Bill as Introduced

HB 762-FN-A – AS INTRODUCED

2001 SESSION

01-1009
09/01

HOUSE BILL ***762-FN-A***

AN ACT increasing the tobacco tax to allow for a healthy families trust fund and for increased funding for the tobacco use prevention fund.

SPONSORS: Rep. M. Fuller Clark, Rock 36; Rep. Buckley, Hills 44; Sen. Wheeler, Dist 21

COMMITTEE: Ways and Means

ANALYSIS

This bill increases the tobacco tax to allow for increased funding of the tobacco use prevention fund and for a healthy families trust fund. The healthy families trust fund is to be administered by the department of health and human services and provides funding for: medical assistance for persons 65 years of age and older; the Children's Health Insurance Program and expansion of the Children's Health Insurance Program to parents; a pharmacy assistance program; a pilot program providing health insurance coverage for child care workers; and the senior prescription drug discount program.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

01-1009
09/01

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand One

AN ACT increasing the tobacco tax to allow for a healthy families trust fund and for increased funding for the tobacco use prevention fund.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 Statement of Purpose. It is the intent and purpose of this act to address the health care needs of the citizens of New Hampshire. The general court recognizes that a healthy citizenry contributes greatly to the overall health of the economy and general well being of the state. The general court declares that it is the policy of the state of New Hampshire to share in the costs of tobacco control programs and health care access in order to assist the more critically needy components of the population in attaining access to quality health care.

2 Cigarette Tax Increased. Amend RSA 78:7 to read as follows:

78:7 Tax Imposed. A tax upon the retail consumer is hereby imposed at the rate of [~~52 cents~~] ***$1.02*** for each package containing 20 cigarettes or at a rate proportional to such rate for packages containing more or less than 20 cigarettes, on all tobacco products sold at retail in this state. The payment of the tax shall be evidenced by affixing stamps to the smallest packages containing the tobacco products in which such products usually are sold at retail. The word "package" as used in this section shall not include individual cigarettes. No tax is imposed on any transactions, the taxation of which by this state is prohibited by the Constitution of the United States.

3 Distribution of Funds. Amend RSA 78:32 to read as follows:

78:32 Distribution of Funds.

I.***(a)*** The commissioner shall determine the additional amount of revenue produced by any additional tax in excess of 37 cents ***and less than 53 cents*** for each package containing 20 cigarettes or at a rate proportional to such rate for packages containing more or less than 20 cigarettes, on all tobacco products sold at retail in this state imposed by RSA 78:7 and shall certify such amount to the state treasurer by October 1 of each year for deposit in the education trust fund established by RSA 198:39.

[~~II.~~]***(b)*** The commissioner shall make quarterly estimates of the amount of additional revenues that will be produced by such increase in tax rate for the next fiscal year and shall certify such amount to the state treasurer for deposit in the education trust fund established by RSA 198:39. Such estimates shall be certified on June 1, September 1, December 1, and March 1 of each year.

II. The commissioner shall determine the additional amount of revenue produced by any additional tax in excess of 52 cents for each package containing 20 cigarettes or at a rate proportional to such rate for packages containing more or less than 20 cigarettes, on all tobacco products sold at retail in this state imposed by RSA 78:7 and shall certify such amount to the state treasurer by June 30 of each year for deposit as follows:

(a) The sum of no less than $7,800,000 shall be deposited in the tobacco use prevention fund established pursuant to RSA 126-K:15.

(b) The remainder of the amount shall be deposited in the healthy families trust fund established pursuant to RSA 126-P:1.

4 Applicability. Section 2 of this act shall apply to all persons licensed under RSA 78:2. Such persons shall inventory all taxable tobacco products in their possession and file a report of such inventory with the department of revenue administration on a form prescribed by the commissioner within 20 days after the effective date of this act. The tax rate effective July 1, 2001 shall apply to such inventory and the difference, if any, in the amount paid previously on such inventory and the current effective rate of tax shall be paid with the inventory form. The inventory form shall be treated as a tax return for the purpose of computing penalties under RSA 21-J.

5 Tobacco Use Prevention Fund. Amend RSA 6:12, I (yyy) to read as follows:

(yyy) Moneys received under RSA 126-K:15 ***and RSA 78:32, II(a),*** which shall be credited to the tobacco use prevention fund.

6 New Subparagraph; Healthy Families Trust Fund. Amend RSA 6:12, I by inserting after subparagraph (dddd) the following new subparagraph:

(eeee) Moneys received under RSA 78:32, II(b), which shall be credited to the healthy families trust fund established in RSA 126-P:1.

7 Tobacco Use Prevention Fund. Amend the introductory paragraph of RSA 126-K:15 to read is follows:

126-K:15 Tobacco Use Prevention Fund. There is hereby established in the office of the state treasurer a fund to be known as the tobacco use prevention fund. Of tobacco settlement funds received by the state of New Hampshire, $3,000,000 annually, commencing with fiscal year 2001, shall be deposited in the tobacco use prevention fund. ***The sum of $7,800,000 from tobacco tax revenues shall be deposited annually in the fund, pursuant to RSA 78:32, II(a).*** Moneys in this fund shall be nonlapsing and continually appropriated, beginning with fiscal year 2001, for tobacco use prevention and cessation programs, which shall include but not be limited to:

8 New Chapter; Healthy Families Trust Fund. Amend RSA by inserting after chapter 126-O the following new chapter:

CHAPTER 126-P

HEALTHY FAMILIES TRUST FUND

126-P:1 Healthy Families Trust Fund.

I. There is hereby established in the office of the state treasurer a separate fund to be known as the healthy families trust fund. This trust fund shall be administered by the state treasurer. There shall be credited to this fund:

(a) All revenues collected pursuant to RSA 78:32, II(b) as certified by the commissioner of revenue administration.

(b) Any rebates credited to this fund pursuant to RSA 167:98.

(c) Any premiums, grants, gifts or other contributions explicitly made to this fund.

II. Amounts credited to said fund shall be expended by the commissioner of health and human services in the following priority:

(a) The medical assistance program, to provide Medicaid coverage for seniors with incomes at or below 100 percent of the federal poverty level who are eligible for said program according to RSA 167:6, VII;

(b) The pharmacy assistance program, established pursuant to RSA 167:98 in an amount not to exceed $40,000,000;

(c) The Children's Health Insurance Program, administered by the department of health and human services, pursuant to Title XXI of the Social Security Act;

(d) The Children's Health Insurance Program for parents administered by the department of health and human services, pursuant to Title XXI of the Social Security Act;

(e) Any pilot program established within the department of health and human services which provides health insurance coverage for child care workers; and

(f) To increase the prescription reimbursement dispensing fee to pharmacists for the senior prescription drug discount program; provided that funding dedicated to said program from this fund shall only be used for the dispensing fee for pharmacists and not for the operation of said program.

III. Any funds allocated from this fund that are not expended for the prioritized programs shall lapse to this fund at the end of each biennium, beginning with the biennium ending June 30, 2003.

9 Medical Assistance for Seniors. Amend RSA 167:6, VII to read as follows:

VII. For purposes hereof, a person shall be eligible for medical assistance as categorically needy or as medically needy. A person shall be eligible as categorically needy if he receives financial assistance under RSA 167:6, I, IV, V or VI, or is otherwise eligible to receive such assistance but does not. A person shall be eligible as medically needy if he meets the categorical, age, and technical requirements under RSA 167:6, I, IV, V or VI, and if his income and assets meet the standards as prescribed for the medically needy program. A person shall also be eligible as categorically needy or as medically needy who is eligible for medical assistance pursuant to the mandates of federal law or regulation or pursuant to optional state coverage groups which are allowed by federal regulation and defined by the commissioner of the department of health and human services in accordance with rules adopted under RSA 541-A, but who does not receive assistance or would not be otherwise eligible to receive assistance under paragraph I, IV, V, or VI of this section. ***A person shall be eligible for the medical assistance program, who meets the criteria established in paragraph I of this section and has an income at or below 100 percent of the federal poverty level.***

10 New Subdivision; Pharmacy Assistance Program. Amend RSA 167 by inserting after section 97 the following new subdivision:

Pharmacy Assistance Program

167:98 Program Established. There is hereby established the pharmacy assistance program, to be funded by the healthy families trust fund established pursuant to RSA 126-P:1. The department is hereby authorized to administer this program.

167:99 Definitions.

I. "Department" means the department of health and human services.

II. "Eligible person" means a resident of New Hampshire who:

(a) Is 65 years of age or older; or

(b) Is 18 years of age or older and has been determined to be "disabled" by the Social Security Administration; and

(c) Has a gross annual household income of not more than 200 percent of the federal poverty level. For the purposes of determining eligibility under this section, annual income shall not include the cost of Medicare Part B premiums unless the cost of the premium is paid by the department; and

(d) Is not eligible for the medical assistance program under this chapter.

III. "Program" means the pharmacy assistance program established under this subdivision.

IV. "Drugs" means all prescription drugs that have been approved as safe and effective by the federal Food and Drug Administration or are otherwise legally marketed in the United States, including insulin, insulin syringes, and insulin needles.

V. "Enrollee" means an eligible individual who receives benefits under the pharmacy assistance program established by this subdivision.

167:100 Administration of the Program.

I. The department of health and human services shall administer the pharmacy assistance program in order to provide prescription drug coverage to eligible persons who lack sufficient access to necessary prescription drugs. Enrollment in the program shall be voluntary and shall be funded by the healthy families trust fund, established under RSA 126-P:1, in an amount not to exceed $40,000,000 in each fiscal year.

II. Enrollees shall be provided a benefit of not more than $1,250 for the cost of prescription drugs that are purchased as part of this program.

III. The department shall verify the income of applicants for the program according to the most recent income tax returns for the applicant. If an applicant is not required to pay income tax, the department shall verify the applicant's income through submission of monthly checks received by said applicant.

IV. The department shall conduct outreach marketing efforts to ensure that eligible senior citizens and people with disabilities are aware of the availability of the program, to provide eligible individuals with the guidelines of said program, and to maximize enrollment in said program.

V. The department shall have the authority to close enrollment to the program or create a waiting list, if the commissioner reasonably believes that the costs of said program will exceed the available appropriation for said program.

VI. The department shall establish a procedure for enrollees to appeal a decision by the department to deny payment for a certain drug.

167:101 Copayments. The department shall develop copayment requirements for all purchases of drugs by an enrollee in the program. Said copayment amounts shall not be more than $5 for generic drugs or $12 for brand drugs. The department shall provide information in writing to individuals who enroll in the program as to which drugs are covered by the program, the copayment amounts, and any restrictions on drugs.

167:102 Rebates. The department may negotiate a rebate arrangement with pharmaceutical companies. Revenues received from such rebate shall be credited to the healthy families trust fund, established pursuant to RSA 126-P:1, and may be used to supplement the funding, eligibility, and drug coverage of the program.

167:103 Reports. The department shall report to the general court on the pharmacy assistance program on or before January 1 of each year, commencing one year following implementation of the program. This report shall be submitted by the department to the house and senate finance committees, the senate public institutions, health and human services committee and the house health, human services and elderly affairs committee. The report shall address the enrollment status of the program, outreach efforts by the department to educate senior citizens and persons with disabilities about the program, the expenditures and projected expenditures of the program, utilization of the program, and demographics of enrollees.

167:104 Rulemaking. The department shall adopt rules, pursuant to RSA 541-A, in order to implement the program established by the subdivision.

11 Reference Change; Education Trust Fund. Amend RSA 198:39, I (d) to read as follows:

(d) Funds collected and paid over to the state treasurer by the department of revenue administration pursuant to RSA 78:32, ***I,*** relative to tobacco taxes.

12 Expansion of Medicaid Coverage to Parents of Children Eligible for Medicaid.

I. The commissioner of the department of health and human services shall establish a program providing benefits under the medicaid program to parents of children, who are eligible for medicaid pursuant to Title XIX of the Social Security Act, who have incomes at or below 133 percent of the federal poverty level. The commissioner shall administer this program under Title XXI of the Social Security Act. The commissioner shall apply to the federal Health Care Financing Administration for a waiver pursuant to Title XXI of the Social Security Act in order to extend the S-CHIP program to include parents with incomes at or below 133 percent of the federal poverty level. The program shall receive funding from the healthy families trust fund established pursuant to RSA 126-P:1.

II. The commissioner shall adopt rules, pursuant to RSA 541-A, in order to implement the program. The department shall conduct significant outreach efforts in order to provide information to eligible parents on the availability of said program. The commissioner shall report to the general court on the implementation of the program 12 months following the effective date of this section and on or before January 20 of each subsequent year. The report shall detail the number of enrollees in the program, the outreach efforts undertaken by the department for the program, and the estimated annual cost of the program.

13 Pilot Program Established. Health Insurance Coverage for Child Care Workers.

I.(a) The general court hereby finds that it is the intent of this pilot program to provide health insurance coverage for child care workers who care for the children of New Hampshire's lowest income working families. Child care is a vital component of New Hampshire's welfare to work initiatives and this pilot program will provide an incentive for licensed child care agencies to accept state subsidized children.

(b) The general court further finds that this pilot program will increase benefits in a field which currently has low wages and few employer-sponsored benefits. It is the intent of the general court that increasing the availability of health insurance coverage will result in stabilizing the child care workforce.

II. There is hereby established a 3-year pilot program within the department of health and human services for providing employees of certain child day care agencies with access to health care insurance. The pilot program shall receive funding from the healthy families trust fund, established pursuant to RSA 126-P:1. For the purposes of this program, "department" shall mean the department of health and human services. The pilot program shall terminate on July 1, 2004, unless the legislature acts to extend the program.

III.(a) The state shall pay 50 percent of the premium for medical and surgical benefits, including group hospitalization, hospital medical care, and surgical care, for each full-time employee of a family day care home or family group day care home, as such homes are defined in RSA 170-E:2, IV (a) and (b), provided such homes meet the following eligibility requirements:

(1) The family day care home or family group day care home is licensed pursuant to RSA 170-E;

(2) The family day care home or family group day care home has provided care for 2 or more children for which the home received payment under any of the department's child care programs for 9 or more of the preceding 12 months prior to applying to the department for health care coverage under this program; and

(3) The family day care home or family group day care home continues to provide child care services for 2 or more children, for which either home is receiving payment under any of the department's child care programs as of the time the application to the department for health care coverage is submitted.

(b) To be eligible for the benefit established in this paragraph, a full-time employee of a family day care home or family group day care home shall not be eligible to receive health insurance benefits under a spouse's employer-sponsored health insurance programs.

IV. The state shall pay a percentage of the premium for medical and surgical benefits, including group hospitalization, hospital medical care, and surgical benefits, for each full-time employee of a child day care agency, as defined in RSA 170-E:2, IV (c)-(e) and (g), which provides child day care services paid for in whole or in part by the department and which is licensed pursuant to RSA 170-E.

(1) The state shall pay 35 percent of the premium for a full-time employee of a child day care agency where, during the 6-month period immediately preceding application to the department for health care insurance, the number of children served by that agency who are enrolled in any of the department's child care subsidy or assistance programs is not less than 35 percent or more than 50 percent of the child day care agency's total licensed capacity.

(2) The state shall pay 50 percent of the premium for a full-time employee of a child day care agency where, during the 6-month period immediately preceding application to the department for health care insurance, the number of children served by that agency who are enrolled in any of the department's child care subsidy or assistance programs is greater than 50 percent of the child day care agency's total licensed capacity.

(b) To be eligible for the benefit established in this paragraph, a full-time employee of a child day care agency as defined in this section shall not be eligible to receive health insurance benefits under a spouse's employer-sponsored health insurance program.

(c) No benefit provided under this paragraph shall exceed benefits provided by the medicaid program.

V. The department of health and human services shall prepare a report detailing the number of participating providers, the number of workers covered by the provisions of the pilot program, the changes in the number of licensed providers, and an estimate of the effect on staff retention. The report shall be submitted to the speaker of the house of representatives, the senate president, and the governor no later than November 1 of each year of the pilot program.

VI. The commissioner of the department of health and human services shall adopt rules, pursuant to RSA 541-A, relative to application procedures, eligibility criteria, limitations and restrictions, insurance coverage benefits limited to the level of benefits provided through the medicaid program, and any other matter consistent with the provisions of the pilot program.

14 Repeal. Section 13 of this act, relative to a pilot program providing health care insurance for child care workers, is repealed.

15 Effective Date.

I. Section 14 of this act shall take effect July 1, 2004.

II. The remainder of this act shall take effect July 1, 2001.

LBAO
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HB 762-FN-A - FISCAL NOTE

AN ACT increasing the tobacco tax to allow for a healthy families trust fund and for increased funding for the tobacco use prevention fund.

FISCAL IMPACT:

The Office of Legislative Budget Assistant is unable to complete a fiscal note for this bill as it is awaiting information from an agency.

