a great need for legal support in eviction proceedings. To meet the need, partnerships with law schools, the legal community, and community organizations can help expand access to legal support.

- Resources should also be allocated for outreach and education activities to inform communities and potential clients of legal support. Such activities should be accessible and culturally and linguistically appropriate.
- When allocating funding, policymakers should consider providing adequate pay rates for legal professionals and multidisciplinary teams to provide high-quality services to tenants. Teams may include attorneys, paralegals, and social workers.

**Eligibility can be set according to community needs.** For example, legal counsel/legal assistance can be provided for all housing court cases, be offered to all renters below a certain income level, be offered to all eviction proceeding cases regardless of income, or other criteria.

### Where has the policy been implemented?

Currently, no state legislature has adopted legislation that guarantees tenants a right to counsel during eviction proceedings. As of January 2021, seven cities have enacted right to counsel measures for tenants in eviction proceedings. These cities include: New York City, New York; San Francisco, California; Newark, New Jersey; Cleveland, Ohio; Philadelphia, Pennsylvania; Boulder, Colorado; and Baltimore, Maryland.<sup>524</sup>



### EXAMPLE: NEW YORK, NEW YORK

In August 2017, New York City became the first city in the country to guarantee right to counsel for low-income tenants facing eviction. The law will be fully implemented by 2022 and will guarantee full legal representation for renters with incomes at or below 200 percent of the federal poverty guidelines and onetime legal consultations for all renters.<sup>525</sup> During the first year of implementation, among 15 prioritized zip codes, 56 percent of tenants facing eviction proceedings in Q4 2014 had formal legal representation and 2 percent received some legal assistance or advice.<sup>526</sup>

Evictions in the zip codes covered by the law decreased by 11 percent compared with 2 percent in the rest of the city.<sup>527</sup> The city estimates cost savings of \$320 million annually as well as cost savings due to reduced service costs for children in families experiencing homelessness, less job-loss supports, reduced need for rental law enforcement costs, and a reduction in eviction cases filed.<sup>528</sup>

## Promoting Safe and Healthy Learning Environments for Children

Decades of research has highlighted the linkages between quality education in creating opportunities for better health and the negative relationship of poor health on educational outcomes.<sup>529,530,531,532</sup> Early and middle childhood are critically important for a child's healthy development. How children develop from birth to age 12 will affect future social, emotional, and physical development, which influence school readiness and, ultimately, success later in life.<sup>533,534,535</sup> Educational settings have direct contact with a vast majority of America's children and youth on an almost daily basis. With the right set of resources, supports, and policies in place, these institutions can positively contribute to the development of the nation's children and youth and provide them with the opportunity to lead healthy and prosperous lives.

More highly educated people have greater life expectancies. White men with the most education (16 years or more) have a life expectancy 14.2 years greater than that of Black men with the least amount of education (12 years or fewer).<sup>536</sup> Similar rates were found when comparing white and Black women, with highly educated white women having a life expectancy 10.3 years greater than the least educated Black women.<sup>537</sup> An individual's educational attainment can significantly affect their health status throughout adulthood as well as their life expectancy. For example, college graduates have a diabetes prevalence of 7 percent, compared with 15 percent for adults without a high school education.<sup>538</sup>

The impact of the COVID-19 pandemic on America's education system cannot be overstated. Educators, administrators, children, and parents had to quickly adapt traditional education delivery models to support public health efforts to curb the spread of the virus. The pandemic has shone a light on how important safe and supportive school environments are to a child's physical and mental well-being. A large majority of children and youth experienced mental health harm during the first wave of the pandemic, with 66 percent of preschool-age children and 70 percent of school-age children reporting a deterioration of at least one domain of mental health.<sup>539</sup> In response



Congress passed three emergency appropriations that provided the Department of Education with nearly \$190.5 billion as part of the Emergency and Secondary School Emergency Relief (ESSER) Fund. The ESSER funding can go to a wide range of needs arising from the coronavirus pandemic including students' social, emotional, mental health, and academic needs.

Without the structure, security, and accountability of the in-person school day, existing weaknesses in the home environment, including parents who did not have the opportunity to work remotely, lack of support at home, violence or dysfunction at home, and food insecurity, resulted in missing and absent kids. As children begin returning to physical classrooms en masse over the remaining part of 2021, it will be critical that policymakers recognize the multifaceted role that schools play in contributing to a child's well-being, beyond classroom instruction.<sup>540</sup>

## POLICY: Increasing Access to High-Quality Early Childhood Education Programs

### What are early childhood education programs?

Early childhood education (ECE) is a general term used to describe any type of educational program offered to children prior to enrollment in kindergarten. Often referred to as preschool, these programs include but are not limited to Head Start, state-sponsored pre-kindergarten (pre-K), locally funded pre-K, and private or home-based centers.

### Why are ECE programs important?

Ninety percent of a child's brain development occurs within the first five years of life.<sup>541</sup> Additional research has shown that children who are not developmentally ready to enter kindergarten lag behind their peers in educational outcomes, future career prospects, and well-being throughout their lives.<sup>542</sup> While brain science demonstrates the importance of early childhood education, per child spending on high-quality pre-K and other learning environments have lagged and remained flat since 2002.<sup>543</sup>

Policymakers at the federal, state, and local level can utilize a number of established programs and policies to increase both the quality of, and access to, high-quality ECE programs.

### What are the health and learning impacts of ECE programs?

- **Promotes healthy development:** Scores of research studies over the past three decades have shown the positive medium- and long-term impacts of high-quality ECE programs.<sup>544</sup> These programs, which typically promote healthy eating and physical activity, directly promote

well-being for children through increased access to nutritious meals and exercise, increased health screenings, greater likelihood of receiving dental care, and improved mental health.<sup>545,546,547,548,549</sup>

- **Improves cognitive outcomes and academic knowledge:** ECE programs improve cognitive outcomes and academic knowledge for disadvantaged children.<sup>550</sup> But such programs are not only beneficial for low-income children. Children who attend high-quality ECE programs show improved language, math, and reading skills.<sup>551</sup> The longer-term benefits of ECE programs include reductions in teen births and interactions with the criminal justice system throughout a participant's lifetime.<sup>552</sup> A detailed analysis of the monetary benefits of preschool programs in Los Angeles found that approximately half of the cost of such a program would be directly recouped through reduced public spending on Medicaid and other social programs as a result of health improvements associated with preschool expansion.<sup>553</sup>
- **Improves academic success:** Research indicates that high-quality ECE programs not only better prepare students for the transition to kindergarten but can also have positive impacts later in life, such as academic success and lower poverty rates.<sup>554</sup> An inadequate transition from pre-K to primary school can impact a student's academic performance and their emotional and social adjustment.<sup>555</sup> States should ensure effective transitions from pre-K to primary school, including through curricula alignment.



- **Improves health:** Investments in high-quality ECE, including pre-K programs, can reduce the risk for: shorter and less healthy lives, chronic illnesses, obesity and eating disorders, difficulty in maintaining healthy relationships, lower academic performance, behavioral problems in school, high school dropout, the need for special education and child-welfare services, mental and behavioral health, exposure to harmful environmental hazards, depression and anxiety, suicidal thoughts and attempts, alcohol and other drug misuse, teen pregnancy, sexually transmitted diseases, aggression and violence, domestic abuse and rape, not acquiring key parenting skills or child-care support, and difficulty securing and maintaining a job.<sup>556,557,558</sup> Despite the evidence, some families lack access to quality, affordable ECE programs.

While federal resources for some ECE programs have increased in recent years, support for state-funded preschool programs, specifically, has not grown significantly in recent years nationwide.<sup>559</sup>

### What are the economic benefits of ECE programs?

- **Reduces drivers of education spending:** Early childhood education programs have been shown to create outcomes that have a direct impact on local spending. Children enrolled in high-quality ECE programs have shown lower rates of special education use and reduced grade repetition, which are significant cost drivers for local school districts.<sup>560</sup>
- **Improves financial well-being:** These programs also have a significant economic impact on the parents of enrolled children. ECE programs that are funded by local, state, and federal funds can also alleviate the financial burden on families with young

children.<sup>561</sup> Every \$1 invested in ECE programs results in increased salaries and employment of the parents, which yields a \$2 to \$3 return for states' economies.<sup>562</sup> It is also estimated that high-quality ECE programs can improve property values by \$13 for every \$1 invested in local programs and attract new homebuyers.<sup>563</sup>

### Where and how are ECE programs supported and funded?

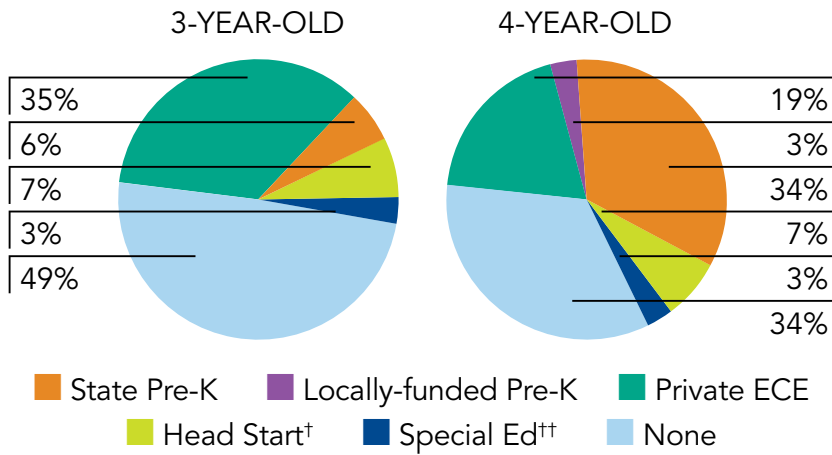
Federal funding for ECE programs is very complex. Multiple federal funding sources play a role in funding ECE, such as, Head Start, Pre-School Development Grants, Child Care & Development Block Grant, Child and Adult Care Food Program, and other competitive grants.

The levels of funding and sources of revenue streams for pre-K programs vary greatly from state to state.<sup>564</sup> Nine states include pre-K funding in their K–12 funding formulas, thus tying it to the budgetary process for K–12 education.<sup>565</sup> Other states fund pre-K through general block grants or local programs, which are less secure revenue streams.<sup>566</sup>

Seven states and the District of Columbia provided state-funded pre-K to nearly 50 percent or more of their jurisdiction's 4-year-olds; four of those states and the District of Columbia served more than 70 percent.<sup>567</sup> Only Vermont (59 percent) and the District of Columbia (73 percent) enrolled more than 50 percent of their jurisdictions' three-year-old children in state-sponsored pre-K.<sup>568</sup> Six states provide no funding for pre-K programs.<sup>569</sup>

Across all state and federally funded programs, about 66 percent of 4-year-olds and 51 percent of 3-year-olds are enrolled in some form of preschool education.<sup>570</sup> Of children engaged in ECE programming, 35 percent of 3-year-olds and 19 percent of 4-year-olds attend preschool in a private program.<sup>571</sup>

**Percent of Population Enrolled in ECE**



† Some Head Start children may also be counted in state pre-K.

†† Estimates children in special education not also enrolled in state pre-K or Head Start.

Source: NIEER 2021<sup>572</sup>



**EXAMPLE: ALABAMA'S FIRST CLASS PRE-K**

For 14 consecutive years, Alabama's First Class pre-K program has been recognized by the National Institute for Early Education and Research as one of the highest-quality, state-funded pre-K programs in the country.<sup>573</sup> Alabama's First-Class pre-K program is a grant program, first implemented in 2000, that supports full-day preschool for all 4-year-olds in a wide range of settings, including Head Start programs, private centers, public schools, faith-based centers, and community organizations.<sup>574</sup> In order to ensure consistent high-quality education delivery in all of the state-sponsored sites, all classrooms must follow the Alabama First Class Framework.<sup>575</sup>

For the 2019-2020 school year, an additional 3,219 children were enrolled in the program and state funding increased approximately \$25.4 million (26 percent increase from 2018–2019).<sup>576</sup> However, while the goal of the program is to provide access to pre-K for all 4-year-old children, there are 3,000 children currently on wait lists.<sup>577</sup>

## KEY CONSIDERATIONS AND POLICY RECOMMENDATIONS

### Support quality ECE programs by funding and providing adequate resources for successful implementation.

- Congress should increase funding for key programs such as the Child Care Development Block Grant, Head Start/Early Head Start, and Preschool Development Grant Birth Through Five to expand access to quality ECE programs for low-income families, improve the quality of education and care provided, and address infrastructure needs.
- Local policymakers should leverage local revenue or innovative funding streams to bolster and expand local ECE programs. Strategies may include creating dedicated sales tax to support ECE programs, property taxes and set-asides, and pay-for-success models.<sup>578</sup>
- Local policymakers should ensure that local zoning and land-use regulations are consistent with the expansion of preschool capacity near where parents live and work.

### Promote and improve quality of ECE programs.

- The U.S. Department of Education and U.S. Department of Health and Human Services should work with state policymakers to improve coordination between Head Start and state pre-K programs.

- States should develop statewide policies to eliminate or severely limit the use of expulsion, suspension, and other exclusionary discipline practices.<sup>579</sup>
- States should create or further enhance financial incentives for participation in state-wide Quality Rating and Improvement Systems (QRIS).
- States should support funding for QRIS technical-assistance efforts, especially those targeting lower-quality ECE programs.
- States should include family childcare homes and community-based programs in state funding systems for ECE and require these sites to follow a curriculum framework in order to receive funding.

**Provide adequate compensation, resources, and training to support a high-quality ECE workforce.** While many states provide supports and resources to classrooms and teachers to engage in professional development activities, these efforts are often inadequate and do not meet the needs of the current or future workforce.

- States should increase starting salary for ECE teachers and establish pay parity across settings for ECE educators with similar qualifications and responsibilities. The average starting salary for ECE teachers is currently about \$36,550 nationwide.<sup>580</sup>

# POLICY: Integrating Social Emotional Learning Programs in Schools

## What is social-emotional learning?

The Collaborative for Academic, Social, and Emotional Learning defines social emotional learning (SEL) as “the process through which all young people and adults acquire and apply the knowledge, skills, and

attitudes to develop healthy identities, manage emotions and achieve personal and collective goals, feel and show empathy for others, establish and maintain supportive relationships, and make responsible and caring decisions.”<sup>581</sup> This report refers to

local, state, and federal policies that facilitate, encourage, or require the adoption of SEL interventions in school settings. SEL interventions are often part of broader, trauma-informed strategies being implemented in schools nationwide.

## CASEL’s SEL Framework



Source: CASEL<sup>582</sup>

## KEY ASPECTS OF SEL INTERVENTIONS

The Collaborative for Academic, Social, and Emotional Learning framework identifies five core, interrelated areas of competency in SEL.<sup>583</sup> They are:

- **Self-awareness.** The ability to understand one’s own emotions, thoughts, and values and how they influence behavior across contexts.
- **Social awareness.** The ability to understand the perspectives of and empathize with others.
- **Relationship skills.** The ability to establish and maintain supportive and healthy relationships.
- **Responsible decision-making.** The ability to make constructive and caring choices about social interaction and personal behavior in a variety of settings.
- **Self-management.** The ability to manage one’s emotions, thoughts, and behaviors effectively in different situations.

## Universal, School-Based SEL Programming: Process of Change

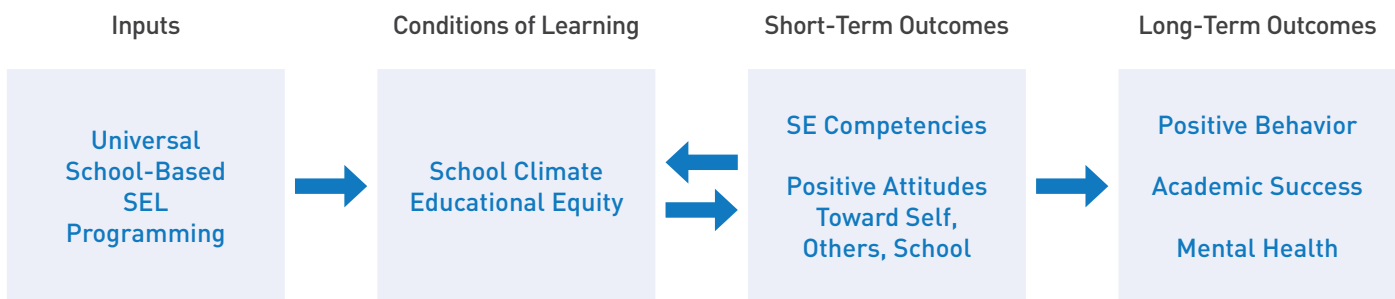


Figure 1. SEL programming creates the conditions of learning to support a long-term, developmental process of positive student outcomes

Source: CASEL<sup>584</sup>

In school settings, implementing SEL may take the form of:<sup>585</sup>

- Direct instruction on social and emotional skills;
- Integration of SEL with academic content;
- Development of a positive learning environment; and
- General teaching practices that support student development and application of social and emotional skills.

### Why are SEL interventions important?

Social emotional learning impacts all children and particularly children who have experienced adverse childhood experiences (ACEs). Evidence shows that children learn best when social, emotional, and cognitive growth are linked to one another.<sup>586</sup> The CDC estimates that up to almost two-thirds of all adults in the United States have experienced at least one type of serious childhood trauma, also known as ACEs.<sup>587</sup> The effects of ACEs go beyond just impacting an individual's childhood. Rather, ACEs have long-lasting effects, including being linked to chronic health problems, mental health and substance misuse issues, and reduced educational achievement; they are also associated with at least five of the top 10 leading causes of death. While a number of evidence-based strategies have been developed and disseminated to prevent ACEs, schools, teachers, and support staff are often faced with the task of creating safe and supportive environments to prevent ACEs and support children who have undergone trauma and experienced one or more ACEs.