Speakers

SIGN UP SHEET

To Register Opinion If Not Speaking

Bill # HB 762-FN Date 3/15/2001

Committee Ways & Means

** Please Print All Information **

Name	Address	Phone	Representing	(check one) Pro	Con
Dorothea N. Kelsey	60 Penacook St	7539825	NH Association for the Elderly	✓	
James F. Dwyer	15 Evergreen Dr. Merrimack	429-9542	Elders of Young Children	✓	
JoAnn St Pierre	70 Charbotte St, Manchester	625-6557	private citizen	✓	
Dom D'Ambruoso	Box 604, Concord	228-0477	RTR		✓
Anne Campbell	4 Park St	2252097	NHCAA	✓	
Linda Steir	3 Pine Knoll Dr Atkinson	362-9930	self	✓	
Marileth McCue	60 Gubber St. Manchester	669-5833	American Heart Assoc	✓	
Joyce Bond	2 Bowers Rd, Derry	434-7009	Amer. Heart	✓	
Jonathan Baird	RR1 Box 163 Danbury NH		myself	✓	
Rep Barbara C. French			Meers	✓	
Charles Chamberlain	Henniker	837-3735	Self	✓	
Alton Chamberlain	Harrisville	827-3735	Self	✓	
Michelle Catrambone	Hampstead, NH	329-4901	Self	✓	
Senator Wheeler	D-21			✓	
Dawn Tuttle	180 W. Parish Rd Concord NH	753-4712	self	✓	
Bill McCarthy	123 Wibird St Portsmouth	431-1436	SEIA	✓	
Peter Leuchman	Hillsboro 13	672-7245		✓	
Lisa K. Carpenter	New London, NH	526-8899		✓	
	NH Nurses Assoc. + NH Nurse Practitioners Assoc.			✓	
MO BAILEY	NH CHILDREN'S ALLIANCE FOR ACTION			✓	
TOM BUNNELL	BI-STATE PRIMARY CARE ASSOCIATION 3 SOUTH ST. CONCORD 03301	228-2830	BI-STATE PRIMARY CARE ASSN	✓	
Bruce Berke	~~112~~ 102 N. Main St Concord	228-2370	Philip Morris Mgt Corp		✓

SIGN UP SHEET

To Register Opinion If Not Speaking

Bill # HB 762 Date 3/15/2001

Committee Ways & Means

**** Please Print All Information ****

Name	Address	Phone	Representing	(check one) Pro	Con
JAMES P. PILLIOD	BELMONT			✓	

Hearing Minutes

HOUSE COMMITTEE ON WAYS AND MEANS

PUBLIC HEARING ON HB 762-FN-A

BILL TITLE: increasing the tobacco tax to allow for a healthy families trust fund and for increased funding for the tobacco use prevention fund.

DATE: March 15, 2001

LOB ROOM: 202 **Time Public Hearing Called to Order:** 10:10 a.m.

Time Adjourned: 11:20 a.m.

(please circle if present)

Committee Members:

Bill Sponsors:

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

(See attached.)

HOUSE WAYS AND MEANS COMMITTEE
PUBLIC HEARINGS and EXECUTIVE SESSION
March 15, 2001
Room 202 LOB

Members present: Chairman Alukonis, Reps. Bradley, Camm, V. Clark, Downing, Konys, Lasky, Langone, Major, McGuirk, and McRae.

HB762

Chairman Alukonis called the committee to order at 10:10 a.m. and invited Rep. Martha Clark, sponsor of the bill, to address us.

Rep. Clark said that this bill does two things: it raises the cigarette tax by 50 cents, which is projected to yield $83 million in revenues next year, and decline about $2 million per year after that; and to use that money to provide health care services to citizens who otherwise would not have medical access. She read an excerpt from a report which indicated that NH residents who do not have medical coverage through employment typically do not have any because they can not afford it. Copies of four studies were provided for committee members and for the file, and she urged us to study them. She said that the most expensive part of the program would be the section that covers prescription drugs for seniors. She said that the overall program is planned to provide a surplus in the first few years, to provide a cushion against the expected decline in revenues. She hopes that Federal funds will also become available for the purposes of the bill. Also, she expects that the increase in cigarette prices will discourage more young people from starting to smoke.

Rep. Major: In your calculation of revenue estimates, a decline in sales of about 1.5% per year. Do you think that is still probable after the addition of a tax increase? I point out that tobacco sales are already considerably lower than what was projected for this year.
Ans: I imagine that this committee will have to look at the latest figures, and determine what that rate of decline is more likely to be.
Followup: Was the decrease you did include reflective of your tax increase, or of national trends?
Ans: It was the projected effect of this legislation.

Rep. Konys: Are the other New England states looking at adopting this legislation this year?
Ans: Yes. They have been filed in most of the states, to raise the tobacco tax; I'm not sure if the one in Maine has actually been filed yet. The distribution of the funds raised is different in different states, though they are all for health-care related issues.
Followup: Are they all raising the tax 50 cents?
Ans: At least 50 cents; some a little more.

Rep. Raymond Buckley, co-sponsor of the bill, could not stay to speak to the bill.

Sam Mekurt, of the NH Citizens' Alliance for Action, spoke in support of the bill and said that this is the right thing to do and the right time to do it. It was decided to introduce similar legislation in the whole group of states to minimize tax-differential considerations in debate about the various bills. She described the many areas that could be assisted by the funds raised in this bill. She said the idea was fiscally

responsible, helping to reduce the costs of smoking-related illness. She read a list of members in the Alliance and left a copy of her testimony for the file.

No questions.

Richard Anthony, from the American Cancer Society, spoke in support of the bill and said that he had started smoking at age 15, and continued until at age 50 he was diagnosed with throat cancer. He had to have surgery, which left him unable to speak until he was fitted with a device to provide sounds. He described the inability to obtain employment with his disability and the financial burdens his disease has placed on him; and he said that this bill, had it passed many years ago, would have helped him.

No questions.

Douglas Barry, president of the American Lung Association of NH, also spoke in support of the bill. He also predicted that additional cost would prevent teenagers beginning to smoke, and would also discourage supplying friends with cigarettes. He disparaged the large contributions that cigarette manufacturers make to Federal senators and congressmen.

No questions.

Dennis Herbert, of the American Cancer Society, spoke in favor of the bill and said that cancer has been implicated as a major cost of many types of cancers, and a long list of other diseases. He said that virtually everyone has been touched by its pernicious evils. He said it causes 430,700 deaths a year and creates $138 billion in annual costs. He made reference to the results of the "Smoke Free New England" survey, and provided a copy of his testimony for the file.

No questions.

Nancy Pederzini, of the American Heart Association, spoke in support of the bill. She also distributed copies of her testimony. She said that one in five cardiovascular deaths are related to smoking tobacco, and that the best way to reduce tobacco use is to combine a large tax increase with a strong tobacco control program. She referenced a California program as an example. Passage of this bill would only bring NH's smoking cessation effort up to the minimum recommended by the CDC.

Rep. Giuda: Do you have any figures on the amount of health care cost reduction that this program would be expected to provide?
Ans: No, I'm sorry but I don't.

Robert Stauffer, of the NH Association for the Elderly, spoke in support of the bill. He said he wanted to give a senior perspective on this bill. For seniors health care access, particularly in the area of prescription drugs, is their most significant policy issue. He said that there are currently 17,000 seniors in NH with incomes below the Federal poverty level, but only half of them qualify for Medicaid. This bill would provide prescription coverage for up to 40,000 more seniors.

No questions.

Karin Cloutier, who said that she was representing childcare workers, spoke in support of the bill. She is a full-time teacher at a children's center and does not have health care coverage through her employer. Her income is insufficient to allow her to buy it privately. She would like our help.

No questions.

Candice Leonard, of the Children's Alliance, spoke in support of the bill. She said that recent Kids Count data showed that the percentage of births to mothers who smoke is greater in NH than in most other states. Those babies are more at risk of respiratory and neurological problems. She also pointed out that the Healthy Kids program would be continued and expanded if this bill passes. Helping to correct minor health problems would then prevent them developing into more serious problems. And including health insurance for child care workers would help to reduce the turnover in that employment area. She provided copies of her testimony.

No questions.

Kris MacNeil, owner of MacNeil's Corner Market, then spoke in opposition to the bill. She said that once again the smokers of the state were being asked to provide the funds for various worthwhile causes. She asked why alcohol drinkers are not being asked to pay for the cost of related diseases and accident results, or gasoline purchasers for the cost of services at accident sites, or fatty-snack consumers for the costs associated with heart diseases. She said that the smokers in New Hampshire are already paying their fair share. Since we're already getting a large amount of money from the tobacco settlement, she thinks that we should use that not only for health issues, but for greater enforcement activities to prevent black market and grey market sales. She pointed out that 25% of the independent stores in NH, and 40% nationwide, have already closed because of the huge increases in tobacco taxes.

No questions.

Kim McGlinchy, from Strafford NH, said that she and her husband do not have health insurance, though now her children are covered by Healthy Kids. She is a graduate student and part-time waitress, and her husband is a roofer. Because of an accident he had, they had a significant loss of income at the same time that medical bills mounted; she said that situations like that cause many people to declare bankruptcy. She left a copy of her testimony for the file.

No questions.

Next, Lyanne Cochi and Bob Nowak, representing the NH Chapter of the New England Convenience Store Association, appeared to oppose passage of this bill. She said that designing new programs to be funded by a declining and volatile revenue source is just not good fiscal policy. He said that as a small businessman, he knows that they are losing sales from across the border because of past tax increases. He pointed out that people who do not come to buy cigarettes also do not buy gasoline, lottery tickets, or other items. They left a copy of their testimony for the file.

No questions.

Gina Balkus, director of government relations for Dartmouth-Hitchcock Medical Center, spoke in favor of the bill and provided written testimony. She said that they wholeheartedly support any measure that will reduce tobacco usage. They also support the additional funding for the various medical purposes outlined in the bill.

Theresa de Langis, of the Commission on the Status of Women, distributed copies of their public policy report, a copy of which is in the file. HB762 is part of their agenda. She said that NH ranks high in mortality rates for women from cancer and from heart disease, and that tobacco cessation programs could help to reduce those rates. However, their major support is of the attempts to provide benefits for child care workers. Since these positions pay low salaries, the workers normally can not afford medical insurance. She urges our support of this bill.

Rep. Giuda: Do you have any statistics relative to low-income child cares services in the northern part of the state, versus the southern?
Ans: I don't, but I can try to get it for you.
Followup: Have you thought about providing business tax incentives to providing on-site child care?
Ans: We are a non-profit state agency and do not have the resources for something like that.

Tricia Brooks, executive director of the Healthy Kids Corporation, spoke in favor of the bill and provided written testimony. She described the work that has been done in children's health and how much the additional support that would be provided by this bill's passage would help. Every state dollar spent in her program leverages another $4 in services from other sources. She referenced a Josiah Bartlett Center report, part of which is reproduced in her materials.

Rep. Giuda: Do you have any sense for how much a 50 cent increase in cigarette taxes will do to sales?
Ans: No. My interest is in health care issues.

Brook Dupee, from the Dept. of Health and Human Services, said that the department supports the tax increase portion of the bill, particularly because of the disincentive for teenagers to begin smoking.

Rep. Giuda: How are the smoking cessation funds are utilized?
Ans: I will leave a copy of our tobacco control program, which explains that. About 7% of the funds are for administrative costs.

Linda Garrish, from Manchester, spoke in support of the bill and said that it is reasonable and appropriate, a bill that clearly states what it wants to do and does provide a mechanism for doing it. She thinks that this is one of the most substantial bills our legislature has seen in some time. She smokes, and says that she smokes a little less now because of past tax increases. Unfortunately, new smokers have started. This is a long-term problem and needs a long-term solution. She said that she, and many other disabled and/or senior citizens, can not afford supplemental insurance coverage, especially those that include prescription drug benefits. She does sympathize with the difficulties of "Mom and Pop" stores, but believes that problem should be addressed in some other manner.

No questions.

George Roberts, representing the U.S. Tobacco Company, said that he thinks that all of the uses of funds in the bill are laudable, but that once again it is improper to use tobacco as the emotional whipping-post for all problems. In particular he does not see how providing child care worker benefits can be tied to tobacco usage. He reminded us that the tobacco settlement was supposed to pay for health care issues and smoking prevention. Because the state chose to use them to balance the budget instead, does not make it right to raise the tax level even higher. He also indicated that there may well be constitutional issues in taxing some tobacco products and not others. He said that years ago he served on the Appropriations committee, and they eliminated a number of small taxes on various projects. He said that anyone who develops lung disease, who ever smoked for even a very brief time, is recorded as having the disease as a result of smoking.

Rep. Downing: Do you have any idea of how the state should generate the revenue it needs, other than raising this tax?
Ans: I can only answer for my own opinion, which is through an income tax. He expounded at length on the advantages of an income tax and how to effectuate one.

No further testimony was offered.

Written testimony in support of the bill was left by Linda Steir, a member of the Governor's Commission on Disability; Mary Ann Cooney, of the New Hampshire Smoke Free Alliance; Tom Bunnell, of the Bi-State Primary Care Association; and Palmer Jones, of the NH Medical Society.

Written testimony in opposition to the bill was left on behalf of the RJ Reynolds tobacco company.

The hearing was adjourned at 11:20 a.m. The committee took a fifteen minute break.

Upon return the committee went into executive session. Present were Chairman Alukonis and Reps. Camm, Clark, Downing, Giuda, Hess, Konys, Langone, Lasky, Major, McRae, and McGuirk.

On HB151, Rep. Langone moved ITL, seconded by Rep. Hess. Rep. Giuda asked if there was any particular reason for the motion; Rep. Alukonis commented that it is probably unconstitutional to exempt one type of pension and not others. Rep. Lasky said that it was premature to exempt anything from a tax which does not exist. Vote 13-0, but no consent calendar.

HB 185 Rep. Giuda moved OTP, seconded by Rep. Hess. Rep. Konys indicated that she would have preferred ITL because there are other property tax bills that she prefers; she would have liked to see the current scheme sunset. Rep. Camm asked if any better bill couldn't replace the repeal; Rep. Konys responded all the more reason for not needing this one. Rep. Hess commented that eliminating the repeal early was necessary because a property tax of some sort is going to be part of the mix. Rep. Giuda said that we needed it in order to assure communities that state aid would in fact be forthcoming. Rep. McGuirk asked whether passage of this bill assumes the Supreme Court will not uphold Judge Galway's ruling. He does not think the bill is necessary. Rep. Giuda pointed out that Judge Galway's ruling did not declare the statewide property tax unconstitutional, only the assessment of it. Rep. Lasky said that she does have a problem with the way the education tax is distributed, included

Sub-Committee Actions

HOUSE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE WORK SESSION ON HB 762-FN-A

BILL TITLE: **increasing the tobacco tax to allow for a healthy families trust fund and for increased funding for the tobacco use prevention fund.**

DATE: 3/20/01

Subcommittee Members: Reps. MAJOR, CAMM, LASKY, BRADLEY, DICKENSON

Comments and Recommendations:

Amendments:

Sponsor: Rep. _____ OLS Document #: _____ Adopted/Failed

Sponsor: Rep. _____ OLS Document #: _____ Adopted/Failed

Sponsor: Rep. _____ OLS Document #: _____ Adopted/Failed

Motions: ~~OTP, OTP/A, ITL, Interim~~ RETAINED Study (Please circle one.)

Moved by Rep. LASKY

Seconded by Rep. DICKENSON

Vote: 5/0

Motions: OTP, OTP/A, ITL, Interim Study (Please circle one.)

Moved by Rep. _____

Seconded by Rep. _____

Vote: _____

Respectfully submitted,

Rep. Paula Bradley

Sub-Committee Minutes

House Ways & Means Committee
Subcomittee on Sales, Meals & Rooms, Consumption Taxes, and Regulated Revenues

MINUTES

The Subcommittee was called to order on October 24, 2001 at 1:00 PM by Representative Major. Committee members present were: Representatives Cote, Camm, Lasky, and Alukonis.

SB183-FN-A-L relative to distribution of certain meals and rooms tax revenue to municipalities with affordable housing

A motion of Inexpedient to Legislate was made by Representative Lasky, seconded by Rep. Camm. The motion passed unanimously, 5-0.

HB 644-FN-A-L requiring the sweepstakes commission to hold a sealed bid auction for permits to operate slot machines and providing municipalities the option of allowing the operation of slot machines.

A motion of Inexpedient to Legislate was made by Representative Camm, seconded by Rep. Lasky. The motion passed unanimously, 4-0. Rep. Cote was not present for the vote.

HB 378 requiring organizations engaged in the conduct of charitable gambling to reserve at least 80 percent of the revenue for use within New Hampshire.

A motion of Inexpedient to Legislate was made by Representative Alukonis, seconded by Rep. Camm. The motion passed unanimously, 5-0.

HB 558-FN-A-L increasing certain state taxes, establishing a tax on gambling winnings, and expanding the meals and rooms tax to include a tax on entertainment.

Further action on HB 558 was deferred until October 24, 2001

CACR 24 relating to establishing a maximum rate for a sales tax. Providing that the rate of any sales tax established in law shall not exceed 2 1/2 percent, provided that a higher rate may be established by a 2/3 vote of those present and voting in each house of the general court.

A motion of Inexpedient to Legislate was made by Representative Lasky, seconded by Rep. Alukonis. The motion passed unanimously, 5-0.

HB 762-FN-A increasing the tobacco tax to allow for a healthy families trust fund and for increased funding for the tobacco use prevention fund.

Further action on HB 762 was deferred at the request of Rep. Lasky until October 24, 2001

Alukonis

House Ways & Means Committee
Subcommittee on Sales, Meals & Rooms, Consumption Taxes, and Regulated Revenues

MINUTES

The Subcommittee was called to order on October 31, 2001 at 10:00 AM by Representative Major. Committee members present were: Representatives Cote, Camm, Lasky, and Alukonis.

HB 558-FN-A-L increasing certain state taxes, establishing a tax on gambling winnings, and expanding the meals and rooms tax to include a tax on entertainment.

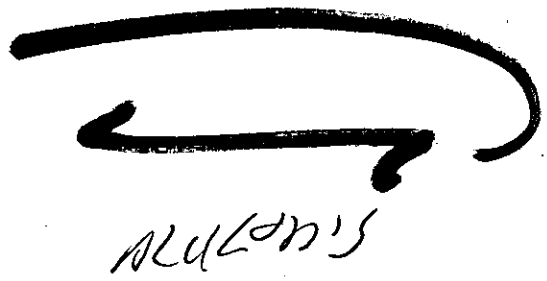
Rep. Alukonis moved, seconded by Rep. Camm that HB 558 be reported as Inexpedient to Legislate. Representatives Alukonis, Camm and Major Voted in favor; Lasky and Cote against. The motion passed 3-2.

HB 762-FN-A increasing the tobacco tax to allow for a healthy families trust fund and for increased funding for the tobacco use prevention fund.

Rep. Lasky offered an amendment (1910h)

Rep. Lasky moved, seconded by Rep. Cote to adopt the amendment. Representatives Alukonis, Camm and Major Voted against; Lasky and Cote voted in favor. The motion failed 2-3.

Rep. Camm moved, seconded by Rep. Alukonis that HB 762 be reported as Inexpedient to Legislate. Representatives Alukonis, Camm and Major Voted in favor; Lasky and Cote against. The motion passed 3-2.



Testimony

Memorandum

To: Representative David J. Alukonis, Chair
House Ways and Means Committee

From: David Rienzo, Assistant Attorney General

CC: Michael Walls, Associate Attorney General

Date: January 8, 2002

Re: Tobacco industry payments to the State pursuant to the Master Settlement Agreement

On December 31, 2001, the State of New Hampshire received a payment of $12,945,238.46 pursuant to the above-referenced agreement. In our November 15, 2001 memorandum to this Committee, this Office estimated the State would receive approximately $13,600,000. Subsequently we were informed by the Independent Auditor that our expected payment would be $14,250,504.00. As you can see, the actual payment did not reach our lower estimate. This is due to the unexpected diversion of approximately $231,574,248.22 of its scheduled payment amount by Brown and Williamson, one of the major payors, into a disputed payments account. This reduction of $1,305,265.54 in payment to New Hampshire represents New Hampshire's approximately 0.56% share of the entire amount paid into the Settlement Account.

At this point, it is unclear when the underlying disputes which prompted Brown and Williamson to divert this amount into the Disputed Payments Account will be resolved, or whether in the future other payors may also decide to make similar diversions. The Office of the Attorney General is closely monitoring this situation, and is currently considering what actions to take to protect the State's interest in these funds.



NEW HAMPSHIRE NURSES' ASSOCIATION

48 West Street, Concord, NH 03301-3595 Tel (603) 225-3783 Fax (603) 228-6672

HB 762 **An ACT increasing the tobacco tax to allow for a healthy families trust fund and for increased funding for the tobacco use prevention fund**

Position: ***SUPPORT*** (March 14, 2001, House Ways & Means Committee)

New Hampshire's nurses have a long and rich history of advocating on behalf of health care. This bill represents an opportunity to redirect health care dollars to the health care needs of New Hampshire's citizens. Over the past several years, we have watched, helplessly, as tens of millions of dollars, earmarked for health care, have been siphoned off to support the general fund, at the expense of those in need. This must stop. *Please support HB 762.*

Each and every one of the important health care projects targeted in HB 762 has merit. **Increased medical assistance for our senior citizens, including a senior prescription drug discount program.** The elderly among us not only deserve this added support, it is cost effective. The better the services provided, the more likely a senior is to remain healthy and be a productive member of society. It is fiscally irresponsible to place elderly people in a position where they are too frail or ill to remain in their homes without services, but ineligible financially for admission to a skilled nursing facility. The result is a high proportion of costly hospital beds being occupied with patients who should be receiving their care in a more comfortable, appropriate and cost-effective setting.

Support for the Children's Health Insurance Program ("CHIP"). Surely no one would disagree that providing comprehensive health insurance coverage for needy children is good public policy. Healthy children stay in school, learn better, and grow to become healthy adults, who are gainfully employed. They are the foundation of our future – we must not compromise their health because of our failure to provide them with adequate insurance when their parents are unable to do so. In the end, it will only cost society more – socially, spiritually, and economically.

A pilot program to provide coverage for child care workers. It just makes good "cents." If we fail to adequately compensate child care workers, then we knowingly foster a weak link in our employee base. With low unemployment rates, it is hard to attract qualified professionals into the field. Parents are fearful of leaving their children to be physically tended to and cognitively enriched by people who lack experience and training in child care and child development. As a result of their fears, many parents opt out of the work force altogether. We must do something now to begin to upgrade the quality of child care workers, so that more parents are willing to return to work themselves.

Finally, **increased funding for tobacco use prevention.** The numbers speak for themselves. Seventeen hundred (1700) people die each year in New Hampshire from smoking. Annual health care expenditures in New Hampshire directly related to tobacco use exceeds $300 million. New Hampshire residents' state and federal tax burden caused by tobacco-related health costs is $180 million. New Hampshire spends $90 million in Medicaid payments that are directly related to tobacco use. Additional annual expenditures in New Hampshire for babies' health problems caused by mothers smoking or being exposed to second hand smoke during pregnancy are estimated to be between $6 and $18 million. Seventy thousand (70,000) children in New Hampshire are exposed to secondhand smoke at home. 24% of adults in New Hampshire smoke.

Please help us guarantee that health care dollars are spent meaningfully to improve access to quality health care, and to improve the health and quality of life for New Hampshire citizens.

Thank you for your support of HB 762.

AOI 1503

Brook Dupee
Department of Health and Human Services
Testimony on House Bill 762
Before the Ways and Means Committee
3/15/01

the 50¢ tobacco tax increase contained in

Good morning, Mister Chairman and members of the Committee. For the record, my name is Brook Dupee. I am the Assistant Director of the Office of Community and Public Health in the Department of Health and Human Services, and I am here today to speak in support of HB 762.

Tobacco use is the leading cause of preventable death and disease in our state. I'm sure you are aware of the various health hazards of its use, but I want to highlight three statistics of particular concern in New Hampshire:

1. Over one-third of NH high school students smoke on a regular basis (source: 1999 YRBS). If this trend continues, 23,000 of these youth will eventually die from smoking-related diseases (source: 1996 CDC).
2. The annual health care expenditure in NH directly related to tobacco use is $302 million. Of that, the state portion of Medicaid payments related to tobacco use are $94 million (source: 2001 CDC publication. *Investment in Tobacco Control*).
3. Approximately 2000 NH residents die annually from smoking-related illness (source: 2000 NH Tobacco Prevention Program analysis using SAMMEC software from CDC).

So why is the department of health and services taking a positoin on a tax bill? Increasing cigarette prices via a tax has been proven in other states, such as Alaska, California and Massachusetts, to reduce adult consumption (source: 1996 CDC, 2000 Alaska). Youth are particularly sensitive to price increases because it provides an incentive not to start as well as an incentive to quit. In fact, substantial price increases in combination with a comprehensive prevention program such as is being developed by the Department, have been shown to be the most effective way to substantially curb teen smoking, again in Massachusetts and California.(CDC Publication: *Best Practices for Comprehensive Tobacco Control Programs*, 1999)

The NH Legislature has allocated 3 million dollars annually from the national Tobacco Settlement award, to go into the Tobacco Use Prevention

Fund. This fund supports integrated and evidence-based interventions on a community and statewide level to ultimately reduce the high prevalence of smoking among youth and young adults in New Hampshire.

A tax increase such as the 50-cent per pack tax being proposed would effectively strengthen the investment the Legislature has made to protect the health of our youth and to save money in future health care costs.

Thank you for this opportunity to testify in favor of HB 762. I'll be happy to answer any questions you may have.

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EXECUTIVE VICE PRESIDENT
Palmer P. Jones

HB 762

The New Hampshire Medical Society wishes to be recorded in support of the 50-cent increase in the cigarette tax.

The funding from the 50-cent tobacco tax will be allocated as follows:

- Increase funding for tobacco control from $3M to 10.8M.
- Establish the Health New Hampshire trust fund for the revenue created by this new tobacco tax.
- Increase Medicaid for seniors up to 100% of the federal poverty level.
- Establish a Pharmacy Assistance Program for seniors and people with disabilities.
- Fund the states cost of the Children's Health Insurance Program (CHIP) which is currently paid by a private foundation.
- Expand Medicaid for parents up to 133% of the federal poverty level, using the CHIP program.
- Establish a three-year pilot project providing assistance with health care insurance coverage for child care workers.
- Increase the reimbursement for the Senior Prescription Drug Discount Program.
- Smoking kills more than 400,000 people each year in the U.S.
- Annually, smoking kills more people than AIDS, motor vehicle accidents, alcohol, illegal drugs, suicides and fires combined.
- Smoking is the leading preventable cause of death and disease in the U.S.
- Every day, another 3,000 young people become regular smokers.
- Nicotine addiction among young people is an epidemic that has enormous consequences for public health.
- **Increasing the tax on tobacco products is a proven deterrent for young people.**
- I urge you to support the interests of New Hampshire's children – not the interests of the tobacco lobby.

Thank you.

Palmer P. Jones,
Executive Vice President

HB762Testimony2001.doc

Statement on behalf of the R. J. Reynolds Tobacco Company Opposing the adoption of House Bill 762

March 15, 2001

The R. J. Reynolds Tobacco Company opposes the adoption of House Bill 762 in its current form on the grounds that there are more viable and sustainable funding alternatives than the tobacco excise tax increase contained therein.

House Bill 762 has many laudable public policy objectives. From providing medical assistance to persons 65 years of age and older, to strengthening the Children's Health Insurance Program, the proposed Healthy Families Trust Fund would help underwrite important health initiatives for New Hampshire's most vulnerable citizens. If enacted, these programs should have a solid financial foundation.

Unfortunately, data from the Office of the Legislative Budget Assistant (LBA) and the New Hampshire Education Funding Commission strongly suggest that revenues from the tobacco excise tax are far too volatile to support such an important initiative. Indeed, according to the LBA's February 2001 report, state tobacco tax revenues fell by $4.5 million--or 7.1 percent--compared with 2000. Said revenues were down by an estimated $1.1 million last month alone.

That is not all. Economic research conducted by the New Hampshire Education Funding Commission projects that the tobacco tax base could shrink by 4 percent annually, with revenues dropping from an estimated $67.7 million in 2001 to as little as $62.4 million by 2003. Based on these figures, we cannot help but conclude that the tobacco excise tax is too risky a revenue source for the proposed Healthy Family's Trust Fund.

R. J. Reynolds believes that New Hampshire's revenues from the 1998 Major Settlement Agreement (MSA) with the Tobacco Industry provides a more stable and appropriate revenue source for the public health initiatives proposed in House Bill 762. These funds are substantial. New Hampshire received $16.2 million in 1999 and $38 million in 2000. This year's payments will total $46.1 million--a figure that will increase to $55.4 million in 2002 and $55.9 million in 2003. In the final analysis, current projections suggest that New Hampshire can expect as much as $1.3 billion over the next twenty-five years. These payments were established to help New Hampshire improve public health, and we urge the General Court to use them for that purpose.

Furthermore, we note that several large foundations have recently awarded sizeable grants to support smoking cessation, and suggest that the General Court to consider these and other related opportunities when evaluating revenue sources for new pilot programs and tobacco-related public health projects. In the past year, for example, the Robert Wood Johnson Foundation gave $93 million in grants to tobacco use and substance abuse programs, while the American Legacy Foundation, a non-profit charitable organization, launched a three-year $35 million program to support state and community tobacco control initiatives. Foundation grants could help New Hampshire address these important public health issues without raising taxes.

Respectfully submitted,
Dom S. D'Ambruoso

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necsa
New England Convenience Store
Association

New Hampshire
Chapter

Statement of Opposition to HB 762-FN-A
Increasing the tobacco tax to allow for a healthy families trust fund and for increased funding for the tobacco use prevention fund

House Ways & Means Committee
March 15, 2001

Thank you Mr. Chairman and Members of the House Ways & Means Committee:

My name is Lyanne Cochi and I am the Government Relations Director for the NH Chapter of the New England Convenience Stores Association (NECSA). On behalf of NECSA's member stores and employees, I appear before you today to oppose the passage of the proposed increase in the tobacco tax in House Bill 762.

With me today is Bob Nowak, a storeowner and member of NECSA. Both of us will share with you the reasons why NECSA and its members oppose what would be the third tax increase on this product in five years.

As I just referenced, the tobacco tax has been raised twice during the last four years. Those two tax increases more than doubled the rate of the tax, taking it from 25 cents per pack of cigarettes to 52 cents per pack. Also adding costs to a pack of cigarettes, and therefore having an impact on the sales of this product, was the Master Settlement Agreement between the states and the domestic tobacco manufacturers. As such, the State of New Hampshire has seen its share of annual revenue from tobacco sales in the state increase from approximately $48mm to nearly $135mm (52 cent tax = $94mm+/- and approx $40 from the MSA).

What have these changes produced besides the revenue gain? Fewer sales. During the most recent complete fiscal year, 2000, the state realized a 7% decline in sales and revenues from fiscal year 1999. And for the first 8

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months of fiscal year 2001, sales and revenues are again on pace to decline by 7% from the FY 2000 numbers. These are not strong trends for a revenue source that some are looking to support new programs.

Prior to the 1997 and 1999 tax increases as well as the added costs created by the master Settlement Agreement, New Hampshire used to collect $2mm in revenue for each penny of tax. However, the 15 cent tobacco tax increase enacted in 1999 only produced an additional $18.8mm in revenue. Clearly, the tobacco tax is a declining revenue source and is not a stable source for new programs to rely on. In fact, even the Governor's Blue Ribbon Commission Report stated that as well.

Bob Nowak's Testimony

Thank you Mr. Chairman,

As a small businessman and convenience store owner, I am also opposed to this bill. NH's continuing decline in sales is taking place for several reasons, people smoking less, the cost of cigarettes but the biggest reason is because we are losing sales from across our borders.

We already have a higher tax than Vermont and the more the cost of cigarettes increases, lowering the percentage of savings that purchasers will have, the fewer tobacco sales we are having in NH. To support this position I offer the following. Studies have shown that the number of smokers in NH have remained level of about the same while tobacco sales have steadily declined over the last two to three years. Now if the state adopts Governor Shaheen's proposed sales tax plan, then even fewer cross border sales will take place as fewer people come to NH to shop.

In addition to tobacco revenues, NECSA also believes that accompanying revenue loss will occur as a result of fewer sales in beer, food, lottery, and gas. All of these types of sales contribute to the state's treasury and will be negatively impacted by an increase in the tobacco tax.

The proponents of this bill would be wise to encourage their colleagues to use the Master Settlement Agreement funds for these new programs. Those revenues are steady and predictable.

Thank you for your time this morning and NECSA urges you to oppose the increase in the tobacco tax because of the negative impact it will have on state revenues, jobs in NH and businesses operating in NH.

HB 762--AN ACT INCREASING THE TOBACCO TAX TO ALLOW FOR A HEALTHY FAMILIES TRUST FUND AND FOR INCREASED FUNDING FOR THE TOBACCO USE PREVENTION FUND (02/15/01 9:00 A.M. 202 LOB)

Good morning. I am Kris MacNeil. My husband and I own a convenience store here in Concord, which we have recently re-opened. I am here today to oppose this bill, HB 762.

Once again, smokers are asked to cough up more funds out of their pockets to pay for a tobacco intervention program, and this time, to support health care for the critically needy components of the population--the elderly, the poor and the children. The sponsors of this bill justify this by asking the General Court to declare that it is the policy of the State of New Hampshire to share in the costs of tobacco control programs and health care access for those least able to afford it. Gee, I don't see them asking for the State of New Hampshire to share in the costs of alcohol control programs for those who purchase their addictions from the State Liquor Stores placed strategically on the highways next to the rest areas. It seems to me that here in New Hampshire, our teens are drinking more than the national average. And, let's look for some increases in the beer and wine taxes, as the Center for Disease Control says that cheap beer is a leading contributor to the spread of sexually transmitted diseases. Or, by golly, a higher gasoline tax would compensate medical costs for those who dangerously drive their cars more than the federal safety standard, encouraged, of course by our government's propensity to up the speed limits on highways. And what about the Federal Centers for Disease Control who say that Motor Vehicle accidents are the leading cause of death for children over the age of one, and of those, 64 percent were in a car driven by a drunken driver? And don't forget that Diesel exhaust inside school buses has now been seen to expose children to as much as 46 times the cancer risk considered significant by the E.P.A. I don't see these sponsors asking for a tax based on fatty gram content in our fast food chains and other snack foods to address the needs of our increasingly sedentary population, and the increases seen in the accompanying obesity that leads to higher rates of heart disease, stroke or diabetes. Let's not forget, too, that linked to folks who sit too long at desks, buses, airlines or cars is deep vein thrombosis--in which a blood clot forms in a deep vein in the calves--affecting about 1 in 1,000 people, and it is the fourth-leading cause of death in the United States. And now the National Safety Council claims that 20 million Americans were seriously injured by preventable accidental injuries. There's a drain on your health care system. And let's not even get into the cost of dental care and all the cool things that could be taxed to offset its cost. But our sponsors want you to believe that smokers cause all our health problems, and thus should, exclusively, be expected to pay for these.