### What are the health benefits of SEL interventions?

- **Prepares students for school and beyond:** A significant body of evidence has demonstrated the positive impacts of SEL interventions. These impacts include improved social-emotional skills, reduced conduct problems, increased academic achievement, and may impact decreased dropout rates, and reductions in physical acts of aggression.<sup>589</sup> SEL interventions do not just impact children while they are in school, but have long-lasting impacts; research shows that the impact of SEL programs can be felt later in life.<sup>590</sup> Researchers found that the teacher-rated social competence of kindergarten children consistently predicted outcomes in substance use, mental health, criminal justice, employment, and education into adulthood.<sup>591</sup> Kindergarteners who were given higher social-competence ratings were more likely to graduate from high school and college, in addition to being fully employed at age 25.<sup>592</sup> SEL interventions have also been associated with lower rates of drug use and teen pregnancy, and can reduce violent behavior and justice system engagement.<sup>593,594,595</sup>
- **Improves academic performance:** Students participating in SEL programs show improved academic performance, by 11 percentile points, compared with students who did not participate in SEL programs.<sup>596</sup> Significant associations have also been found between social-emotional skills in kindergarten and young adult outcomes in education, employment, mental health, and criminal activity.<sup>597</sup>
- **Reduces teacher burnout:** The benefits of SEL interventions go beyond just impacting the students;

they benefit teachers as well. Teachers who have high levels of social competence can better nurture relationships with their students, regulate their own emotions, and serve as behavioral role models for children.<sup>598</sup> These factors reduce teacher burnout as they can more effectively address students' behavioral issues.<sup>599</sup>

### What are the economic benefits of SEL interventions?

- **Yields robust return on investment:** An examination of six SEL interventions (4Rs, Positive Action, Life Skills Training, Second Step, Responsive Classroom, and Social and Emotional Training [Sweden]), found that these programs, on average, returned \$11 for every \$1 spent. A separate analysis found that two models (The Seattle Social Development Project and the Life Skills Project) each had a benefits (minus costs) of \$2,779 and \$1,256 per participant, respectively.<sup>601</sup> It is important to note that the Life Skills project is a low-cost intervention (\$34 per participant), and every \$1 invested in the intervention resulted in over \$37 returned to participants and society.<sup>602</sup> Universal prevention programs that teach several SEL skills have also been shown to have a positive return on investment. In a 2002 examination of prevention programs targeting substance use and misuse, the Substance Abuse and Mental Health Services Administration found that large investments in school-based prevention would result in \$18 returned for every dollar invested, saving state and local governments approximately \$1.3 billion if implemented nationally.<sup>603</sup>



## KEY CONSIDERATIONS AND POLICY RECOMMENDATIONS

### Support SEL programs in schools by funding and providing adequate resources for successful implementation.

- Congress can ensure increased and sustained funding for school-based programs at the U.S. Department of Education, CDC (e.g., Division of Adolescent and School Health and Healthy Schools), and Substance Abuse and Mental Health Services Administration (e.g., Project AWARE).
- States should ensure that schools have the resources, training, and technical assistance they need to succeed in integrating SEL in the classroom.

### Create systems of accountability and continuous improvement.

- Federal policymakers can set accountability for racial and ethnic disparities in discipline practices. Punitive discipline practices in schools should be revisited and revised to support SEL especially in early childhood.
- Use statewide accountability and continuous improvement systems to collect student social-emotional competency, school climate, and discipline data.

### Collect and leverage data to support educators in integrating SEL programs and promoting student success.

- States should routinely review school discipline data to identify racial

and economic disparities in school discipline policies and practices.

- States should set baseline standards or if one racial group has more expulsions, schools are required to review the data, determine training, policies, and practices that should be changed to address gaps.
- States should help educators make strategic decisions by providing districts with well-validated tools to measure school climate.
- States should promote and support the implementation of Positive Behavior Interventions and Supports frameworks in school districts to foster a positive school climate.
- Localities should leverage data to build local capacity to implement the Student Support and Academic Enrichment Program via Every Student Succeeds Act Title IV grants.

- Local education agencies should leverage the flexibility provided by the Every Student Succeeds Act and expand the definition of student success to facilitate the integration of SEL.<sup>604</sup>

### Where has SEL been required or encouraged?

Thirty-nine states and the District of Columbia already have statutes and regulations that encourage or require SEL or character education programs in schools. Of those jurisdictions, 21 states require social-emotional learning or character education via classroom instruction, professional development, or development of standards.<sup>605</sup> An additional 18 states and the District of Columbia encourage SEL or character education, and five states address SEL in a non-codified policy, such as a Board of Education policies or guidance documents.<sup>606</sup>



### EXAMPLE: ILLINOIS

The Illinois State Board of Education (ISBE) adopted the Illinois Social and Emotional Learning Standards as required by the 2003 Children's Mental Health Act.<sup>607</sup> The ISBE collaborated with the Illinois Children's Mental Health Partnership and the Collaborative for Academic, Social, and Emotional Learning to create 10 SEL standards, state-specific goals, age-appropriate benchmarks, and performance descriptors. As of 2018, Illinois is one of 14 states that has adopted pre-K–12 competencies/standards and aligned their preschool SEL competencies with K–12 SEL competencies.<sup>608</sup>

## POLICY: Promoting Access to National School Lunch and School Breakfast Programs

### What are the School Breakfast and National School Lunch Programs?

The National School Lunch Program (NSLP) and School Breakfast Program (SBP) are federally assisted meal programs that operate in and reimburse schools and residential childcare institutions nationwide to provide nutritious meals to children.<sup>609, 610</sup> The Food and Nutrition Service of the U.S. Department of Agriculture (USDA) administers both programs at the federal level, with state agencies administering the programs within their state, and local food authorities operating the programs.<sup>611,612</sup>

Children qualify for free meals in NSLP and SBP if their families' incomes are at or below 130 percent of the federal poverty level (FPL), and reduced price meals if family incomes are between 130 percent and 185 percent of the FPL.<sup>613</sup> Prior to the COVID-19 pandemic, nearly 30 million children nationwide participated in the National School Lunch Program, and 14.8 million participated in the School Breakfast Programs.<sup>614</sup> For children from low-income families, school meals are an especially critical source of affordable, healthy foods; over 50 percent of students in the United States now qualify for free and reduced-price school meals.<sup>615</sup>

With the COVID-19 pandemic closing schools nationwide for a significant

period of time, Congress granted the USDA authority to issue nationwide waivers to ensure student access to meals.<sup>616,617</sup> Examples of flexibility provided by these waivers include:

- Allows the Summer Food Service Program and NSLP Seamless Summer Option to operate through the 2020–2021 school year. These waivers allow for local food authorities to continue to provide meals to children via curbside pickup and without the need to collect payment.<sup>618</sup>
- Allows for meals to be distributed outside of congregate feeding settings. Additionally, this waiver has enabled schools to deliver meals directly to children and authorized parents to pick up meals on behalf of a child.<sup>619</sup>
- Provides states with the flexibility to waive requirements that summer meal programs are limited to areas where at least half of the children are members of low-income households.<sup>620</sup>
- Allows for states to apply for and provide Pandemic Electronic Benefit Transfer (P-EBT) benefits to children who would have received free or reduced-price meals if their schools were open. States in the contiguous United States can provide up to \$6.82 in daily benefits for each student who would otherwise receive free or reduced-price school meals during the school year and over the summer.<sup>621</sup>

## Why are school meal programs important?

While the food-insecurity rate in the United States is the lowest it has been in more than 20 years, it is still too high, at one in seven, or about 11 million children.<sup>622</sup> Despite progress, significant disparities persist across racial and ethnic populations. Latinos (15.8 percent) and Blacks (19.3 percent) are about twice as likely as white, non-Hispanics (8.1 percent) to be food insecure.<sup>623</sup> American Indian and Alaska Natives are three times more likely to be food insecure than white, non-Hispanic individuals.<sup>624</sup> A recent analysis by Feeding America projects that due to the COVID-19's impact on the economy, up to 13 million children may experience food insecurity in 2021.<sup>625</sup>

Research shows that as children reach school age, hunger, poor nutrition, and food insecurity can harm academic performance and lead to an increased need for mental health counseling and an increased risk of having behavioral problems.<sup>626</sup> Hungry children also get sick more often and are more likely to be hospitalized.<sup>627</sup> Ensuring that children have access to regular and nutritious meals has significant economic implications: an average pediatric hospitalization costs \$12,000.<sup>628</sup>

Food-insecure children can also be especially vulnerable to obesity. Children living in low-income communities often lack access to full service grocery stores, which in turn restricts access to nutritious foods, such as fruits, vegetables, and whole grains.<sup>629</sup> Childhood obesity is also associated with a higher chance of premature death and disability later in life. Children who are overweight and/or obese are more likely to stay obese later in life and develop diabetes, cardiovascular diseases, and other noncommunicable diseases at a younger age.<sup>630</sup>



## What are the health benefits of SBP and NSLP?

- **Improves academic achievement:** Access to school breakfast programs can improve academic achievement and cognition, especially among malnourished or food-insecure children.<sup>631,632</sup>
- **Promotes healthy eating and food security:** School breakfast programs increase healthy food consumption and improve breakfast nutrition.<sup>633,634,635</sup> Student participation in school breakfast programs reduces students' body mass indexes, particularly among non-Hispanic, white students, and may reduce weight gain in children at risk for obesity.<sup>636</sup> Research has also shown that the NSLP reduces the prevalence of food insecurity by 3.8 percent, the rate of obesity by 17 percent and poor general health by 29 percent.<sup>637</sup> Improving access to, and the nutritional content of, school meals and other foods reduces school meal disparities. These programs have increased the availability of more nutritious items and helped close the meal disparity gap associated with school size, location, and student race/ethnicity makeup.<sup>638</sup>

## What are the economic benefits of SBP and NSLP?

While no formal economic evaluations have been conducted of the NSLP and SBP, the health and academic gains from increasing children's access to healthy, nutritious foods can have significant economic effects later in life.