I'm sorry. But this State sued tobacco companies for tobacco settlement monies that were subsequently collected from the big, bad smokers and then put into a tobacco settlement fund. This amounted to $79 million so far. The smokers in New Hampshire are already paying their fair share. Since 1997, the cost of a carton of cigarettes, at my business, has tripled in price, to cover legal fees and this state's settlement money. The State of New Hampshire will receive another $21 million or so in April. Thus far, you utilize $3 million a year on tobacco prevention programs. The Campaign for Tobacco-free kids says New Hampshire spends $340 million on public and private health care expenditures directly related to tobacco use. This state is expected to receive 1.4 billion from the tobacco companies by 2025. Use the money you are getting already. And while we are on this subject, what about using some of this money to shore up your Revenue Department, who cannot even to begin to address the Gray Market tobacco problems this state created? As fast as gray market product is confiscated, it is replaced. None of this product contributes to your tobacco settlement funds. And how about the tobacco-settlement free products that are being shipped in from Florida that also takes away from your monies? And the Black Market that has been created by the high prices of tobacco already? And the Mom and Pop stores that have been forced out of business by a dearth of tobacco-friendly tourists? **You stick another $5 a carton tax on cigarettes, and you won't be able to afford the enforcement issues it causes.** And Mom and Pop stores can't afford this floorstock tax--we'll be paying it in unsellable, unreturnable tobacco. Even in my new location, keeping the bare essential stock, this bill will immediately force me, within 20 days, to give the state of New Hampshire over $10,000 dollars, for stock I already own, that is not returnable, that, historically speaking, I won't even be able to sell for several months, because my customers will stock up prior to this increase. Since we lost our smoking tourists, and their associated sales, and consequently lost our tobacco advertising fees, to the Indian reservations in New York, and the internet sales, we have lost a quarter of our independent stores here in New Hampshire, 40 % nationwide. We are an integral part of our neighborhoods. This state destroyed our business in our very own neighborhood by your previous tax hikes and wars on tobacco, here in a state that, ironically, owns its own liquor enterprise. Quite frankly, use your ill-gotten monies for what they were intended, or raise the prices on your liquor, for health-care costs, and see how you like it when all your customers are buying elsewhere. It is not the state's job to destroy businesses. And that is what this state has done, on purpose, and with no compensation. Don't continue this travesty. The consequences, and ramifications, of this bill are more than this state can afford. Don't force any more small Mom and Pop proprieters out of their neighborhoods.

BI-STATE PRIMARY CARE ASSOCIATION



SERVING VERMONT & NEW HAMPSHIRE

Testimony of Tom Bunnell
House Bill 762
House Ways and Means Committee
March 15, 2001

My name is Tom Bunnell, and I am the Director of NH State Affairs at Bi-State Primary Care Association. Bi-State is a policy advocacy voice for the medically underserved. Its members include New Hampshire's community health centers and other core safety net providers of primary and preventive health care services to the poor, the uninsured, and other vulnerable populations.

You have heard or will hear a great deal today about the importance of the public health and health care access needs targeted by this bill. And they *are* critically important needs.

But beyond the gravity of the needs addressed by this bill, having a dedicated and sustainable source of funding for essential health care needs is *good* public policy.

We all know that smoking has a dramatic and damaging effect on public health, and is a central driver of skyrocketing long-term health care expenses for the State. Increasing our tobacco tax in order to address essential public health and health care access needs makes good sense.

On behalf of Bi-State Primary Care Association and its members, I urge and encourage you to support an "ought to pass" motion on House Bill 762. Thank you.

IMPORTANT INFORMATION

WASHINGTON, DC (March 14, 2001) - The tobacco industry has given more than $32 million in political contributions since 1995 in its efforts to thwart public health measures, and votes in Congress show a strong correlation between the amount Members receive and how they vote on tobacco-related issues, according to a report issued today.

The report also details what the tobacco industry expects for its money from the new Congress and Administration, including defeating legislation to grant the U.S. Food and Drug Administration (FDA) authority over tobacco products, killing the U.S. Department of Justice lawsuit against the tobacco industry and changing U.S. trade policy to support the export of tobacco products.

The report, titled "Buying Influence, Selling Death," was released as the U.S. Senate prepares to debate campaign finance reform legislation.

"Tobacco policy presents one of the clearest examples of how campaign contributions have distorted the political process to protect the special interests rather than the public interest," concludes the report, which was released by Common Cause, the Campaign for Tobacco-Free Kids, the American Heart Association and the American Lung Association.

(The entire report will be available on the Internet at www.tobaccofreekids.org/reports/influence tomorrow morning by 10:00am EST. The report includes a chart listing tobacco PAC contributions to all current members of Congress. Additional information can be found at www.commoncause.org or www.tobaccofreekids.org.)

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Founded in 1904, the American Lung Association includes affiliated associations throughout the U.S., and a medical section, the American Thoracic Society.

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of New Hampshire

Thursday, March 15, 2001
House Bill 762-FN-A
Ways and Means

Good morning. For the record, my name is Douglas Barry and I am the President of the American Lung Association of New Hampshire. We are supportive of House Bill 762, which seeks to raise the tobacco tax by fifty cents.

Raising the costs of tobacco products, make them less accessible to kids. While we support the concept and principle of raising tobacco taxes in general, we know that fewer children will smoke, or they will smoke less, as the amount of the tax is increased.

According to the 1999 Youth Risk Behavior Survey, out of thirty-three participating states, New Hampshire has the seventh highest smoking rate among teenage girls, and overall we have the sixteenth highest smoking rate. As the tobacco tax is increased, fewer children will think twice about spending their money on purchasing cigarettes, other kids will not be as willing to share their cigarettes.

Raising the tobacco tax is not only a sound health policy; it is also a good economic policy. Currently, it is estimated that 1.2 million packs of cigarettes are illegally sold to kids in New Hampshire each year. Health care expenditures in New Hampshire directly related to smoking is $340 million annually. New Hampshire Medicaid payments directly related to smoking is $90 million yearly. Additional expenditures range from $6 to $18 million annually for babies health problems caused by mothers smoking or being exposed to second-hand smoke during pregnancy. The more youths that we can keep off tobacco products now, the lower the States future expenditures due to tobacco use will be.

1,700 New Hampshire residents die each year from smoking and if current trends continue, 23,000 New Hampshire kids that are alive today will die from smoking. The use of tobacco products has many serious health effects including lung cancer, emphysema, respiratory infections, chronic obstructive pulmonary disease, and can increase asthma attacks.

This legislation has further advantages. It would increase the revenue in the Tobacco Use Prevention Fund thereby bringing New Hampshire up to the level recommended by the Centers for Disease Control.

We at the American Lung Association of New Hampshire urge you to pass the 50-cent tobacco tax increase.

Joanne McCarthy, Regional Director of Government Affairs,
Philip Morris Management Corporation. 1(800) 662-8852.

TESTIMONY FOR THE NEW HAMPSHIRE STATE LEGISLATURE ON PROPOSED INCREASES IN CIGARETTE EXCISE TAXES

Philip Morris U.S.A., the nation's largest cigarette manufacturer, would like to express concern and opposition to the proposed excise tax, which affects customers, business partners and employees.

The proposed excise tax hike would be bad for them and for the rest of the people of New Hampshire, even those who do not rely on cigarette sales for some or all of their livelihood.

According to the National Association of State Budget Officers, New Hampshire already has a reserve of $44 million appropriated for FY2001, which it can use to respond to unforeseen circumstances after meeting its budget obligations. With the State already holding this much of its citizens' money in reserve, it seems unnecessary to raise any taxes – even cigarette taxes.

This tax increase is slated to fund the healthy families trust fund and the tobacco use prevention fund. Broad-based and important programs that benefit everyone, such as these, should have reliable and stable sources of funding.

Cigarette taxes are an inappropriate funding mechanism for the important programs you have in mind.

This proposal would fund programs with a revenue source that has been historically declining. Since 1990, cigarette sales nationally have fallen an average of between one and two percent per year. That trend will likely continue.

If a state program is important enough to deserve funding, it's important enough to have a reliable source of revenue. If commitments are made to expand or preserve a program, and sales or excise tax hikes fail to live up to projections or hopes, future legislatures may have to increase taxes again or look for new revenue sources.

There is another revenue-related consideration. Rising taxes on cigarettes at both the state and federal levels, may contribute to the long-term decline in the number of cigarettes sold in the United States. This in turn may substantially reduce the payments to state governments under the Master Settlement Agreement reached between the major tobacco companies and the states in 1998.

This is due to a provision in the agreement that reduces payments to the states as overall cigarette sales fall. Based on a recent issue of State Policy Reports, volume adjustments reduced MSA payments for the year 2000 by roughly 15 percent. Additional federal or state tax increases could accelerate this decline.

Experience in states across the country demonstrates that cigarette tax increases can lead to lost retail sales and jobs as consumers

cross state borders and surf the Internet in search of lower prices. Sales losses typically hurt those employed in the wholesaling and retailing of cigarettes.

Finally, the benefits provided by state government, such as public schools, law enforcement, roads, and so on are shared by all citizens. Asking consumers to help pay for these services seems fair enough. But the cost should be shared by all citizens. In the name of fairness, there should be a limit to what adults should be asked to pay for the right to purchase and enjoy cigarettes in the state of New Hampshire.

Under a progressive tax system -- a fair tax system -- people are taxed according to their ability to pay, not according to the fact that they are politically vulnerable or in the minority. It is unfair to single out adults who choose to smoke and force them to bear the financial burden for projects that will benefit everyone.

Thank you for giving us this opportunity to speak on behalf of the people of Philip Morris U.S.A. and our many business partners, adult consumers and employees.

# # #

NEW HAMPSHIRE
ACADEMY OF FAMILY PHYSICIANS

7 NORTH STATE STREET, CONCORD, NH 03301
603-224-7083

Testimony regarding HB 762
March 15, 2001
Eric Pollak, MD, MPH
New Hampshire Medical Society

As a family physician practicing in Concord, and a member of the New Hampshire Medical Society, I know full well the detrimental affects many of my patients have suffered due to tobacco. The physicians represented by the New Hampshire Medical Society are on the front lines caring for patients who suffer from tobacco related illness. As well, every day we try one-by-one to help smokers to quit. That experience informs the society's strong advocacy of a 50 cent per pack tobacco tax increase.

Tobacco related illness long ago reached epidemic proportions. Whose family hasn't been touched by cancer, or heart disease, or stroke, or emphysema, or pediatric ear infections, for that matter? When faced with epidemics, physicians certainly care for each individual and family they serve. But, fortunately, medical science is complemented by public health science, which seeks to prevent the need for medical care. Physicians cared for polio patients, but isn't it better to have had a vaccine developed? Physicians also care for patients with food poisoning. But isn't it preferable to have clean water and safe waste disposal?

The same public health science that forecast the effectiveness of vaccines and sanitation now forecasts significant reduction in tobacco-related illness by increasing the price of cigarettes. Studies have predicted, and experience has borne out, that a 50-cent per pack increase in price will reduce cigarette consumption substantially. More important is the finding that adolescents are more price sensitive and, therefore, more likely to cut down or quit. This tax increase will work like a vaccine against tobacco related illness.

Smoking is, at its root, a pediatric illness. Most smokers start young; rarely does an adult pick up the habit. Most young smokers anticipate that they won't be smoking in 5 years. Sadly, most are wrong. Price increases have proven to be among the most effective ways to delay or prevent teen addiction.

This tax will help to even the playing field between the companies seeking to sell cigarettes and health advocates seeking to reduce smoking-related illness. Consider that the tobacco industry has for years used effective population-based strategies to entice young smokers to start. Then by creating just the right mix of drugs in cigarettes, the tobacco manufacturers have kept adults who would prefer to stop, addicted. Imagine if the tobacco industry had to sit down one-by-one with potential customers to convince them to start smoking, just as physicians must work one-by-one with their patients to help them quit. There would be no industry. But there is an industry precisely because it does employ population-based science. We seek only to respond to this epidemic by using sound public health principles. And foremost among the proven strategies to reduce smoking related illness is cost increases.

The smoking declines caused by this tax increase will save lives, reduce human suffering, promote the public health, save public health expenditures, and prevent more kids from becoming smokers. Translated to my language, that will mean fewer times that I will be called upon to convene a family meeting to discuss a loved one's grave illness that could have been prevented.

I urge members of the Ways and Means Committee to support HB762. Thank you.

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New Hampshire's

Comprehensive Tobacco Prevention & Control Plan

Developed by:

State of New Hampshire
Department of Health and Human Services

Donald L. Shumway, Commissioner

In Partnership with:

The New Hampshire Tobacco Prevention Task Force

January 2000

Investing in a Healthy Future

New Hampshire Tobacco Prevention Task Force Members

American Cancer Society, New England Division

American Heart Association, New England Affiliate

American Lung Association of New Hampshire

The Governor's Advisory Council on Cancer & Chronic Disease

National Center for Tobacco Free Kids

New Futures

New Hampshire Children's Alliance

New Hampshire Council of Churches

New Hampshire Dental Hygienists Association

New Hampshire Department of Education

New Hampshire Department of Health and Human Services

New Hampshire Family Practice Association

New Hampshire Family Practitioners

New Hampshire Health Care Association

New Hampshire Hospital Association

New Hampshire Medical Society

New Hampshire Nurses' Association

New Hampshire Nurse Practitioners Association

New Hampshire Orthopedics Association

New Hampshire Pediatrics Association

New Hampshire Public Health Association

New Hampshire Respiratory Therapists

New Hampshire Soccer Association

New Hampshire Teen Institute

Norris Cotton Cancer Center

Smoke Free New Hampshire Alliance

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I. Introduction

Tobacco use is the single most preventable cause of death in New Hampshire, killing more people each year than all other causes of death combined. Currently forty percent (40%) of our high school students smoke. Health care expenditures in New Hampshire directly related to smoking are currently estimated at $340 million annually. Of that amount, annual Medicaid costs for tobacco-related health care expenditures are $90 million dollars.[1]

Presently there is no state funding of tobacco prevention activities in New Hampshire. The Department of Health and Human Services' (DHHS) Tobacco Prevention Program has been funded since 1994 solely with federal funds. In the last two years, it received annual grants of $375,000. At the same time, the tobacco industry spent $22 million a year to promote tobacco use in New Hampshire.[2] *Figure 1* illustrates this discrepancy.

In the 1997 legislative session the DHHS requested legislation to limit youth access to tobacco products. The result was Chapt. 338, Laws of 1997, which established licenses for distributors of free tobacco products, provided for the suspension of tobacco licenses, and required lockout devices on tobacco vending machines. This legislative effort brought together over 30 public health organizations that worked together to pass the legislation. These groups continued to meet, and eventually, they and others agreed to form the New Hampshire Tobacco Prevention Task Force (TPTF).

In November 1998, New Hampshire's Attorney General signed a national settlement with the tobacco industry to compensate the State for smoking-related health care costs. New Hampshire may receive up to $1.3 billion over the next 25 years.

It is absolutely necessary that we direct a portion of the tobacco settlement funds to prevent the initiation of tobacco use by youth and to minimize the damage that has already occurred among teen and adult smokers.

A substantial investment in tobacco control activities is necessary to counteract the pervasive culture of tobacco use and to compete with the tobacco companies' advertising and other marketing efforts. According to the federal Centers for Disease Control and Pre-

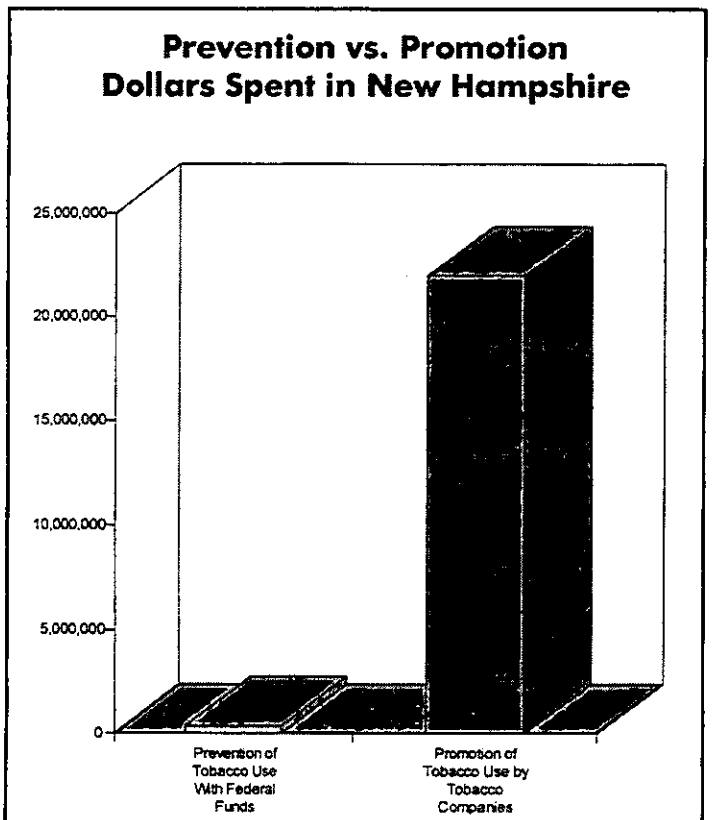


Figure 1.

vention (CDC), the ideal funding for a comprehensive tobacco control effort in New Hampshire requires a minimum of $11 million per year, or approximately $10 per capita, in addition to funds already provided by the federal government. The question of funding levels carried over into the Legislature and, despite the number of pressing financial problems confronting the State this year, $3 million of the national tobacco settlement was appropriated into a non-lapsing Tobacco Use Control Fund dedicated exclusively to tobacco prevention.

In order to maintain momentum in future years we will need to make a compelling case that funds invested in tobacco control cause a drop in the prevalence of tobacco use among teens. While substantially reducing tobacco use among teens is the desired end, this change will not occur immediately. Therefore, to track progress, we will need to also measure changes in intermediate indicators, such as those that occur in youth attitudes and beliefs about tobacco use. These changes will result in ultimate reductions in tobacco use prevalence. The Youth Tobacco Survey (YTS) is the best available means of acquiring a statistical measure of not only tobacco use among NH school students, but also a statistical measure of the factors that convince youth not to use tobacco. The YTS will provide data that was previously not available for students in grades 7-8, age groups that are vulnerable to experimentation with tobacco. The DHHS is working with the Department of Education and local schools to collect this vital information. Current plans call for the YTS to occur in March of 2000.

The next section (Section II) of this document presents the comprehensive plan developed by the DHHS and the TPTF. Each component of the plan is described in detail and in relation to the other components of the plan. Sections III and IV provide the reader with the background facts and figures that support the plan. A description of the TPTF members is presented in an appendix.