- **Reduces obesity-related costs:** It is estimated that obesity costs the United States \$149 billion (2014 USD) in medical expenses annually.<sup>639</sup> Separate analyses estimate that about half of obesity-related medical expenses are paid by publicly financed Medicare and Medicaid programs.<sup>640,641</sup> Indirect costs from obesity also run into the billions of dollars due to missed time at school and work, lower productivity, premature mortality, and increased transportation costs.<sup>642</sup> Taking steps to ensure all children have the opportunity to grow up at a healthy weight—including by having access to nutritious foods and time for active play—can help more kids reach their full potential and avert healthcare costs.

## KEY CONSIDERATIONS AND POLICY RECOMMENDATIONS

**Reduce barriers and promote flexibility** to encourage implementation and participation in school meal programs.

- Federal policymakers should continue to provide regulatory flexibilities as states and localities grapple with the long-term impacts of COVID-19. USDA should maintain COVID-19 nutrition waivers and policies through the entirety of the public health emergency.
- Federal policymakers should continue to improve child nutrition and reduce administrative burden by encouraging USDA's Community Eligibility Program (CEP) enrollment. USDA should ease the administrative burden for school food-service programs by making participation in CEP as easy as possible, including educating schools about CEP and providing technical assistance. CEP provides meals for all enrolled students if 40 percent or more of students are directly certified for free school meals, and schools are reimbursed according to the percentage of directly certified children. CEP has been shown to increase participation rates.<sup>643</sup>

**Expand access to school meals** to meet the needs of food-insecure students, end stigma for participating students, and provide meals during public health emergencies.

- Federal policymakers should continue to provide universal school meals during the pandemic. Because of the COVID-19 pandemic, millions of children are expected to be newly eligible for the free or reduced-priced school meals program during the 2021–2022 school year (or beyond). Federal funding for no-cost meals for all enrolled students will help program finances recover from losses during the pandemic, and mitigate the time and resources needed to deal with an application and verification process already fraught with challenges.
- Congress should enhance CEP 1) so that the schools with highest rates

of poverty receive higher school meals reimbursement and 2) lower the threshold for CEP eligibility for elementary schools to 25 percent of students participating in SNAP.

- States should apply for extension of USDA Food and Nutrition Service waivers to ensure that students can still access meals over the summer and upcoming school year.
- Localities should encourage schools to offer breakfast and/or lunch at no charge to all children as a strategy to end stigma for participating children, to boost participation among hungry children, and to eliminate the burden of collecting fees. Communities should eliminate policies that shame students unable to pay school meal fees.

**Provide adequate funding for school meal programs.** Additional funding would expand access to school meals for students who do not qualify for free meals.

- States should provide additional funding for school meal programs. For example, state supplemental funding can be used to expand the number of schools that provide free breakfast and lunch through CEP or to cover the costs of reduced-price meals to make them free for students who would not qualify for free meals.

**Allocate resources to increase outreach and awareness.**

- Local policymakers should conduct outreach, provide education, and encourage school districts to opt in and implement CEP, which allows qualifying high-poverty schools to offer breakfast and lunch at no charge to all students without having to collect and process individual meal applications.
- For schools that do not participate in CEP, they should distribute school meal applications and actively encourage parents to apply for the National School Lunch Program. Additionally, state agencies responsible for providing other benefits to families, such as unemployment insurance, Temporary Assistance for Needy Families, or Supplemental Nutrition Assistance Program, should ensure that parents or guardians are aware of all of the child nutrition programs administered by USDA and available to families nationwide.

### Where has the policy been implemented?

Thirty-six states and the District of Columbia require all or some schools to offer SBP or NSLP.<sup>644</sup> Six of these states require all schools to offer SBP and NSLP.<sup>645</sup> At least 20 states require all or some schools to offer the NSLP.<sup>646</sup> Six states require Breakfast After the Bell, which allows for students to access breakfast on the go, eat in the classroom, or have the opportunity to eat breakfast during a break in the morning.<sup>647,648</sup>

### EXAMPLE: COLORADO<sup>649,650</sup>

In 2013, Colorado passed House Bill 13-1006, which required public schools that have 80 percent or more students who are eligible for free or reduced-price meals to offer breakfast at no charge. This threshold was later reduced to 70 percent to further expand the program's impact. The bill exempts public or charter schools that do not participate in the NSLP and school districts with fewer than 1,000 students. The law, which was implemented in the 2014–2015 school year, gives more than 80,000 additional children in the state access to a breakfast served after the first bell. As a result, in the first year the law was implemented, Colorado went from being ranked 20th in the country in school breakfast participation to 11th.



## POLICY: Supporting School-Based Health Centers

### What are School-based Health Centers?

School-based health centers (SBHCs) provide students and their families with a wide-range of healthcare services. SBHCs are typically established in schools that serve predominantly low-income communities and provide primary physical care, behavioral healthcare, oral healthcare, case management, nutrition education, substance abuse counseling, and health education and promotion.<sup>651,652</sup> However, services offered may differ depending on the resources available and needs of the local community. SBHCs are not meant to supplant the need for school nurses or other specialized instructional support personnel. Rather, they serve as an accessible site for students in need of more comprehensive services.

### Why are SBHCs important?

Poor health is one of the leading contributors to absenteeism and lower school performance.<sup>653</sup> Children and adolescents from ethnic minority and low-income populations typically experience worse health, are less likely to have a usual source of care, and have higher rates of absenteeism compared with children and adolescents from more socially and economically advantaged populations.<sup>654,655</sup> Given that adolescents have one of the lowest rates of primary care usage of any age group, SBHCs can provide quality, timely care to adolescents who are at the highest risk of not having regular health and wellness visits.<sup>656</sup>

SBHCs also serve communities experiencing higher levels of poverty. Schools with access to SBHCs had an average 70 percent of their student population eligible for free or reduced-price lunch compared with 53 percent of the student population of schools without access to SBHCs.<sup>657</sup>

### What are the health and education benefits of SBHCs?

School-based health centers have shown to positively impact health, behavioral, and academic outcomes of the students they serve.

- **Improves access to health services:** Students served by SBHCs show a substantial increase in receiving recommended preventive services and immunizations, and students with asthma reported reductions in symptoms and incidents.<sup>658</sup> Seventy-one percent of students who used an SBHC reported having a healthcare visit in the past year compared with 59 percent of students who lacked access to a SBHC.<sup>659</sup> The presence of SBHCs was also associated with reductions in hospitalization and emergency department visits for children with asthma.<sup>660</sup> Students served by SBHCs had greater satisfaction with their health, more physical activity, and greater consumption of healthy foods than students without SBHCs.<sup>661</sup>
- **Improves access to mental health services:** In a study of 10 high schools in California, the presence of school-based health centers was associated with an increased likelihood that students will talk to their health provider about mental health and student receipt of mental healthcare.<sup>662</sup> Studies examining SBHC utilization found that mental health counseling as one of the leading reasons for visits by students.<sup>663</sup> SBHCs also help overcome many of the barriers associated with receiving services in mental health settings, such as stigma, noncompliance, and inadequate access.<sup>664</sup>
- **Improves access to reproductive health services:** School-based health centers also serve as a critical

resource to address the reproductive health needs of students. Adolescent girls served by a SBHC are more likely to get reproductive preventative care and use hormonal contraception compared with similar girls without an SBHC.<sup>665</sup> An evaluation of adolescent fertility rates in Denver high schools found that the introduction of a SBHC significantly decreased Black adolescent pregnancy and thus averted potential complications related to teen pregnancy and birth.<sup>666</sup> Female students with access to a SBHC were more likely to have been screened for a sexually transmitted disease.<sup>667</sup>

- **Supports academic success:** A Community Guide systematic review found that SBHCs' educational benefits include increased grade point averages and grade promotion, in addition to reductions in school suspension and student non-completion of high school.<sup>668</sup>

### What are the economic benefits of SBHCs?

A Community Guide systematic review found that SBHCs provide economic benefits beyond the students and families who received healthcare services.<sup>669</sup>

- **Yields robust return on investment:** Studies examining SBHC benefits to society found that each SBHC per year was associated with between \$361,581 and \$912,878 in averted costs.<sup>670</sup> Societal benefit-cost ratios of SBHCs range from 1.38 to 1 to 3.05 to 1.<sup>671</sup> Other economic evaluations focused on savings to Medicaid, found that net savings were \$46 to \$1,166 per user, or \$30 to \$969 per visit.<sup>672</sup>



## KEY CONSIDERATIONS AND POLICY RECOMMENDATIONS

PHACCS utilizes the School-Based Health Alliance's set of seven core competencies that every SBHC is expected to demonstrate to organize policy recommendations.<sup>673</sup>

**Access.** SBHCs should ensure that they are located on or near a school campus and make services available whenever school is open. As with any healthcare facility, SBHC should seek consent to share protected health information with other Health Insurance Portability and Accountability Act (HIPAA)-covered entities and should engage in nondiscriminatory practices. When possible, SBHCs should also make services available to non-students to better serve their communities.

- Localities should conduct a needs assessment to determine the priorities in the community to determine if a SBHC can address unmet need.

**Student focus.** SBHCs should engage in meaningful patient engagement while providing evidence-based comprehensive services.

**School integration.** SBHCs should collaborate with school administrators, teachers, and staff to develop a shared vision for student success that includes shared outcomes and integration of policies and procedures to support student academic achievement and health.

- SBHCs should engage with the community to generate goodwill and buy-in.
- SBHCs should collaborate with local healthcare institutions, including Federally Qualified Health Centers, to identify what services can be provided to students and the broader community.

**Accountability.** SBHCs should engage in quality-improvement initiatives to ensure the effectiveness and accessibility

of the services they deliver. Additionally, SBHCs should evaluate student and community satisfaction with services, and be able to collect and report on key metrics, including individual and population-level outcomes.

**School Wellness.** SBHCs should work to improve the school climate through improving family, staff, and student body wellness. SBHCs should also act as educators on health and wellness topics.

**Systems Coordination.** SBHCs should engage in care coordination and engage in formal partnerships with the local healthcare community to ensure broad coverage of services. Additionally, SBHCs should educate and engage parents, guardians, and caregivers in their child's health.

- Federal policymakers should promote partnerships between community health centers and schools to expand access to SBHCs.

**Sustainability.** SBHCs should have strong administrative and billing systems in place with the ability to evaluate financial performance and sustain funding and resources.

- Federal policymakers should expand the enhanced Medicaid reimbursement rate available to Federally Qualified Health Centers to all SBHCs, regardless of their sponsor type.<sup>674</sup>
- State policymakers should reduce barriers to SBHC reimbursement.<sup>675</sup> For example, states can waive prior authorization requirements for SBHCs to serve students with chosen or designated primary care providers. They can also require Medicaid managed care organizations to reimburse SBHCs for visits even when they are considered out-of-network. However, this does not replace the need for contracting between managed care organizations and SBHCs.

## Where has the policy been implemented?

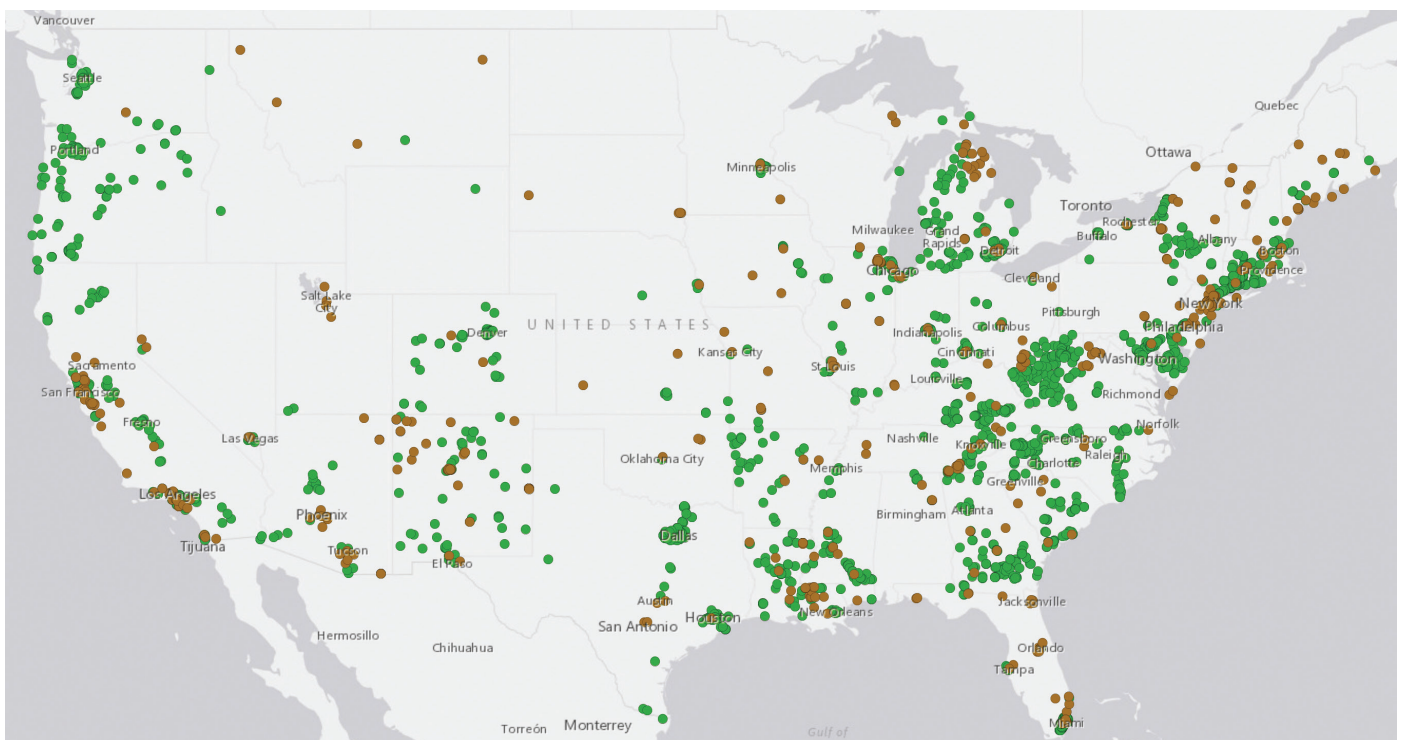
The latest National School-Based Health Care Census from 2016–2017 identified 2,584 SBHC sites operating in 48 states and DC.<sup>676</sup> While a predominant majority of SBHCs are on a fixed site on school campus (81.7 percent), a significant growth

in telehealth exclusive sites (11.5 percent) has been observed over the past decade.<sup>677</sup> Other delivery models include mobile SBHCs and school-linked SBHCs, which provide services on a fixed site near a school campus.

SBHCs are most commonly sponsored by federally qualified health centers (51.2 percent), followed by hospital

or medical center (20.1 percent), nonprofits or community-based organizations (9.5 percent), school systems (5.6 percent), and local health departments (6.3 percent).<sup>679</sup> Forty-six percent of all SBHCs serve urban communities, and 36 percent serve rural communities, a figure that grew from 26 percent in 1998–1999.<sup>680</sup>

## Map of School-Based Health Centers 2016–2017



Source: School-Based Health Alliance<sup>678</sup>

Note: All dots indicated the presence of a SBHC. Green dots have full data and brown dots lacked quality data reporting.



### EXAMPLE: OREGON

SBHCs have been operating in Oregon since 1986 through partnerships among county public health departments, school districts, the Oregon Public Health Division, and members of the community.<sup>681</sup> As of July 1, 2019, Oregon operates a statewide network of 79 certified SBHCs in 26 counties.<sup>682</sup> Every SBHC in Oregon had a behavioral health provider onsite, and 16 (20.3 percent) had a dental provider onsite. Oregon SBHCs served over 38,000 clients in 2018–2019 and provided behavioral health services for 42 percent of all visits for clients ages 5 to 21.<sup>683,684</sup>

## 6

## Health-Promoting Excise Taxes

While the full extent of the COVID-19 pandemic's impact on local and state revenue streams and budgets has yet to be fully realized, questions will likely be raised about how to maintain revenue bases. Every state, except Vermont, has a balanced budget requirement, and many difficult fiscal decisions will need to be made over the coming years.<sup>685</sup> The *how much will this cost* question is not the right lens with which to make decisions. The right question is *what fiscal policies can be adopted that are win-wins*, raising revenue while reducing future expenses through incentivizing behavior change and investment in prevention programs. All levels of government can use financial incentives and disincentives to encourage or discourage behaviors, some of which are harmful and costly to taxpayers.

The taxation of products widely understood to be harmful provides a unique opportunity to join fiscal and health interests in public policy. The United States has taxed alcohol and tobacco products for over 150 years.<sup>686</sup> More recently, some states and localities in the United States have begun taxing other potentially harmful products like sugar-sweetened beverages.<sup>687</sup> The long-term use of tobacco, alcohol, and sugary drinks are significant risk factors for the five leading causes of death, many of which are preventable.<sup>688,689,690,691,692,693</sup> While these risk factors impact all Americans, there are significant racial and ethnic disparities.

Beyond raising revenue and promoting health behaviors, taxation of harmful products can also improve the health of individuals who do

not engage in such risk behavior. For example, smoking tobacco can be harmful to people exposed to secondhand smoke, and alcohol consumption has been linked to motor vehicle crashes, psychological and physical abuse, and relationship problems.<sup>694,695,696</sup> Establishing or increasing taxes on tobacco, alcohol, and sugar-sweetened beverages can be a mechanism to not only disincentivize the use of these products, but also to provide an opportunity to fund health-promoting policies such as those recommended in this report. Taxes on unhealthy products are a critically important mechanism to fund health-promoting programs. However, while they can be a lucrative source of revenue, if successful, revenue falls over time, so they do not fully supplant the need to establish other sustainable funding sources.

## POLICY: Tobacco Taxes

In 2019, 29 percent, or almost one out of every three, American Indians and Alaska Natives reported smoking.<sup>697</sup> This was significantly higher than any other race or ethnicity, including Black (18 percent), white (16 percent), Hispanic (12 percent), and Asian/ Native Hawaiian or Pacific Islander (8 percent) populations.<sup>698</sup> While Black smokers have comparable smoking rates to whites, more than 77 percent smoke menthol cigarettes, which make it easier to start smoking and more difficult to quit, compared with 25 percent of white smokers.<sup>699,700,701,702</sup> In 2016, individuals below the FPL had a smoking rate of 25.3 percent compared with 14.3 percent of individuals at or above the FPL.<sup>703</sup> Through policy change, states can help reduce these risk factors for populations disproportionately affected by tobacco and promote health equity.