II. A Comprehensive Plan to Reduce the Toll of Tobacco Use in New Hampshire

The essential components of a comprehensive program and the per capita allocation for each as recommended by the Task Force are listed below. Where necessary, the Task Force has consulted with the Centers for Disease Control and Prevention about how to adapt their recommendations so as to best capitalize on the available funding.

Community-Based Programs

Prevention Programs

New Hampshire is a state that prefers to address its challenges at the local level. Funding tobacco prevention and control within communities is consistent with this philosophy. Community-based programs assure that everyday citizens can participate in directing initiatives that affect the health and well-being of all citizens.

DHHS has a successful track record of funding coalitions, teams and community programs to carry out local public health initiatives. *Figure 2* illustrates where current tobacco prevention coalitions are located in New Hampshire. New and already established tobacco prevention coalitions can actively work to reduce tobacco use in their community. Examples of such efforts include:

- cooperating with retailers to ascertain that tobacco products are not sold or promoted to minors, as the coalitions in Dover, Keene, Nashua, Manchester and Kearsarge-Lake Sunapee have done in their communities;
- reducing tobacco products advertisement in locations where New Hampshire youth may experience it daily such as has been attempted in the communities of Dover and New London;

Local Coalitions Currently Sponsoring Community-Based Programs

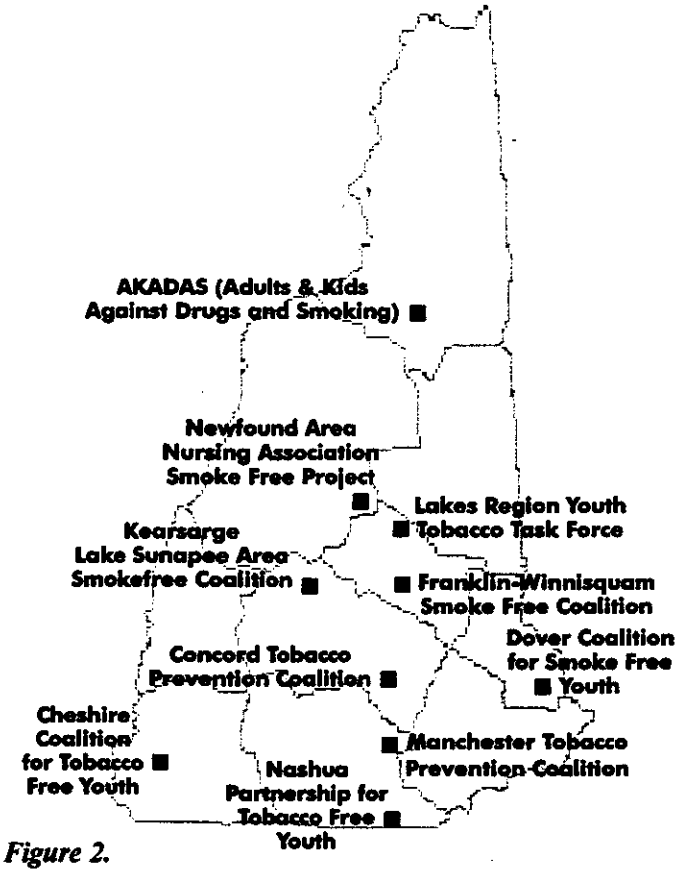


Figure 2.

- forming partnerships with schools, athletic associations and businesses for the creation of tobacco-free environments, such as DHHS's successful alliance with the NH Youth Soccer Association which associates health with being tobacco-free;
- helping adults and youth who smoke to link with accessible and affordable cessation services.

Partnership Grants

Providing funds to New Hampshire organizations, businesses, and other partners is an efficient way to support certain tobacco prevention and control activities. Local partners can use organizational assets to build community resources and leverage funds provided by DHHS to carry out targeted strategies. The Task Force believes that local partners may be better equipped to reach specific populations that are targeted by the tobacco industry, such as women, racial/ethnic minority populations, and blue-collar workers.

Examples of organizations that could address tobacco use include local chapters of the Heart Association, the Cancer Society, the Lung Association, the March of Dimes; the New Hampshire Congress of Parents and Teachers; athletic associations, such as the New Hampshire Soccer Association; and minority health organizations.

Other partners could implement training, advocacy and counter-advertising. Examples of such resources are the University System, Dartmouth Medical School, the New Hampshire Advertising Association, and news media operations.

Examples of activities that could be supported by partnership grants and programs:

- reducing tobacco advertising in communities;
- providing advocacy training for local coalitions, such as the Clean Indoor Air Local Ordinance Workshop in October 1998, sponsored by the American Lung Association of New Hampshire in cooperation with NH Celebrates Wellness;
- promoting the voluntary adoption of smoke free environments; and
- educating community members about the benefits of locally adopted tobacco control ordinances.

Based on the $3 million allocation, recommendation for local prevention and partnership programs in New Hampshire: $1.13 per capita Total: $1,250,000

School-Based Programs

Communities and parents in New Hampshire need to work together to educate children about the hazards of tobacco and to teach them skills to resist the social and commercial influences to use it. Schools are ideal community settings for providing scientifically proven tobacco education as well as for establishing a norm that tobacco use is unacceptable.

New Hampshire schools which have the interest and desire to provide tobacco education could train their staffs to teach proven curricula. The Task Force proposes that schools wishing to provide a comprehensive tobacco education program shall have the resources, professional support and financial assistance needed to implement such curricula.

RSA 126-K, the New Hampshire youth access to tobacco statute, provides that all public schools, K-12, shall be tobacco-free. The Task Force proposes that DHHS and its associated partners team up with school staff, parents and students to support this policy. Schools require support to implement all the necessary components that maintain a tobacco free environment.

Based on the $3 million allocation, recommendation for school-based programs:
$0.23 per capita
Total: $ 250,000

Cessation Programs

Cessation programs and services must be accessible, culturally and linguistically appropriate and effective. Programs for youth should be implemented as they are identified or developed. Potential partners to promote quitting and increase access to cessation services include health care providers, health plans, clinics, workplace health services, media outlets, schools, court diversion programs, and voluntary health organizations.

Examples of initiatives to promote quitting:

- advocating for adequate and standardized cessation services to be adopted by all New Hampshire health plans;
- establishing telephone "quit lines"; and
- providing cessation information to worksites to help employees and their family members who smoke.

Based on the $3 million allocation, recommendation for cessation programs:
$0.23 per capita
Total: $250,000

Programs to Reduce the Burden of Tobacco-Related Disease

Even if all New Hampshire citizens stopped using tobacco, the residual burden of disease among past users and those exposed to environmental tobacco smoke would persist decades into the future. The most frequent health problems attributed to tobacco use are cardiovascular disease, cancer, and stroke. Other chronic diseases correlated with smoking include emphysema, osteoporosis, diabetes, asthma and oral health disease. Under this proposed plan, community organizations and professional groups would focus attention directly on tobacco-related diseases to both prevent them and to detect and treat them in their early stages.

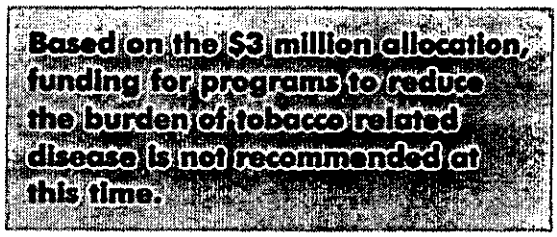
Examples of community organizations that could partner with DHHS to reduce the burden of tobacco-related disease would include community health centers, hospital and clinic-based health education services, and dental clinics.

Professional groups which could partner with DHHS to reduce the burden of tobacco-related disease include state chapters of the Cancer Society, Heart Association, Lung Association; Diabetes Centers of New Hampshire; New Hampshire Public Health Association; New Hampshire Dental Society; New Hampshire Dental Hygienists Association; Medical Society; and other professional organizations representing health care providers.

Examples of initiatives which community organizations or professional groups might implement to reduce the burden of tobacco-related diseases include:

- sponsoring and promoting health screening for the detection of cancer, heart and lung disease;
- informing citizens about ways to further reduce risk factors as the DHHS's Diabetes Education Program does through health education, mass media messages and print materials; and
- training health professionals in strategies to educate patients about behavior changes that promote wellness.

Based on the $3 million allocation, funding for programs to reduce the burden of tobacco related disease is not recommended at this time. The Task Force hopes that it may be included in the future as an important component within a more comprehensive approach to tobacco prevention and control. Meanwhile, the Task Force will continue to foster and support public-private collaboration to provide services that reduce the burden of tobacco-related disease.



Statewide Efforts

Enforcement

Enforcing the laws that restrict youth access to tobacco products and reduce exposure to environmental tobacco smoke discourages youth from initiating tobacco use and protects the health of nonsmokers.

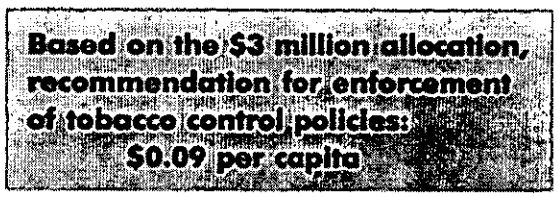
The two primary tobacco statutes that require enforcement in New Hampshire are the youth access to tobacco laws and the New Hampshire Indoor Smoking Act. The New Hampshire State Liquor Commission, Bureau of Liquor Enforcement, is the chief enforcement agency for New Hampshire's youth access to tobacco laws. DHHS monitors compliance with the New Hampshire Indoor Smoking Act. With increased funding and support, both agencies could more effectively reduce minors' access to tobacco and citizens' exposure to secondhand smoke.

Examples of activities to strengthen enforcement of the youth access to tobacco laws:

- funding regular and systematic checks conducted by the NH State Liquor Commission, Bureau of Enforcement and local law enforcement on retailers to assure that they are in full compliance with the laws;
- responding promptly to reports of retailers known to have violated the law; and
- enlisting public support and cooperation for enforcement activities.

Examples of activities to strengthen the enforcement of the Indoor Smoking Act are:

- educating and guiding those in violation about how to come into compliance;
- working with the legislature to improve tobacco control efforts.



Counter-Marketing

Counter-marketing activities can promote quitting and decrease the likelihood of children and young people beginning to use tobacco. Other states have shown that media messages influence public support for tobacco control policy changes and establish a supportive climate for school and community prevention efforts.

The Task Force proposes the implementation of a statewide media campaign that targets specific audiences while addressing key issues and promoting norm changing behaviors. The intent would be to develop an education campaign, promoting a message that tobacco use is harmful and not "the accepted norm" of New Hampshire citizens. Examples of counter-marketing strategies to convey pro-health messages:

- producing and placing TV and radio commercials, such as those produced by DHHS and the Smoke Free NH Alliance with the support of Healthsource, a CIGNA HealthCare Company, Anthem Blue Cross and Blue Shield of New Hampshire and the NH Municipal Association-Health Insurance Trust;
- sponsoring advertisements in theaters, on mass transportation and on billboards;
- acquiring and disseminating videos and print materials such as posters, brochures and decals; and distributing pencils, bags, key chains and apparel that appeal to the youth market. The local coalitions in Manchester, Dover as well as the statewide TPP have utilized these counter-marketing strategies.

Based upon the $3 million allocation, recommendation for tobacco counter-marketing campaign:
$0.64 per capita
Total: $700,000

Evaluation

Evaluation is the only means of assuring that programs are achieving their stated objectives. Surveys help to measure achievement by monitoring behavior, attitudes, and health indicators at regular intervals over a period of time. Survey and evaluation activities will enable us to target resources and demonstrate progress toward goals.

Both survey and evaluation systems will need to be expanded in New Hampshire to measure gains in reducing the impact and burden of tobacco use.

A Youth Tobacco Survey has been developed by Centers for Disease Control and Prevention and has been in use in a number of states for several years. The survey is being tailored for New Hampshire use and the New Hampshire Youth Tobacco Survey (NHYTS) will be implemented in randomly selected 7th and 8th grade public schools. This survey will provide tobacco-specific baseline data on youth knowledge, behaviors and attitudes from a representative sampling of NH students. This data will assist the DHHS to effectively direct program resources as well as to accurately track and document progress.

The NHYTS and other complementary systems, such as the Youth Risk Behavior Survey, will provide overall program accountability to policy makers and those responsible for fiscal oversight.

Examples of surveys and evaluation tools available in New Hampshire to measure tobacco use include:

- the national Youth Tobacco Survey, in the initial planning stages in New Hampshire, will be implemented by DHHS in grades 7-8 with the assistance and support of the Smoke Free NH Alliance and the Department of Education.
- the Youth Risk Behavioral Survey administered by the New Hampshire Department of Education to students in grades 9-12;
- the national Behavioral Risk Factor Survey administered by DHHS to adults;
- surveys carried out by the Division of Alcohol and Drug Abuse Prevention and Recovery to determine retail compliance with the Youth Access to Tobacco Law; and
- the Smoking Attributable Morbidity and Mortality Economic Costs (SAMMEC) analysis.

A comprehensive program will rely on the continuation of these and other survey and evaluation methods as well as a detailed analysis of each to determine the efficacy of New Hampshire's overall effort to reduce tobacco use.

Based upon the $3 million allocation, recommendation for evaluation of tobacco prevention and control efforts:
$0.27 per capita
Total: $300,000

Administration and Management

An effective tobacco control program requires a sound management structure to coordinate programs involving multiple State agencies, local governments, statewide organizations and community groups. In addition, administration and management systems are required to establish contracts and provide ongoing fiscal and program monitoring.

The Task Force proposes that a comprehensive tobacco control and prevention program be managed by DHHS and that it be built on the existing infrastructure. The management would insure coordination of program components and collaboration among and between all local, state and national partners. It would also facilitate administration systems to prepare and implement contracts and provide fiscal and program monitoring.

Based upon the $3 million allocation, recommendation for administration and management of tobacco prevention and control programs:
$0.14 per capita
Total: $150,000

A Summary of the Recommended Program Components and Per Capita Cost Estimations Based on the $3 Million Appropriated by the New Hampshire Legislature

Community-Based Program Components

Prevention and Partnership Programs	$1.13 per capita
School-Based Programs	$0.23 per capita
Cessation Programs	$0.23 per capita
Community-Based Programs Total	***$1.59 per capita***

Statewide Program Components

Enforcement	$0.09 per capita
Counter-Marketing	$0.64 per capita
Evaluation	$0.27 per capita
Statewide Programs Total	***$1.00 per capita***

Administration

Administration Total	***$0.14 per capita***

III. Foundations of the Plan

New Hampshire Needs a Comprehensive Tobacco Prevention Program

Tobacco use kills 1,700 New Hampshire citizens each year, exceeding the number of deaths attributed to alcohol, AIDS, car crashes, illegal drugs, murders, and suicides combined.

Tobacco use by youth in New Hampshire is particularly alarming. Forty percent (40%) of our high school students smoke, and we have the fourth highest smoking rate in the nation for teenage girls. Youth smoking has increased by 50% in the past six years. *Figure 3* shows the steady increase of youth smoking in New Hampshire.

Youth Smoking in New Hampshire (%)

Reported smoking cigarettes on one or more of the past thirty days.

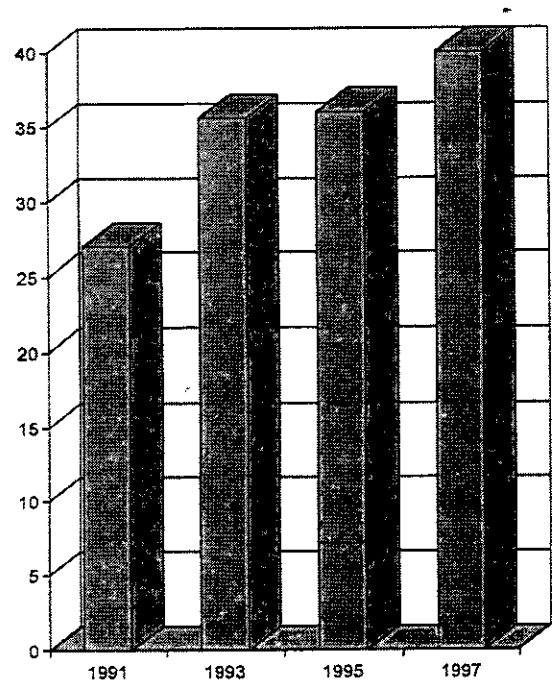


Figure 3.

In addition to Medicaid and other health care expenditures, it is estimated that at least $6 million per year is spent in New Hampshire for the health care of infants with health problems caused by mothers smoking or being exposed to secondhand smoke during pregnancy. Those estimates of expenditures increase to approximately $18 million for children between birth and four years of age who are exposed to secondhand smoke.[4] It is widely acknowledged that the overall economic burden caused by tobacco-related death and illness results in reduced productivity, increased absenteeism from work, increased insurance rates and increased medical and Medicaid costs to treat smokers and those exposed to secondhand smoke.

Successful New Hampshire Tobacco Prevention Activities

Currently, there is no state funding for tobacco prevention programs in New Hampshire. The Department of Health and Human Services' (DHHS) Tobacco Prevention Program (TPP) has been funded since 1994 solely with federal funds from the Centers for Disease Control and Prevention (CDC). Between 1994 and 1996, the TPP received $245,000 annually from CDC. Between 1997 and 1999, the Program received $375,000 annually. The current annual grant award is $763,000. Preventive Health

and Health Services Block Grant monies have supported a single staff position to enforce the New Hampshire Indoor Smoking Act since 1990. Additionally, there have been on-going efforts by private organizations, such as the American Lung Association, American Cancer Society and others who have worked for years through voluntary efforts to reduce tobacco use in New Hampshire.