It is important to note implementing tobacco pricing strategies that apply to only a limited set of products may encourage people who use tobacco products to substitute one tobacco product with a lower-priced one, rather than quit. For example, if the price increases are narrow in scope and only apply to one type of tobacco product (e.g., cigarettes but not smokeless tobacco or e-cigarettes), people who use tobacco may use price-minimization strategies, such as buying lower-priced tobacco or discounted products, to avoid the price increase.<sup>704</sup> Ideally taxation strategies should be accompanied by policies such as prohibitions on discounting or minimum-price laws to optimize effectiveness and cover the full range of tobacco products.

### CIGARETTE EXCISE TAXES AS OF MARCH 2021

Variations in tax rates have led to a situation where average pack prices in the United States range from \$5.25 a pack in Missouri and Virginia to \$12.85 a pack in New York, an approximate 2.5-fold difference that demonstrates the largely unused potential of tobacco taxes.<sup>705</sup>

- **Federal.** The most recent increase to the federal cigarette tax was in April 2009, which increased the tax by \$0.62 to a total of \$1.01 per pack.<sup>706</sup>
- **State.** A significant portion of cigarette taxes are levied at the state level, where states have different approaches and rates of taxation.<sup>707</sup> As of March 2021, just 10 states and the District of Columbia have listed cigarette tax rates per pack greater than \$3.00.<sup>708</sup> While many states have increased the price of tobacco over the last decade, 27 states have not increased their tax in the past 10 years.<sup>709</sup> Additionally, 29 states and DC tax e-cigarettes and vaping products, a product that is used by a high percentage of youth and young adults.<sup>710,711,712,713</sup>
- **Local.** Although most localities do not have their own cigarette tax, there are some exceptions. Over 630 counties and cities have enacted their own cigarette tax rate, which brought in almost \$400 million in revenue in 2019.<sup>714</sup> It is important to note that many localities are prohibited from imposing an excise tax on tobacco products.<sup>715</sup>

See Appendix B for Tobacco Tax Chart.

### What are the health benefits of tobacco taxes?

Increasing tobacco prices decreases youth initiation, decreases tobacco consumption, increases quit rates, and reduces disparities.<sup>716,717,718</sup> Generally, the effects on tobacco consumption are proportional to the increase in the price of the tobacco product. Research suggests that a 10 percent increase in the price of cigarettes reduces total consumption by 3 to 5 percent and 7 percent for youth.<sup>719</sup> Government tobacco-control policies decreased smoking prevalence and increased smoking cessation rates among youth after the price of tobacco products was raised. Higher tobacco prices appear to have a greater effect on adolescents, young adults, and lower-income populations.<sup>720</sup>

## What are the economic benefits of tobacco taxes?

Increasing tobacco taxes can be a win-win by not only shoring up state and local government budgets, but also reducing harm and costs associated with tobacco use. Use of tobacco tax revenue for tobacco control is also enormously cost-effective.

- **Averts significant healthcare costs:** Between FY 1989 and 2008 the California Tobacco Program yielded healthcare expenditure savings of \$134 billion, compared to the \$2.4

billion in costs.<sup>721</sup> In 2017, state and local governments collected approximately \$20 billion in revenue from tobacco taxes, accounting for 0.6 percent of state and local general revenue.<sup>722</sup> Smoking-related healthcare expenditures total about \$170 billion per year (2010 estimate) in the United States with billions being paid directly by smokers through direct healthcare payments and increased health insurance premiums.<sup>723</sup> These costs are not only attributed to smoking but can have a significant impact on state budgets as well. Medicaid beneficiaries

who are smokers cost states and the federal government at least \$39.6 billion each year (2010 estimate) in health-related spending.<sup>724</sup>

Opponents of increasing cigarette taxes argue that increasing the tax will erode revenue since the increased price will result in fewer products being purchased. However, in every single instance where a state has passed a significant (\$1.00 per pack) tax increase, there was a substantial increase in cigarette tax revenue.<sup>725</sup>

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## KEY CONSIDERATIONS AND POLICY RECOMMENDATIONS:

Policymakers at all levels of government have opportunities to further bolster the impact of tobacco taxes levied.<sup>726,727</sup>

### Update tobacco taxes to reflect new products and keep pace with inflation.

- Congress should increase the federal cigarette tax (currently \$1.01), which has not been increased since 2009.
- Federal, state, and local policymakers should ensure tax rates on other tobacco products are equal to the cigarette tax. This is particularly urgent for e-cigarettes, which have experienced extraordinarily rapid growth of youth use.
- Federal, state, and local policymakers establish a mechanism to periodically review tobacco tax rates and adjust for inflation.

- States and localities should modernize tobacco-related definitions to recognize new tobacco products, including e-cigarettes.

### Allocate tobacco tax revenue for tobacco-control and -prevention programs and other health-promoting programs.

- States and localities should dedicate a portion, or a greater proportion, of tax revenue for state tobacco-control and -prevention programs, and specifically target these programs to low-income individuals and other populations disproportionately impacted by tobacco. For any remaining revenue, dedicate the remainder to other policies that improve health, such as those recommended in this report.

### Prohibit tobacco product discounts and ensure robust enforcement of tobacco tax laws.

- States should increase penalties for tobacco tax evasion and contraband trafficking, and strengthen enforcement.
- States should implement high-tech tax stamps on packages, which report encrypted information on payments to the state's revenue collection agency.
- States and localities should implement policies that prohibit the redemption of tobacco product discounts and coupons at the retail level to fully maximize the impact of the tax.

### Support local authority to tax tobacco products.

- States should provide flexibility to municipalities to tax tobacco products and remove any existing preemption policies.



## POLICY: Alcohol taxes

More than 95,000 people die each year as a result of excessive alcohol consumption, which is a leading cause of preventable death in the United States.<sup>728</sup> Approximately one in six American adults binge-drink about four times a month.<sup>729</sup> Binge-drinking behavior is most common among young adults ages 18 to 34, but adults ages 35 and older consume more than half of the total number of binged drinks.<sup>730</sup>

Excessive alcohol consumption was already a significant public health issue in the United States before the COVID-19 pandemic. Recent data shows that stay-at-home orders and mental stress have contributed to increased alcohol consumption over the past year.<sup>731</sup> On average, alcohol was consumed one day more per month for every three out of four adults surveyed.<sup>732</sup> Binge-drinking among women significantly increased, with a 41 percent increase in heavy drinking observed in this population in the past year.<sup>733</sup>

### What are the health benefits of increasing alcohol taxes?

- **Reduces excessive drinking:** Imposing higher taxes on alcoholic beverages has been shown to reduce excessive drinking and related harms, underage drinking, and alcohol-related deaths.<sup>734,735</sup> Evidence suggests that increasing the price of alcohol by 10 percent could reduce overall consumption by nearly 8 percent.<sup>736</sup> Higher alcohol prices have also been shown to reduce motor vehicle crashes and fatalities, sexually transmitted infections, and may reduce violence.<sup>737</sup> The effects of alcohol taxes have been shown to have the greatest impact on

reducing alcohol consumption for lower-income individuals, youth, and people who drink heavily.<sup>738,739</sup>

### What are the economic benefits of increasing alcohol taxes?

- **Averts the costs of excessive alcohol use:** In 2010, excessive alcohol use cost the United States an estimated \$249 billion in medical care (or \$2.05 per drink), and the government paid \$100.7 billion (40.4 percent) of those costs.<sup>740</sup> The median cost per state was \$3.5 billion, and more than 70 percent of the costs were related to binge-drinking. States have varying excise tax rates per type of alcohol, and many states also apply sales taxes on alcoholic beverages.<sup>741</sup> Higher alcohol prices are associated with reductions in alcohol consumption among low-income individuals, youth, and individuals who drink heavily.<sup>742,743</sup> The reduced alcohol consumption among people in these groups is associated with reductions in experiences of alcohol-related adverse outcomes.

While evidence supports the effectiveness of taxing alcohol as a way to curb excessive alcohol use, inflation-adjusted alcohol taxes have declined since 1968.<sup>744</sup> This means that although many states already tax alcoholic beverages, the effects of the tax have been eroding over time because they have not kept up with inflation rates. Total alcohol taxes only account for one-tenth of the economic burden of excessive drinking.<sup>745</sup>

As the table shows, alcohol excise tax rates vary quite considerably across states and by types of alcoholic beverages.