With these limited federal and voluntary resources, DHHS has established a statewide infrastructure of a statewide coalition, 10 local coalitions and over 25 partners. The following highlights demonstrate the foundations from which a more comprehensive approach to tobacco prevention can be developed.

- New Hampshire Soccer Association, New Hampshire Cooperative Extension 4-H Groups, Youth to Youth organizations, and Swiftwater Girl Scout Council have teamed up with DHHS to promote tobacco-free messages to their youth members. An outgrowth of these partnerships has been that these organizations occasionally sponsor smoke-free youth events, contributing to a wider acceptance of a tobacco-free culture in various communities throughout the state.

- The American Lung Association of New Hampshire, the American Cancer Society, New England Division and the American Heart Association, New England Affiliate partnered with the Smoke Free New Hampshire Alliance and its associate Youth Network Opposing Tobacco to plan and carry out a day long conference for youth and their adult leaders at Plymouth State College in 1997 and 1998. "Teens Fight Tobacco, Leading the Way for New Hampshire" provided an opportunity for New Hampshire youth to learn to be leaders in tobacco prevention and to carry out projects which influence their schools and communities to be tobacco-free.

- Healthsource NH, A CIGNA HealthCare Company, Anthem Blue Cross and Blue Shield of New Hampshire and NH Municipal Association – Health Insurance Trust, provided financial assistance for a media campaign to build citizen awareness about the hazards of tobacco use. Their assistance enabled The Brodeur Group to purchase airing time which was then matched by WMUR, WNDS, WNNE, MediaOne, MetroCast & Time Warner Cable. This public/private partnership enabled three television commercials to be aired an average of 18 weeks for three years since 1995.

- Health educators in local hospitals and health departments, police officers, and youth organization leaders have teamed up with schools, parents, law enforcement officials, retailers, newspapers, radio stations and voluntary health organization representatives to form local coalitions in 10 locations around the state to address tobacco use on a community level. These coalitions, shown on the map on page 8, have initiated short term projects to reduce the access and appeal of tobacco and to educate the public about the hazards of tobacco use. Since CDC funding assistance to coalitions is either minimal or non-existent (grant awards are between $12,000 and $20,000 and some receive no funding at all), projects are carried out with volunteers, donations and with a great deal of in-kind assistance from the coalition sponsor.

Despite these many accomplishments, it has been impossible to counteract the pervasive influence of the tobacco industry throughout New Hampshire with such limited resources. Smoking rates among youth continue to rise in New Hampshire in spite of the sincere intentions and good will of individuals and organizations that care about the health of our citizens.

A Comprehensive Tobacco Prevention Program to Save Lives and Money in Our State

Reducing tobacco consumption is what the national tobacco settlement was all about. In filing their lawsuits, the state attorneys general stated that they were primarily concerned about reducing tobacco use, especially by youth.

The table below shows New Hampshire's annual tobacco settlement payment schedule.

Year	Annual Payment
1998	$15,982,417
1999	$0
2000	$42,698,026
2001	$46,107,009
2002	$55,361,060
2003	$55,884,992
2004-2007	$46,642,020
2008-2017	$47,567,668
2018-2025	$53,301,360
Total	$1,304,689,150

This table is subject to change because of the Volume Adjustment provision of the national tobacco settlement agreement. Under this provision, annual payments from tobacco companies will decrease as cigarette sales decrease.

Beginning in April 2000, payments will be adjusted according to the number of cigarettes shipped in the U.S. during the past two years. There has already been an 8.6 percent reduction in the number of cigarettes sold in the U.S. this year, according to the U.S. Department of Agriculture's Economic Research Service. It is therefore difficult to accurately determine how much money New Hampshire will ultimately receive.

In any event, dedication of a portion of the settlement funds to support the establishment of a statewide comprehensive tobacco prevention program would substantially reduce smoking and other tobacco use in our state. Reductions in tobacco use will:

- prevent New Hampshire children from using tobacco and eventually dying of tobacco-related diseases;
- protect the present and future health of New Hampshire's smoking and nonsmoking children and adults; and,
- shield New Hampshire's economy and the economic well-being of its citizens from future costs attributable to smoking.

IV. Evidence that Adequately Funded Tobacco Prevention Programs Will Reduce Smoking Rates

The experiences of California, Oregon, Florida and Massachusetts demonstrate that comprehensive tobacco prevention programs are effective in reducing overall smoking rates at faster rates than elsewhere in the country. These are the only states from which data is currently available.

California

California's cigarette tax was increased in several stages from a base of $0.10 in 1989 to $0.87 per pack in 1998. The initial tax increase funded a comprehensive prevention and control program with particular emphasis on counter-marketing; enforcement of youth access laws; and reduction of citizen exposure to environmental tobacco smoke. The economic deterrent of the tax coupled with adequately funded tobacco prevention and control activities has resulted in notable effects in smoking rates among teens:

- rates of smoking among 8th graders have leveled off since 1993 to approximately 13%, while steadily increasing from 17% to 22% nationally.
- rates of smoking among 10th graders have remained at approximately 18.5% since 1992, while increasing from 22% to 32% nationally.

Oregon

Oregon raised its excise tax on cigarettes from $0.30 to $0.68 per pack in 1996. A portion of the tax revenue was used to fund a comprehensive prevention and control program with an emphasis on school-based tobacco prevention education; decreasing youth access to tobacco and advertisement of products; cessation; and building public awareness about tobacco use. Oregon's results have included a decline in smoking rates and tobacco consumption:

- per capita cigarette consumption declined 11.3% (or ten packs per person) between 1996 and 1998.
- rates of smoking among adults declined 6.4% in two years, representing 35,000 fewer smokers in Oregon. Rates went from 23.4% in 1996 to 21.9% in 1998.

Florida

Florida negotiated an independent settlement with the tobacco industry in 1997. The state appropriated a total of $93 million of those funds over 2 years to establish the Florida Pilot Program on Tobacco Control. The Pilot Program was comprehensive, with a particular emphasis on enforcement of youth access laws; school-based prevention education; the implementation of a counter-marketing campaign; and on the development of baseline data on youth tobacco use behaviors and attitudes. In just one year, there have been remarkable declines in smoking rates:

- rates of smoking among middle school students declined from 18.5% to 15% between 1998 and 1999.
- rates of smoking among high school students declined from 27.4% to 25.2% between 1998 and 1999.

Massachusetts

Massachusetts raised its cigarette tax twice in recent years, from a base of $0.26 in 1993 to $0.76 per pack in 1996. A portion of the tax revenue funded a comprehensive prevention and control program with an emphasis on counter-marketing; reduction of exposure to environmental tobacco smoke; cessation; and enforcement of youth access laws. In-depth scientific analysis has shown that the economic deterrent of the tax coupled with adequately funded tobacco prevention and control activities have affected smoking rates:

- rates of smoking among adults have declined from an average of 23.5% between 1990-92 to 20.6% in 1997. Nationally, rates of smoking declined only from an average of 24.1% between 1990-92 to an average of 23.4% between 1993-95.
- rates of smoking among high school students declined from 35.7% in 1995 to 34.4% in 1997, while increasing from 34.4% to 36.4% nationally.
- rates of smoking among 8th graders declined by a half a percentage between 1993 and 1996, while increasing by 4% nationally.

Figures 4 and 5 show the extent of the New Hampshire's tobacco use problem and help illustrate where New Hampshire ranks relative to the nation and compared to California, a state with a comprehensive program in place for nearly 10 years.

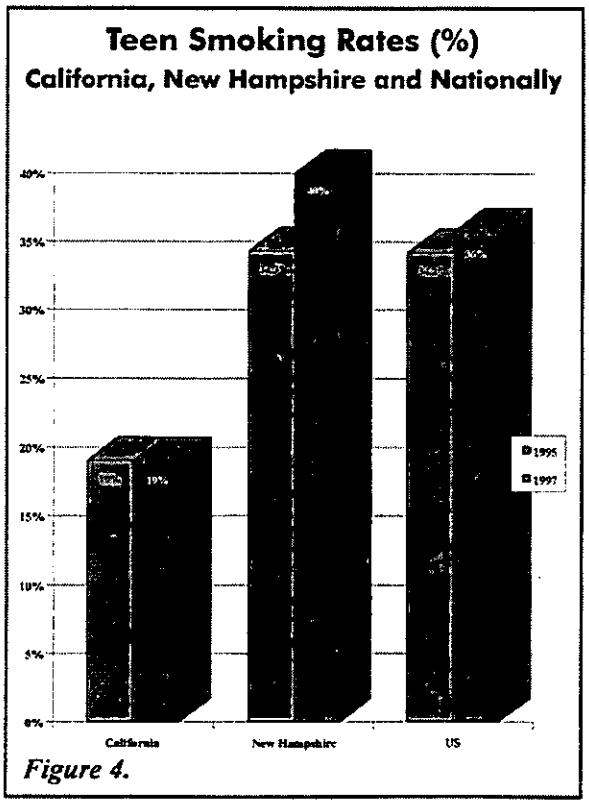


Figure 4.

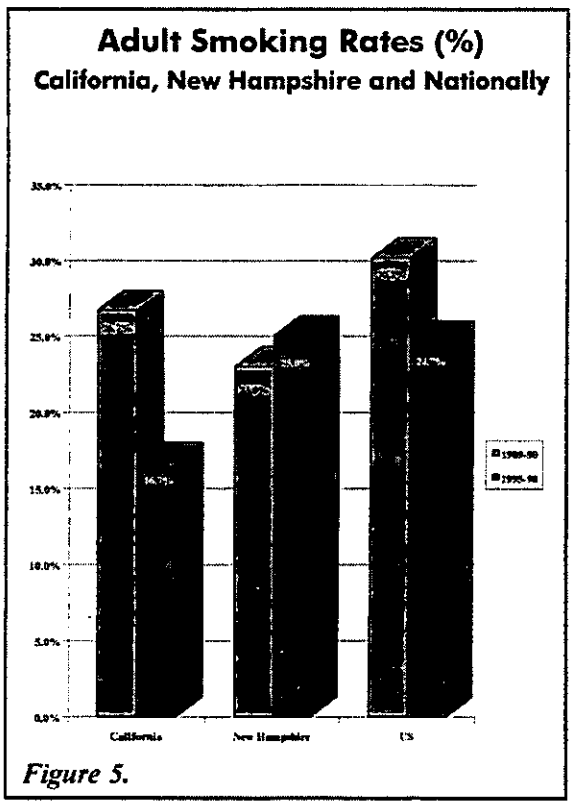


Figure 5.

Comprehensive Program In New Hampshire

Benefiting from lessons learned in other states which have successfully reduced tobacco use, DHHS and its partners would utilize an allocation from the settlement to achieve the following goals:

- prevent New Hampshire children and youth from starting to use tobacco;
- assist New Hampshire citizens currently using tobacco to stop;
- protect New Hampshire citizens from exposure to environmental tobacco smoke; and
- reduce the impact of tobacco-related disease and illness.

New Hampshire Has the Capacity to Address Tobacco Use

The following list includes the many partners currently involved in local and statewide efforts to address tobacco use in New Hampshire. Partners work with DHHS and its community-based coalitions to educate the public about the effects of tobacco use, to develop initiatives to reduce the appeal of tobacco use and to restrict youth access to tobacco products. Each is committed to actively participate in the comprehensive program proposed in this plan. See Appendix for detailed descriptions of Statewide and Local Partners.

Statewide Partners

- American Cancer Society, New England Division (ACS)
- American Heart Association, New England Affiliate (AHA)
- American Lung Association of New Hampshire (ALANH)
- Anthem Blue Cross and Blue Shield of New Hampshire
- Healthsource, A CIGNA HealthCare Company
- New Futures
- DHHS Tobacco Prevention Program and the Division of Alcohol and Drug Abuse Prevention and Recovery
- New Hampshire Media Outlets
  Television Stations: WMUR, WNDS, WNNE, MediaOne, MetroCast & Time Warner Cable
  Radio Stations: WERZ, WFTN, WHDQ, WGIR, WXLQ
- New Hampshire Medical Society
- New Hampshire Municipal Association-Health Insurance Trust
- New Hampshire Public Health Association (NHPHA)
- New Hampshire State Liquor Commission, Bureau of Liquor Enforcement
- New Hampshire Soccer Association (NHSA)

Local Partners: Community-Based Coalitions

- Adults and Kids Against Drugs and Smoking, Randolph
- Cheshire Coalition for Tobacco Free Youth
- Concord Tobacco Prevention Coalition
- Dover Coalition for Smoke Free Youth
- Franklin-Winnisquam Smoke Free Coalition
- Kearsarge Lake Sunapee Area Smokefree Coalition
- Lakes Region Youth Tobacco Task Force
- Manchester Tobacco Prevention Coalition
- Nashua Partnership for Tobacco Free Youth
- Newfound Area Nursing Association Smoke-free Project

V. Conclusion

The national tobacco settlement provides New Hampshire a unique opportunity to remedy the state's most pervasive public health problem. Allocating a portion of the settlement funds to a statewide comprehensive tobacco prevention and control program is vital if society is to reduce tobacco consumption. Adequately funded comprehensive tobacco prevention programs in other states have been successful in reducing smoking rates and there is every reason to believe that similar efforts in New Hampshire will succeed as well.

The Tobacco Prevention Task Force in cooperation with the Department of Health and Human Services and its many local partners is prepared to take on this challenge with a program strategy that is success-oriented, responsible and has the potential to be evaluated in full. Nothing less will suffice if we wish to rewrite the statistics on lung cancer and heart disease for New Hampshire's next generation.

Appendix

Statewide Partners

American Cancer Society, New England Division (ACS)

This organization is the largest private, not for profit source of funding for cancer research. Its commitment to research has yielded many important answers in the science of cancer, and will continue to play a part in the latest scientific achievements and breakthroughs regarding cancer prevention, early detection and treatment. ACS will continue to look to research as the key to conquering cancer in the 21st century. In New Hampshire, ACS provides health and policy education and advocacy to consumers, organizations and lawmakers relative to tobacco use in New Hampshire. As part of its comprehensive effort to educate school-aged children about cancer prevention strategies, ACS has a formal relationship with New Hampshire schools and will provide tobacco education materials on request.

American Heart Association, New England Affiliate (AHA)

A non-profit, voluntary health organization dedicated to reducing disability and death from cardiovascular diseases and stroke. Sponsor and promote programs, advertisements, events and initiatives which include messages supporting tobacco prevention and cessation. Specifically, AHA programs in which tobacco is addressed include its Heart Power School Kits, Heart Walks, health fairs and "cardiac arrests" and its "Heart at Work" worksite wellness promotions. Within New Hampshire, AHA provides 150 school kits statewide and 36 worksite programs statewide.

American Lung Association of New Hampshire (ALANH)

The Association was founded in 1916 and is the oldest, voluntary, non-profit health association in the state. The American Lung Association first used the "Christmas Seal" to raise money in the fight Tuberculosis. Its current mission is to prevent lung disease in New Hampshire through education, prevention and research. ALA endorsed tobacco prevention and education curriculums are taught in many NH elementary schools and ALA teen cessation programs are being implemented in a variety of middle and high schools. ALA endorsed smoking cessation programs are the most prominent group programs in NH and are available in most regions of the state. Major initiatives have recently begun to address smoking in public places, especially restaurants. Other program priorities include asthma education for adults and children, programs for people with Chronic Obstructive Pulmonary Disease (COPD) and indoor and outdoor air quality concerns. The Association directly supports peer reviewed national and local pulmonary research projects. Legislative advocacy efforts educate legislators and consumers on relevant lung health issues in Washington and Concord. The association holds a variety of special events including fund raising, volunteer recognition and an annual meeting.

Anthem Blue Cross and Blue Shield of New Hampshire

A managed care organization whose mission is to improve the health status and reduce the burden of illness among the people of New Hampshire by offering affordable quality health services. Provides financial support for the Smoke Free New Hampshire media campaign, the annual Merit Award and the development and publication of the Healthcare Providers and Dental Practitioners How-to Kits. Sponsors the New Hampshire Soccer Association (NHSA) enabling the promotion of tobacco free messages to athletes, coaches and parents.

Healthsource, A CIGNA HealthCare Company

A managed care organization whose mission is to improve the health care experience for its members. Provides financial support for the Smoke Free New Hampshire media campaign, the annual Merit Award and the development and publication of the Healthcare Providers and Dental Practitioners How-to Kits.

New Futures

An initiative of the New Hampshire Charitable Foundation. New Futures' mission is to foster, promote, and support effective strategies to reduce alcohol, tobacco and other drug problems. Provides collaboration for Smoke Free New Hampshire Alliance projects. Published *We Need to Talk* which describes the prevalence of alcohol, tobacco and other drug (ATOD) use in New Hampshire and the need to begin to create solutions. Provides education to decision makers relative to the benefits of policy and fund allocation to support tobacco prevention efforts.

New Hampshire Department of Health and Human Services, Division of Alcohol and Drug Abuse Prevention and Recovery (ADAPR)

ADAPR is dedicated to developing, supporting and advocating for comprehensive services to reduce Alcohol, Tobacco, and Other Drug Abuse (ATODA) and promote healthy individuals, families, and communities. Conducts Synar compliance checks annually. Staff and volunteers conduct a systematic and scientific survey of tobacco sales outlets statewide using unconsummated buys to determine New Hampshire's rate of compliance with the New Hampshire Youth Access law.

New Hampshire Department of Health and Human Services, Tobacco Prevention Program

Coordinates and builds state and local resources, overseeing a comprehensive approach to the problem of youth and tobacco use. Presently supports seven major components to tobacco prevention: the Smoke Free New Hampshire Alliance, community coalitions, training and workshops, data collection and dissemination, resource center, media campaign, and tobacco control plan.

New Hampshire Media Outlets

Includes WMUR, WNDS, WNNE, MediaOne Cable, MetroCast, Time Warner Cable that each provide matched air time as a result of purchased time for TV commercials. Radio stations including WERZ, WFTN, WHDQ, WGIR, WXLQ provided matched air time as a result of purchased air time for media campaign radio commercials.

New Hampshire Medical Society

New Hampshire Medical Society staff educate policy makers about the economic and health costs of tobacco use. Many society members take active roles in their practices, communities, and within their affiliations with local and statewide organizations to educate New Hampshire citizens about the hazards of tobacco, the need to avoid tobacco use and secondhand smoke, and strategies to quit using tobacco.

New Hampshire Municipal Association – Health Insurance Trust

A managed care organization that provides the highest quality employee benefit products consistent with the lowest possible cost for public employers and employees. Provides financial support for the Smoke Free New Hampshire Media Campaign, the Annual Merit Award and the development and publication of the Healthcare Providers and Dental Practitioners How-to Kits.

New Hampshire Public Health Association (NHPHA)

This association exists for the purpose of promoting and improving the public health of the people of New Hampshire. Provides education to its members and the public on tobacco-related issues through its quarterly newsletter, *The Public Health*, and through public forums and mass media channels. Sponsors the Turning Point Initiative, a statewide collaborative addressing comprehensive public health in New Hampshire in the 21st century.

New Hampshire State Liquor Commission, Bureau of Liquor Enforcement

Currently the enforcement agency for state liquor laws. The Bureau of Enforcement has the responsibility for enforcement of New Hampshire's youth access to tobacco laws as it relates to youth and retailers. In 1998, the US Food and Drug Administration (FDA) contracted with the Bureau for to enforce federal regulations related to retail sales of tobacco products to people under the age of 18.

New Hampshire Soccer Association (NHSA)

Promotes the game of soccer and provides organized soccer activity, an environment that emphasizes the ideals of good sportsmanship and fair play and goodwill through physical fitness. Provides promotion of the tobacco-free message through events, activities, coach training and NHSA newsletter.

Local Partners

Adults and Kids Against Drugs and Smoking (AKADAS)

This coalition is sponsored by the Trailmaster Program and targets the communities of: Randolph, Jefferson, Lancaster, Gorham, Berlin, Lancaster, Groveton, Stark, Shelburne and Milan. Their focus is on counter-advertising, environmental tobacco smoke education, youth prevention activities and smoking cessation.

Cheshire Coalition for Tobacco Free Youth

This coalition is sponsored by Cheshire Medical Center and targets communities in Cheshire County. Their focus is on counter-advertising, youth access, youth prevention activities and smoking cessation.

Concord Tobacco Prevention Coalition

This coalition is sponsored by Concord Hospital's Center For Health Promotion and targets the City of Concord. Their focus is on environmental tobacco smoke and smoking cessation.

Dover Coalition for Smoke Free Youth

This coalition is sponsored by the Dover Police Department and targets the community of: Dover. Their focus is on counter-advertising, youth access, environmental tobacco smoke education, youth prevention activities and smoking cessation.

Franklin – Winnisquam Smoke Free Coalition

This coalition is sponsored by Franklin Regional Hospital and targets the communities of Franklin, and Tilton. Their focus is on counter-advertising, environmental tobacco smoke education, and youth prevention activities.

Kearsarge Lake Sunapee Area Smokefree Coalition
This coalition is sponsored by New London Hospital and targets the communities of New London, Sunapee, Newport, and Warner. Their focus is on youth access, environmental tobacco smoke education, counter-advertising, youth prevention activities and smoking cessation.

Lakes Region Youth Tobacco Task Force
This coalition is sponsored by the Lakes Region General Hospital and targets the communities of Meredith, Belmont and Laconia. Their focus is on youth access, counter-advertising, environmental tobacco smoke education and youth prevention activities.

Manchester Tobacco Prevention Coalition
This coalition is sponsored by the Manchester Health Department and targets the City of Manchester. Their focus is on youth access, youth prevention activities and smoking cessation.

Nashua Partnership for Tobacco Free Youth
This coalition is sponsored by the Southern NH Regional Medical Center
and targets the City of Nashua as well as Merrimack, Hollis, Hudson, and Amherst. Their focus is on environmental tobacco smoke education, youth prevention activities and youth access.

Newfound Area Nursing Association Smoke-free Project
This coalition is sponsored by the Newfound Area Nursing Association and targets the communities of Bristol, Alexandria, Bridgewater, New Hampton, Danbury, Groton, Hebron and Hill. Their focus is on youth prevention activities and smoking cessation.

References

[1] L.Miller, et al., "State Estimates of Total Medical Expenditures Attributable to Cigarette Smoking, 1993" Public Health Reports 113; 447-58 (September/October 1998)

[2] National Center for Tobacco-Free Kids "Tobacco Toll in New Hampshire" December 1998

[3] CDC "Program and Funding Guidelines for Comprehensive Tobacco Control Programs" November 1998

[4] National Center for Tobacco-Free Kids "Tobacco Toll in New Hampshire" December 1998

New Hampshire HEALTHY KIDS

Testimony
HB 7622
House Ways and Means Committee
March 15, 2001

My name is Tricia Brooks. I am the Executive Director of New Hampshire Healthy Kids Corporation, a position I have held since the inception of the program in 1994. I am here today in support of HB 672.

Access to adequate health care represents one of the most important public policy issues facing New Hampshire and the nation. That's why New Hampshire Healthy Kids Corporation supports the Health Now! Campaign and HB 672. This initiative represents an opportunity to generate new revenue that is needed to increase access and improve the health and quality of life of our State's residents.

A specific goal of the campaign is to ensure the continuing success of the Children's Health Insurance Program (CHIP), which provides free and low-cost health coverage to uninsured children. New Hampshire's CHIP program was implemented in 1999 as a partnership between the Department of Health and Human Services and the New Hampshire Healthy Kids Corporation. Since that time, more than 12,000 children have gained access to health coverage through Healthy Kids. But our work is not done. It is estimated that another 9,000 – 10,000 children are eligible but not enrolled.

Before we move forward in covering every eligible child, we must secure the State funds needed to draw down federal dollars specifically designated for children's health coverage. To date, the State's financial share has been funded through a private grant from the Healthy New Hampshire Foundation. However, the program's success has outgrown the Foundation's ability to fully fund the state match in future years.

As the attached fact sheet suggests, there are numerous reasons to substantiate why children's health coverage is important. Insured children are much more likely to

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receive the preventive and timely medical care they need to stay healthy. Healthy kids learn better and are more likely to reach their potential as tomorrow's workforce. The Children's Health Insurance Program is a great investment. Every 20¢ of State funds buys $1 worth of health coverage by leveraging other funds.

A source of revenue to fund the Children's Health Insurance Program and tackle other health care access issues in New Hampshire is critically needed. Over the past two years, Healthy Kids Corp. has been working in collaboration with the Department of Health & Human Services on the SB 183 Adult Coverage Study Committee. Our research clearly points out that the problem of uninsurance is largely among low-income working adults who cannot access health insurance through an employer. Experience in other states indicates that significant subsidies are needed to expand coverage to these groups. And funding such initiatives will be our biggest challenge.

Without government intervention, we will continue to see a broadening gap of inequity in regard to health care access that is based predominantly on income. Already we know that if you earn less than $7 per hour that is only a 43% likelihood that you have employer based coverage, compared to a 93% offer rate for someone earning more than $15 per hour. At the same time, that low-income individual must pay an average of $130 per month for coverage, compared to $84 per month for the higher income worker. Through our SB 183 work, we also know that families and individuals need to have incomes at or about 200% of the federal poverty level before they have $1 to dedicate to health coverage. This data is based on the "New Hampshire Livable Wage Study" published in June 2000 by the Josiah Bartlett Center.

Many people believe that the right to life, liberty and the pursuit of happiness is an empty promise without good health. It is time that we examine our core values in regard to providing 100% access to basic health care. To ensure 100% access, we must be willing to remove the disparities that exist in the health care today. To do so will take an appropriate source of sustainable funding that is provided by this bill. I urge you to take a leadership role in working toward 100% health care access in New Hampshire by voting in favor of HB 762.

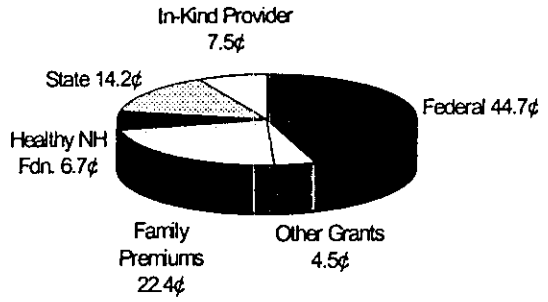
New Hampshire HEALTHY KIDS

The Children's Health Insurance Program is a Great Investment

You Can't Spend a Better Dollar

- **Every 20 cents of State money buys $1 of health coverage for uninsured children.** Premiums paid by families, federal funding, provider discounts, and private grants support 80% of the program's cost.

CHIP Financial Partnerships Make the Difference



Projected Funding Mix for CHIP
January - December 2001
Assumes Inclusion of CHIP Funding in State Budget Beginning July 2001

- New Hampshire's **CHIP program promotes family responsibility** by offering a way for families to pay a greater share of their health care cost as their income increases rather than lose benefits.
- Health insurance provides kids with **access to a medical home and a personal physician** who coordinates needed care and helps parents nurture their child's growth and development.
- Health coverage means families can **take advantage of the preventive and primary care services** kids need most to stay healthy and avoid unnecessary emergency room visits.
- **Healthy kids learn better**, miss fewer school days and are better able to reach their potential as tomorrow's workforce.
- Health coverage for kids **means greater work productivity for parents** who miss fewer workdays due to a child's poor health and who have the peace of mind that coverage provides.

Children Need Health Insurance

Health coverage is key to staying healthy. Without health insurance, children are far less likely to get medical care when they are sick or injured. **Compared with insured children, uninsured kids are:**

- 2½ times less likely to see a doctor in a year
- 6 times less likely to have a usual source of care and twice as likely to seek care in an emergency room
- 3½ times less likely to receive needed medical care and 4 times less likely to receive needed dental care
- 3 times less likely to fill a prescription or buy eyeglasses because of cost

Families Need Assistance in Obtaining Health Coverage for their Children

The SB 183 Adult Coverage Study Committee recently reported to the NH Legislature that families must earn incomes at or about 200% of the federal poverty level before they have $1 to dedicate to the purchase of health coverage (see chart below). The group's conclusion is based on data published by the Josiah Bartlett Center regarding the level of income needed to meet basic living expenses such as housing, food, utilities and transportation.

Income Needed to Pay for Basic Living Needs

Family Unit	Annual Livable Wage *	Percent of FPL
Two parents & two children Both parents working)	$40,655	238%
Two parents & two children (one parent working)	$28,555	167%
Two parents & one child (both parents working)	$34,655	245%
Two parents & one child (one parent working)	$26,532	188%
Single parent & two children	$34,505	244%
Single parent & one child	$28,713	255%

** The livable wage in this chart excludes a contribution to health insurance and 5% savings that was included in the original report.*

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STATE OF NEW HAMPSHIRE
COMMISSION ON THE STATUS OF WOMEN

February 26, 2001

Dear Legislator,

On behalf of the Advisory Committee to the recently published report, ***The Status of Women in New Hampshire***, I proudly announce the 2001 Women's Agenda.

Our legislative agenda focuses on issues of critical concern to the state's women. The bills included empower New Hampshire women to achieve economic autonomy, to better balance work and family, and to be fully counted in statistical data collected and analyzed by the state. We strongly urge you to support the 2001 Women's Agenda.

2001 Women's Agenda

HB 359 Requiring data collected by state agencies to be analyzed relative to age and gender

HB 469 Raising the minimum wage for hourly employees

HB 589 Extending eligibility for unemployment benefits to part-time workers

LSR 1009 Establishing a NH trust fund for health care for low wage workers, including child care providers

HB 658 Making an appropriation to the Homeless Prevention Fund

Please see the attached "Research-in-Brief" for more information on ***The Status of Women in New Hampshire***. If you have any questions about the report, would like to request a copy, or are interested in other resources offered through the Commission on the Status of Women, please to do not hesitate to contact me by phone or e-mail (tdelangis@admin.state.nh.us).

Thank you for your efforts on behalf of New Hampshire women.

Respectfully Yours,

Theresa de Langis

Theresa de Langis
Executive Director, Commission on the Status of Women
Chair, Advisory Committee to The Status of Women in New Hampshire

Status of Women in NH Advisory Committee

Theresa de Langis
Chair
NH Commission
On the Status of Women

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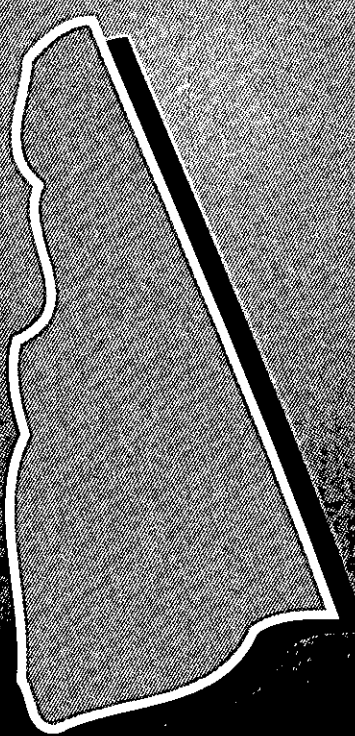
Ellen Shemitz
Children's Alliance of NH

Jane Stapleton
NH Commission
On the Status of Women

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The Status of Women in New Hampshire

POLITICS • ECONOMICS • HEALTH • DEMOGRAPHICS



INSTITUTE FOR WOMEN'S POLICY RESEARCH

About This Report

The Status of Women in New Hampshire is part of an ongoing research project conducted by the Institute for Women's Policy Research (IWPR) to establish baseline measures of the status of women in all 50 states and the District of Columbia. The effort is part of a larger IWPR Economic Policy Education Program, funded by the Ford Foundation, intended to improve the ability of advocates and policymakers at the state level to address women's economic issues. The first two series of reports were released in 1996 and 1998 and included a summary national report and 24 state reports. This report is part of the third series, which includes eight other states as well as an update of the national report. See IWPR's website (www.iwpr.org) for more information.

The data used in each report come from a variety of sources, primarily government agencies, although other organizations also provided data where relevant. The Economic Policy Institute (EPI) analyzed much of the economic data presented in the report. EPI is a nonprofit, nonpartisan research organization that seeks to broaden the public debate about strategies to achieve a prosperous and fair economy. EPI's studies and popular education materials are available at www.epinet.org.

While every effort has been made to check the accuracy and completeness of the information presented, any errors are the responsibility of the authors and IWPR. Please do not hesitate to contact the Institute with any questions or comments.

About the Institute for Women's Policy Research

The Institute for Women's Policy Research (IWPR) is a public policy research organization dedicated to informing and stimulating the debate on public policy issues of critical importance to women and their families. IWPR focuses on poverty and welfare, employment and earnings, work and family issues, the economic and social aspects of health care and domestic violence, and women's civic and political participation.

The Institute works with policymakers, scholars, and public interest groups around the country to design, execute, and disseminate research that illuminates economic and social policy issues affecting women and families, and to build a network of individuals and organizations that conduct and use women-oriented policy research. IWPR, an independent, nonprofit organization, also works in affiliation with the graduate programs in public policy and women's studies at The George Washington University.

IWPR's work is supported by foundation grants, government grants and contracts, donations from individuals, and contributions from organizations. Members and affiliates of IWPR's Information Network receive reports and information on a regular basis. IWPR is a 501(c)(3) tax-exempt organization.

About IWPR's Partners in this Project

In producing these reports, IWPR called upon many individuals and organizations in the states. Kathryn Frey, former Executive Director, New Hampshire Commission on the Status of Women, served as Chair of the New Hampshire Advisory Committee, coordinating the various individuals on the Committee, who represented organizations from all over the state. Ms. Frey organized the committee meetings, helped author and coordinate the focus boxes, and assisted IWPR in raising funds for the project. Marie Metoyer and Jane G. Stapleton, New Hampshire Commission on the Status of Women, also served as acting Co-Chairs of the committee. The Committee made many contributions, including reviewing the draft report for accuracy, making suggestions to ensure that the data contained in the report would be useful, authoring and providing data for focus boxes, and organizing the dissemination of and publicity surrounding the release of the report. Many individuals and organizations in New Hampshire assisted in locating data and reviewing this report, and one organization has joined in co-publishing the report.

Additional Copies

In New Hampshire, for additional copies of the report contact:

New Hampshire Commission on the Status of Women
State House Annex, Room 334
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Concord, NH 03301
Tel: (603) 271-2660
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For additional copies of this report or the National Report, bulk copies of this report, or reports for other states, contact:

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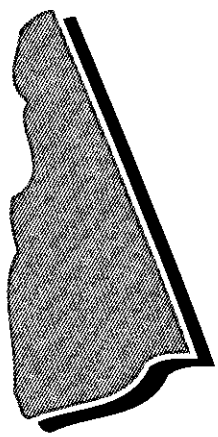
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The Status of Women in New Hampshire

POLITICS ◆ ECONOMICS ◆ HEALTH ◆ RIGHTS ◆ DEMOGRAPHICS

Edited by Amy B. Caiazza, Ph.D.



Institute for Women's Policy Research

with the assistance of the New Hampshire Advisory Committee

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Acknowledgments

In its third round, *The Status of Women in the States* has become larger, more complex, and more comprehensive than ever. Its growing size and visibility are the direct result of the contributions of the many impassioned and talented people who have worked on the report series, particularly members of the state advisory committees, and of the cooperation of myriad state and national organizations. IWPR's staff, partners, and colleagues contributed vast amounts of time, energy and expertise to the project.