*See appendix C: Alcohol Excise Taxes (2020) and Revenue (2017)*

## KEY CONSIDERATIONS AND POLICY RECOMMENDATIONS

### Update and maintain alcohol taxes to keep pace with inflation.

- Congress should increase alcohol excise taxes and index alcohol tax rates to inflation. Federal excise taxes on alcohol have eroded over time. As of 2015, the inflation-adjusted federal beer tax had declined by 42 percent and the Consolidated Appropriations Act of 2021 further reduced federal excise tax rates on beer and distilled spirits.<sup>746,747</sup>
- States should increase alcohol tax rates and index the tax rates to inflation. From 1991–2015, state alcohol excise taxes saw inflation-adjusted declines of about 30 percent across all beverage types.<sup>748</sup>

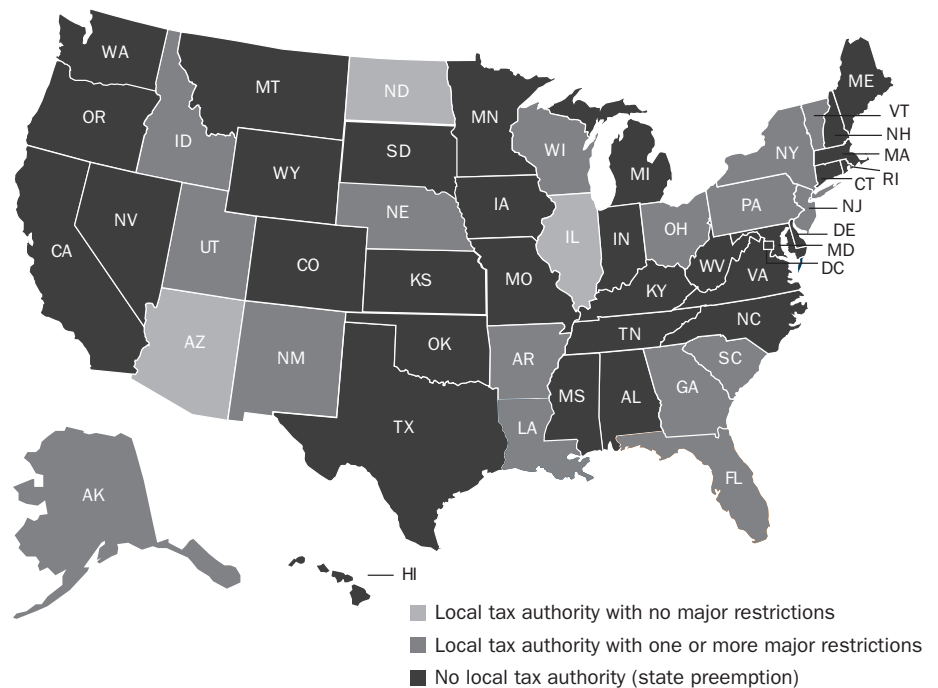
### Support localities' ability to tax alcohol

- For the 31 states that preempt local alcohol tax authority, grant localities the ability to impose ad valorem and/or excise taxes.<sup>749</sup>
- For the 19 states with local tax authority, allow for taxes to be imposed on all retailers, beverage types, and beverages of varying alcohol content.<sup>750</sup>

### Allocate alcohol tax revenue to health-promoting programs

- States and localities (with local taxing authority) should utilize revenue raised to support health-promoting programs.

### Local Tax Authority, January 2015



*Journal of Studies on Alcohol and Drugs*<sup>751</sup>

## POLICY: Sugar-Sweetened Beverage Taxes

The regular consumption of sugar-sweetened beverages (SSBs) has been linked to obesity, type 2 diabetes, heart disease, tooth decay, nonalcoholic liver disease, and death.<sup>752,753,754,755</sup> The average SSB provides approximately 150 calories, almost all of which are from added sugars, and contains little to no nutritional value.<sup>756</sup> Data from the Behavioral Risk Factor Surveillance System from 2011 to 2014 showed that 63 percent of all youth and 49 percent of adults drank an SSB on any given day.<sup>757</sup>

### What are the health benefits of SSB taxes?

SSB taxes can work through several mechanisms. The most classic is through increasing prices and thereby reducing purchases and consumption; second, by raising awareness; third, by incentivizing non-price responses (such as product reformulation); and lastly by generating revenue that can be invested in health or other social needs.

- **Obesity prevention:** Despite recently emerging as a policy solution to address the consumption of sugary drinks, evidence to date shows the positive impacts of SSB taxes. Modeling studies suggest that SSB taxes reduce sugary-drink sales and consumption.<sup>758,759</sup> Researchers have identified a national sugary-drink tax as the most cost-effective obesity-prevention intervention of seven studied, estimating it could prevent more than half a million cases of childhood obesity over the course of a decade.<sup>760</sup>
- **Decreases sugary beverage consumption:** Studies of the impacts of taxes enacted in Berkeley, California, and Philadelphia, Pennsylvania, found that sales and consumption of sugary beverages decreased, and consumption of water increased after

these taxes went into effect.<sup>761,762,763,764</sup>

Reductions in sugary-beverage sales in Berkeley were found at one year out, and self-reported consumption continued to decline over three years; but Philadelphians' reductions in sugary-drink consumption a year after implementation of the tax were not significantly higher than reductions in nearby cities.<sup>765,766</sup> In a four-city (Philadelphia, Pennsylvania; San Francisco, California; Seattle, Washington; and Oakland, California) study of the impact of SSB taxes, researchers found a 12.2 percent decline in household SSB purchases, or 53 ounces per month per one-cent per-ounce increase in price, primarily driven by the decline in Philadelphia.<sup>767</sup>

- **Provides revenue for health-promoting programs:** In Seattle, an analysis conducted 12 months after the city's SSB tax went into effect found that lower-income children and parents reduced their SSB consumption after the tax's implementation.<sup>768</sup> Additionally, in response to the COVID-19 pandemic, revenue raised by the city's SSB tax provided 6,250 food-insecure households with \$800 worth of grocery vouchers.<sup>769</sup> The provision of these funds was made in consultation with the Seattle Sweetened Beverage Tax Community Advisory Board, which provides recommendations on how the revenue raised from the SSB tax is best utilized to serve the community.<sup>770</sup>

Similar impacts have also been observed from other countries. Studies in Barbados, Catalonia (Spain), Chile, Mexico, Saudi Arabia, the United Kingdom, and the United States have identified declines in sales/purchases of SSBs.<sup>771</sup> In Mexico, for example,

following the implementation of a 1 peso (approximately \$0.05) per liter SSB tax in 2014, purchases of taxed beverages decreased 5.5 percent in 2014 and 9.7 percent in 2015.<sup>772</sup> The decrease in SSB purchases also coincided with a 2.1 percent increase in untaxed beverages purchased.<sup>773</sup> In Saudi Arabia, there was a 41 percent decline in carbonated SSB sales between 2016 and 2018 after implementation of an SSB tax.<sup>774</sup>

### What are the economic benefits of SSB taxes?

**SSB taxes can create a new funding stream to provide new or enhanced government programs and services to low-income communities; those most impacted by the consumption of sugary drinks.** A number of cities directed sugary-drink tax revenue toward programs that promote healthy eating and active living and/or help disadvantaged communities ensure that local policies boost health and reduce inequities.

- Seattle, Washington: The city has committed \$5 million to grocery vouchers for food-insecure households between March and July 2020.<sup>775</sup>
- San Francisco, California: The city raised an estimated \$16 million in 2018 from their one-cent-per-ounce SSB tax, which has been invested in community and school programs.<sup>776</sup>
- Philadelphia, Pennsylvania: Approximately 4,000 children have enrolled or already graduated from pre-k slots funded by the SSB tax.<sup>777</sup>
- Boulder, Colorado: The city utilizes SSB revenues to fund a number of community-based programs that focus on improving health in communities of color and low-income communities.<sup>778</sup>

## Where have SSB taxes been implemented?

To date, over 40 countries, cities, and regions covering more than 2 billion people have initiated SSB taxes, including eight localities in the United States.<sup>779</sup>

## What types of taxes have been implemented?

About 75 percent of SSB excise taxes worldwide are specific taxes.<sup>780</sup> Having a specific tax is preferable to an ad valorem tax as they increase the price of all taxed products in a similar manner, are more likely to be reflected in the price of the product on the shelf, and are not subject to industry price manipulation. Specific taxes can take many forms, such as those that apply a tax based on the volume of a product (single-tiered or tiered volume-based) or sugar-based, which apply an excise tax based on the sugar content of the product.<sup>781</sup> However, these taxes do need to be updated annually to reflect changes in the consumer price index to ensure their effectiveness is not eroded by inflation over time.<sup>782</sup>

While ad valorem taxes are used by some jurisdictions, they are not the preferred tax instrument as they may incentivize consumers to buy cheaper SSBs to replace more expensive products.

## Industry arguments against SSB taxes

Opponents of SSB taxes argue that the tax will have a negative impact on employment or the economy. However, the experiences of Philadelphia, Berkeley, and Mexico have shown that there is no association with a sugary-drink tax increase and employment in related sectors, including supermarkets, soft drink manufacturers, and other affected industries.<sup>783,784,785</sup> Opponents have also disseminated campaigns calling the measures a “grocery tax” and suggesting they would increase food prices; however, researchers in Berkeley found that no grocers reported increasing non-beverage grocery prices.<sup>786</sup>

Despite widespread adoption, there continues to be strong pushback from the beverage industry. The beverage industry has spent millions of dollars lobbying against sugary beverage

taxes, and their efforts have had an effect.<sup>787</sup> Legislators quickly repealed a beverage tax enacted in Cook County, Illinois, in 2016.<sup>788</sup> Voters defeated proposed taxes in Telluride, Colorado, in 2013 and in Santa Fe, New Mexico, in 2017, and several states—including California, Michigan, Washington, and Arizona—have preempted local governments from implementing their own beverage taxes.<sup>789</sup> In California, the soda industry supported a ballot initiative that would have made it more difficult to raise revenue at the local level from any source and only withdrew it when they had successfully lobbied the state legislature to preempt local soda taxes.<sup>790</sup>

Because SSB taxes are similar to other excise taxes and are inherently regressive, more robust spending on the needs of the communities most impacted by the negative consequences of overconsumption of sugary drinks can prevent the tax from having negative consequences for health equity.

## KEY CONSIDERATIONS AND POLICY RECOMMENDATIONS

### Establish SSB taxes.

- Policymakers at all levels of government have opportunities to advance SSB taxes to reduce SSB consumption and mobilize revenue. Use of taxes tiered to sugar content or proportional sugar content should also be explored to incentivize reformulation to lower sugar content.
- Congress should enact a federal SSB excise tax. It is estimated that a federal SSB tax would save between

\$17.1 billion and \$23.6 billion in healthcare costs over 10 years.<sup>791, 792</sup>

- States and localities (where applicable) should adopt SSB taxes to reduce consumption, raise revenue, and avoid the potential problems of cross-border shopping when taxes are limited to a city.

### Support localities’ authority to tax SSBs.

- State legislatures should not preempt localities from implementing SSB

taxes. States with existing SSB tax preemption should pass legislation lifting the preemption.

### Allocate SSB tax revenue to health-promoting programs.

- Allocate revenue raised by SSB taxes to health-promoting programs and services, such as health equity or wellness funds, healthy food incentives, or other social needs.

# Methodology

The policies included in this report were identified via a review of over 2,300 policies, programs, and strategies from a number of trustworthy governmental and nongovernmental databases (Table below). Each policy was reviewed for its strength of health and economic evidence, its contribution to reducing health disparities, and its relevancy in addressing some of America’s most pressing health issues, many of which have been further exacerbated by the COVID-19 pandemic.

To guide the review and selection of policies, PHACCS identified discrete sectors and focus areas (which act as the report’s chapters) that have long-standing inequities that have not been adequately addressed or have been further exacerbated by past policies. In addition to reviewing the literature, the authors consulted with subject matter experts to validate findings and identify emerging policies that have yet to be evaluated and included in online repositories.

The authors of this report are presenting a selection of evidence-based policies that have the potential to improve health, control costs, and promote health equity. The report is not intended to serve as a comprehensive listing of evidence-based policies in each of its five discrete areas. Rather, the authors intend for the document to serve as an actionable resource that describes evidence-based strategies that the authors believe are attainable for local, state, and/or federal adoption.

**DATABASES UTILIZED IN POLICY RESEARCH REVIEW**

Database	Database Categorization (if applicable)
Washington State Institute for Public Policy <sup>793</sup>	N/A
CrimeSolutions <sup>794</sup> (United States Department of Justice)	<ul style="list-style-type: none"> <li>• Effective</li> <li>• Promising</li> </ul>
Social Programs That Work <sup>795</sup>	<ul style="list-style-type: none"> <li>• Top Tier</li> <li>• Near Top Tier</li> </ul>
County Health Rankings & Roadmaps <sup>796</sup>	<ul style="list-style-type: none"> <li>• Scientifically supported</li> <li>• Expert opinion</li> <li>• Some evidence</li> </ul>
Clearinghouse for Labor Evaluation and Research (United States Department of Labor) <sup>797</sup>	<ul style="list-style-type: none"> <li>• High casual evidence</li> <li>• Moderate casual evidence</li> </ul>
Blueprints for Healthy Youth Development <sup>798</sup>	<ul style="list-style-type: none"> <li>• Model Plus</li> <li>• Model</li> <li>• Promising</li> </ul>
What Works Clearinghouse (United States Department of Education) <sup>799</sup>	<ul style="list-style-type: none"> <li>• Highest rated</li> <li>• Positive effects</li> <li>• Potentially positive effects</li> </ul>
Evidence-Based Cancer Control Programs (National Institutes of Health) <sup>800</sup>	<ul style="list-style-type: none"> <li>• Minimum program score of 3.0</li> </ul>
The California Evidence-based Clearinghouse for Child Welfare <sup>801</sup>	<ul style="list-style-type: none"> <li>• Well-Supported by Research Evidence</li> <li>• Supported by Research Evidence</li> <li>• Promising Research Evidence</li> </ul>



# State Cigarette Excise Tax Rates<sup>802</sup>

STATE CIGARETTE EXCISE TAX RATES	
State	Cigarette Excise Tax
Alabama	\$0.68
Alaska	\$2.00
Arizona	\$2.00
Arkansas	\$1.15
California	\$2.87
Colorado	\$1.94
Connecticut	\$4.35
Delaware	\$2.10
District of Columbia	\$4.50
Florida	\$1.34
Georgia	\$0.37
Hawaii	\$3.20
Idaho	\$0.06
Illinois	\$2.98
Indiana	\$1.00
Iowa	\$1.36
Kansas	\$1.29
Kentucky	\$1.10
Louisiana	\$1.08
Maine	\$2.00
Maryland	\$3.75
Massachusetts	\$3.51
Michigan	\$2.00
Minnesota	\$3.04
Mississippi	\$0.68
Missouri	\$0.17
Montana	\$1.70
Nebraska	\$0.64
Nevada	\$1.80
New Hampshire	\$1.78
New Jersey	\$2.70
New Mexico	\$2.00
New York	\$4.35
North Carolina	\$0.45
North Dakota	\$0.44
Ohio	\$1.60
Oklahoma	\$2.03
Oregon	\$3.33
Pennsylvania	\$2.60
Rhode Island	\$4.25
South Carolina	\$0.57
South Dakota	\$1.53
Tennessee	\$0.62
Texas	\$1.41
Utah	\$1.70
Vermont	\$3.08
Virginia	\$0.60
Washington	\$3.03
West Virginia	\$1.20
Wisconsin	\$2.52
Wyoming	\$0.60

# State Alcohol Excise Tax Rates

STATE ALCOHOL EXCISE TAX RATES			
State	Distilled Spirit Excise Tax Rate (per gallon for 40% alcohol) <sup>803</sup>	Beer Excise Tax Rate (per gallon for 5% alcohol) <sup>804</sup>	Wine Excise Tax Rate (per gallon) <sup>805</sup>
Alabama	N/A	\$1.05	N/A
Alaska	\$12.80	\$1.07	\$2.50
Arizona	\$3.00	\$0.16	\$0.84
Arkansas	\$2.50	\$0.24	\$0.75
California	\$3.30	\$0.20	\$0.20
Colorado	\$2.28	\$0.08	\$0.32
Connecticut	\$5.94	\$0.24	\$0.79
Delaware	\$4.50	\$0.26	\$0.97
District of Columbia	\$1.50	\$0.09	\$0.30
Florida	\$6.50	\$0.48	\$2.25
Georgia	\$1.89	\$1.01	\$0.42
Hawaii	\$5.98	\$0.93	\$1.38
Idaho	N/A	\$0.15	\$N.A
Illinois	\$8.55	\$0.23	\$1.39
Indiana	\$2.68	\$0.12	\$0.47
Iowa	N/A	\$0.19	\$1.75
Kansas	\$2.50	\$0.18	\$0.30
Kentucky	\$1.92	\$0.08	\$0.50
Louisiana	\$3.03	\$0.40	\$0.76
Maine	N/A	\$0.35	\$N.A
Maryland	\$1.50	\$0.09	\$0.40
Massachusetts	\$4.05	\$0.11	\$0.55
Michigan	N/A	\$0.20	\$0.51
Minnesota	\$5.03	\$0.15	\$0.30
Mississippi	N/A	\$0.43	\$N/A
Missouri	\$2.00	\$0.06	\$0.42
Montana	N/A	\$0.14	\$n.a
Nebraska	\$3.75	\$0.31	\$0.95
Nevada	\$3.60	\$0.16	\$0.70
New Hampshire	N/A	\$0.30	\$n.a
New Jersey	\$5.50	\$0.12	\$0.88
New Mexico	\$6.06	\$0.41	\$1.70
New York	\$6.44	\$0.14	\$0.30
North Carolina	N/A	\$0.62	\$1.00
North Dakota	\$2.50	\$0.16	\$0.50
Ohio	N/A	\$0.18	\$0.32
Oklahoma	\$5.56	\$0.40	\$0.72
Oregon	N/A	\$0.08	\$n.a
Pennsylvania	N/A	\$0.08	N/A
Rhode Island	\$5.40	\$0.11	\$1.40
South Carolina	\$2.96	\$0.77	\$1.08
South Dakota	\$3.93	\$0.27	\$0.93
Tennessee	\$4.40	\$1.29	\$1.21
Texas	\$2.40	\$0.19	\$0.20
Utah	N/A	\$N/A	N/A
Vermont	N/A	\$0.27	\$0.55
Virginia	N/A	\$0.28	\$n.a
Washington	\$14.25	\$0.76	\$0.87
West Virginia	N/A	\$0.18	N/A
Wisconsin	\$3.36	\$0.06	\$0.25
Wyoming	N/A	\$0.02	N/A

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1730 M Street, NW, Suite 900  
Washington, DC 20036  
(t) 202-223-9870  
(f) 202-223-9871