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In addition to the official staff for the project, many other IWPR researchers also contributed to drafting and editing the reports, including Dr. Stacie Golin, Study Director; Dr. Catherine Hill, Study Director; Dr. Vicki Lovell, Study Director; Holly Mead, Research Fellow; Dr. Cynthia Negrey, Study Director; and Dr. Lois Shaw, Senior Consulting Economist. All of these researchers took time from their own projects to assist in producing the reports, and the staff of the Status of Women in the States owes them a debt of gratitude. Associate Director of Research Barbara Gault and Director and President Heidi Hartmann also reviewed and edited the reports. Both Dr. Gault and Dr. Hartmann took time out of an otherwise busy summer (including vacation time) to help complete the reports, and, more importantly, both provided ongoing encouragement, new ideas, fantastic energy, and a host of inspirations to the project—and to all of IWPR's work.

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Finally, IWPR's communications and production staff played a pivotal role in the publication of the reports. Nasserie Carew, Associate Director of Communications, oversaw the layout and final preparation of the reports and was responsible for planning and coordinating the dissemination of and publicity surrounding the release of the reports. Her work was crucial to transforming the reports into their final format and to helping IWPR's state advisory committees call attention to their findings.

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Preface

On behalf of the members of the New Hampshire Advisory Committee, I am proud to present this report to the citizens of New Hampshire. *The Status of Women in New Hampshire* was prepared by the Institute for Women's Policy Research (IWPR) as part of an ongoing series of reports for all the states. It is the belief of the Advisory Committee that this will be an informative and useful tool as we assess the status of women in New Hampshire and engage in future policy changes to help women achieve true equality in all areas of life. We are pleased to have had an opportunity to participate with IWPR in the preparation, review and dissemination of the report.

I would like to take this opportunity to thank the members of the Advisory Committee for the time and effort they have put into reviewing and providing valuable feedback on this report. Members of the committee directly contributed to this report by authoring "focus boxes" on child care, economic disparity, education, domestic violence, sexual assault, and housing. These focus boxes provide an important additional perspective to this report.

The report demonstrates that, when it comes to the status of women, New Hampshire is a study in contradictions. The state's shortfalls stand in dramatic contrast to the important progress that has already been made by the women of New Hampshire.

The Advisory Committee feels that this report presents a number of challenges to the policymakers, advocates and legislators of this state. First, it is a challenge to identify the meaning of the grades attributed to New Hampshire in the report. The Institute for Women's Policy Research graded each of the states using a curve. New Hampshire's higher grades should not, in the opinion of the Advisory Committee, lead to an acceptance of the status quo. Although we can applaud the progress that has been made to earn these grades, New Hampshire women, like those in all of the states, continue to face obstacles that prevent economic, political, and social parity with men. It is apparent that inequality among women and men still exists in all five areas outlined by the report: political participation, employment and earnings, economic autonomy, reproductive rights, and health and well-being.

The second challenge presented by the report is to place the data in context. There is no dispute that New Hampshire is currently enjoying a very strong period of economic growth, with the state ranking eighth highest in per capita income nationwide (US Department of Commerce, Bureau of Economic Analysis, 1999). Given such growth, can we really celebrate a grade of B- for economic autonomy, C+ for employment and earnings, C+ for political participation, B- for reproductive rights, or B- for health, especially when New Hampshire ranks 34th in the nation, and second to last in the New England region, on measures of pay equity? Currently, the average woman worker in New Hampshire can expect to make $.30 less per dollar than her male counterpart. That figure translates into $10,735 less in earnings per year. Addressing pay inequity is just one way policies could be changed to help women and their families reach economic self-sufficiency.

Indeed, as this report points out, many of New Hampshire's employment policies actually hurt working women, especially those who are single-heads of households. Temporary disability insurance is not mandatory in the state, and unemployment insurance benefits do not extend to low-wage and part-time workers, the preponderance of whom are women. Because the state does not allow workers to use unemployment insurance for paid family leave, many New Hampshire families are financially unable to benefit from the federal Family and Medical Leave Act.

The final challenge lies in getting behind the "averages." Although this report gives us a good look at how women fare generally in the indicator areas, in many cases, the constraints of the data do not allow the report to examine the experiences of different kinds of women. We need to be able to address the specific needs of

women of different races, ethnicities, ages, sexual preferences, disability status, and regions. For example, the status of minority women is not adequately understood, as available data are insufficient for understanding the unique challenges minority women might face as New Hampshire citizens. Geographic differences (southern urban areas versus northern rural areas) exist for women, yet we have no data to assess these differences. Older women have different parity issues than younger women, while women with disabilities have challenges other women do not.

As a result, one of the committee's primary recommendations based on the report is that policymakers, advocates and legislators advocate for the investment of funds in data collection, in order to get a clearer picture of the obstacles and barriers that face all kinds of women, their children and families.

The status of women in New Hampshire is better than in many states. We should not, however, complacently rest on our laurels or think that the job is done. New Hampshire's grades and rankings should be interpreted as reasonable starts on the road to gender equity. However, there is still much work to do. We hope this report sparks questions, debate, and ultimately action, to improve the well-being of women across New Hampshire.

Kathryn Frey
Former Executive Director, New Hampshire Commission on the Status of Women
Former Chair, New Hampshire State Advisory Committee, *The Status of Women in New Hampshire*

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Introduction

During the twentieth century, women made significant economic, political and social advances, but they are still far from achieving gender equality. Throughout the United States, women still earn less than men, are seriously underrepresented in political office, and make up a disproportionate share of those in poverty. To make significant progress toward gender equity, policymakers need reliable and relevant data about the issues affecting women's lives. Moreover, as many policymaking responsibilities shift to the states, advocates, researchers and policymakers need state-level data about women. Recognizing this need, the Institute for Women's Policy Research (IWPR) initiated a series of reports on *The Status of Women in the States* in 1996. The biannual series is now in its third round and will, over the course of a decade, encompass reports on each of the 50 states and the District of Columbia. This year, IWPR produced reports on nine states as well as a national report summarizing results for all the states and the nation as a whole.

Goals of *The Status of Women in the States* Reports

The staff of IWPR prepared these reports on *The Status of Women in the States* to inform citizens about the progress of women in their state relative to women in other states, to men and to the nation as a whole. The essence and goals of the reports have remained the same since 1996: 1) to analyze and disseminate information about women's progress in achieving rights and opportunities; 2) to identify and measure the remaining barriers to equality; and 3) to provide baseline measures and a continuing monitor of women's progress throughout the country. In addition, members of each state advisory committee prepared information on several topics to highlight issues of particular importance to women in their state.

In each report published in 2000, indicators describe women's status in political participation, employment and earnings, economic autonomy, reproductive rights, and health and well-being. In addition, the reports provide information about the basic demographics of the state (see Appendix I). For the five major issue areas addressed in this report, IWPR compiled composite indices based on the indicators presented to provide an overall assessment of the status of women in each area and to rank the states from 1 to 51 (including the District of Columbia; see Appendix II for details). The composite index on women's health status is an innovation for the 2000 reports; earlier reports presented information on women's health but did not rank the states on this issue.

Although state-by-state rankings provide important insights into women's status throughout the country—indicating where progress is greater or less—in no state do women have adequate policies ensuring their equal rights. Women have not achieved equality with men in any state, including those ranked relatively high on the indices compiled in this report. All women continue to face important obstacles to achieving economic, political and social parity.

To address the continuing barriers to women in this country, the 2000 series of reports includes another innovation: in addition to rankings for each of the issue areas, each state is given a grade for women's political participation, employment and earnings, economic autonomy, reproductive rights, and health and well-being. IWPR designed the grading system to highlight the gaps between men's and women's access to various rights and resources. States were thus graded based on the difference between their performance and goals (such as no remaining wage gap or the proportional representation of women) set by IWPR (see Appendix II). For example, since no state has eliminated the gap between women's and men's earnings, no state received an A on the employment and earnings composite index, despite rankings near the top for some states on the indicators encompassed by this index. Because women in the United States are closer to achieving some goals than others, the curve for each index is somewhat

different. Using the grades, policymakers, researchers and advocates in high-ranking states can quickly identify remaining barriers to equality for women in their state.

In addition to assessing women's status throughout the country, IWPR designed *The Status of Women in the States* to actively involve state researchers, policymakers and advocates concerned with women's status. Beginning in 1996, state advisory committees helped design *The Status of Women in the States* reports, reviewed drafts, and disseminated the findings in their states. IWPR's partnership with the state advisory committees has developed into a participatory process of preparing, reviewing, producing and publicizing the reports. Their participation has been crucial to improving the reports in each round.

About the Indicators and the Data

IWPR referred to several sources for guidelines on what information to include in these reports. Many of the economic indicators chosen, such as median earnings or the wage gap, are standard indicators of women's status. The same is true of indicators of voter participation and women's electoral representation. In addition, IWPR used the Beijing Declaration and Platform for Action from the U.N. Fourth World Conference on Women to guide its choice of indicators. This document was the result of an official convocation of delegates from around the world. It outlines issues of utmost concern to women, rights fundamental to achieving equality and autonomy, and remaining obstacles to their advancement.

IWPR also turned to members of its state advisory committees, who reviewed their state's report and provided input for improving the project as a whole. Finally, IWPR staff turned to experts in each of the subject areas for input about the most critical issues related to the various topics. An important source of this expertise for the 2000 reports was IWPR's Working Group on Social Indicators of Women's Status, described in detail below. Ultimately, the IWPR research team made data selection decisions on the basis of several principles and constraints: relevance, succinctness, representativeness, reliability, and comparability of data across all the states and the District of Columbia. As a result, while women's status is constantly changing throughout the United States, the evidence contained in this report represents a compilation of the best available data for measuring women's status.

To facilitate comparisons among states, IWPR used data collected in the same way for each state. While most of the data are from federal government agencies, other organizations also provided data. Many figures rely on the U.S. Census Bureau's Current Population Survey (CPS), a monthly survey of a nationally representative sample of households. To ensure sufficiently large sample sizes for cross-state comparisons, several years of data were combined and then tabulated. CPS data analyses were conducted for IWPR by the Economic Policy Institute (EPI). While the decennial censuses provide the most comprehensive data for states and local areas, since they are conducted only every ten years, decennial census data are often out of date. CPS data are therefore used to provide more timely information. For this set of reports, IWPR incorporated new economic data from the years 1996-98. Some figures necessarily rely on older data from the 1990 Census and other sources; historical data from 1980 or earlier are also presented on some topics.

Because CPS data have smaller sample sizes than the decennial Census, the population subgroups that can be reliably studied are limited (for information on sample sizes, see Appendix II). The decision to use more recent data with smaller sample sizes is in no way meant to minimize how profoundly differences among women—for example, by race, ethnicity, age, sexuality and family structure—affect their status or how important it is to design policies that speak to these differences. Identifying and reporting on areas within the states (cities, counties, urban and rural areas) were also beyond the scope of this project. The lack of disaggregated data often masks regional differences among women within the states: for example, pockets of poverty are not identified and groups with lower or higher status may be overlooked. While IWPR does not mean to downplay these differences, addressing them was not possible due to data and other constraints.

A lack of reliable and comparable data at the state level limits the treatment of several important topics: domestic violence; older women's issues; pension coverage; issues concerning nontraditional families of all types, including intergenerational families; lesbian issues; and issues concerning women with disabilities. The report also does not analyze women's unpaid labor or women in nontraditional occupations. In addition, income and poverty data across states are limited in their comparability by the lack of good indicators of differences in the cost of living by states: thus, poor states may look worse than they really are, and rich states may look better than they really are. IWPR firmly believes that all of these topics are of utmost concern to women in the United States and continues to search for data and methods to address them. However, many of these issues do not receive sufficient treatment in national polls or other data collection efforts.

Such data concerns highlight the sometimes problematic politics of data collection: researchers do not know enough about many of the serious issues affecting women's lives because women do not yet have sufficient political or economic power to demand the necessary data. As a research institute concerned with women, IWPR presses for changes in data collection and analysis in order to compile a more complete understanding of women's status. Currently, IWPR is leading a Working Group on Social Indicators of Women's Status designed to assess current measurement of women's status in the United States, determine how better indicators could be developed using existing data sets, make recommendations about gathering or improving data, and build short- and long-term research agendas to encourage policy-relevant research on women's well-being and status.

To address gaps in state-by-state data and to highlight issues of special concern within particular states, IWPR added another innovation in 2000. This year, state advisory committees were invited to contribute text presenting state-specific data on topics covered by the reports. These contributions enhance the reports' usefulness to the residents of each state, while maintaining comparability across all the states.

Finally, the reader should keep a few technical notes in mind. In some cases, differences reported between two states or between a state and the nation for a given indicator are statistically significant. That is, they are unlikely to have occurred by chance and probably represent a true difference between the two states or the state and the country as a whole. In other cases, these differences are too small to be statistically significant and are likely to have occurred by chance. IWPR did not calculate or report measures of statistical significance. Generally, the larger a difference between two values (for any given sample size), the more likely the difference is statistically significant. In addition, when comparing indicators based on data from different years, the reader should note that in the 1990-2000 period, the United States experienced a major economic recession at the start of the decade, followed by a slow and gradual recovery, with strong economic growth (in most states) in the last few years.

About IWPR

IWPR is an independent research institute dedicated to conducting and disseminating research that informs public policy debates affecting women. IWPR focuses on issues that affect women's daily lives, including employment, earnings, and economic change; democracy and society; poverty, welfare, and income security; work and family policies; and health and violence. IWPR also works in affiliation with the George Washington University's graduate programs in public policy and women's studies.

The Status of Women in the States reports seek to provide important insights into women's lives and to serve as useful tools for advocates, researchers and policymakers at the state and national levels. The demand for relevant and reliable data at the state level is growing. This report is designed to fill this need.

Overview of the Status of Women in New Hampshire



Women in New Hampshire exemplify both the achievements and shortfalls of women's progress over the past century. Many New Hampshire women are witnessing real improvements in their economic, political and social status, and these advances are evident in relatively high rankings on several of the composite indices calculated by IWPR. Of the 50 states and the District of Columbia, New Hampshire scores eighth in political participation, tenth in economic autonomy, 13th in reproductive rights, 14th in employment and earnings, and 19th in health and well-being (see Chart 1, Panel A).

Despite New Hampshire's strong performance, women in the state have not achieved equality with men. Women in New Hampshire still face significant problems that demand attention from policymakers, women's advocates, and researchers concerned with women's status. As a result, in an evaluation of New Hampshire women's status compared with goals set for women's ideal status, New Hampshire earns the grades of B- in reproductive rights, economic autonomy, and health and well-being and a C+ in employment and earnings and political participation (see Chart I, Panel B).

Chart I. Panel A.
How New Hampshire Ranks on Key Indicators

Indicators	National Rank*	Regional Rank*
Composite Political Participation Index	**8**	**3**
Women's Voter Registration, 1992-96	25	5
Women's Voter Turnout, 1992-96	27	6
Women in Elected Office Composite Index, 2000	9	3
Women's Institutional Resources, 2000	31	5
Composite Employment and Earnings Index	**14**	**3**
Women's Median Annual Earnings, 1997	17	4
Ratio of Women's to Men's Earnings, 1997	34	5
Women's Labor Force Participation, 1998	8	1
Women in Managerial and Professional Occupations, 1998	15	3
Composite Economic Autonomy Index	**10**	**4**
Percent with Health Insurance Among Nonelderly Women, 1997	5	2
Educational Attainment: Percent of Women with Four or More Years of College, 1990	9	4
Women's Business Ownership, 1992	40	4
Percent of Women Above the Poverty Level, 1997	5	1
Composite Reproductive Rights Index	**13**	**3**
Composite Health and Well-Being Index	**19**	**4**

See Appendix II for a detailed description of the methodology and sources used for the indices presented here.
* The national rankings are of a possible 51 referring to the 50 states and the District of Columbia except for the Political Participation indicators, which do not include the District of Columbia. The regional rankings are of a maximum of six and refer to the states in the New England Region (CT, ME, MA, NH, RI, VT).
Calculated by the Institute for Women's Policy Research.

Chart I. Panel B.
Criteria for Grading and New Hampshire's Grades

Index	Criteria for a Grade of "A"	Grade, New Hampshire	Highest Grade, U.S.
Composite Political Participation Index		C+	B
Women's Voter Registration	Women's Voter Registration, Best State (91.2%)		
Women's Voter Turnout	Women's Voter Turnout, Best State (72.5%)		
Women in Elected Office Composite Index	50 Percent of Elected Positions Held by Women		
Women's Institutional Resources	Commission for Women and a Women's Legislative Caucus in Each House of State Legislature		
Composite Employment and Earnings Index		C+	B+
Women's Median Annual Earnings	Men's Median Annual Earnings, United States ($34,532)		
Ratio of Women's to Men's Earnings	Women Earn 100 Percent of Men's Earnings		
Women's Labor Force Participation	Men's Labor Force Participation, United States (74.9%)		
Women in Managerial and Professional Occupations	Women in Managerial and Professional Occupations, Best State (46.3%)		
Composite Economic Autonomy Index		B-	B+
Percent with Health Insurance	Percent with Health Insurance, Best State (91.9%)		
Educational Attainment	Men's Educational Attainment (percent with four years or more of college, United States, 24.0%)		
Women's Business Ownership	50 Percent of Businesses Owned by Women		
Percent of Women Above Poverty	Percent of Men Above Poverty, Best State (91.5%)		
Composite Reproductive Rights Index	Presence of All Relevant Policies and Resources (see Chart VI, Panel B)	B-	A-
Composite Health and Well-Being Index	Best State or Goals Set by Healthy People 2010 (U.S. Department of Health and Human Services) for All Relevant Indicators (see Appendix II for details)	B-	A-

See Appendix II for a detailed description of the methodology and sources for the indices and grades presented here.
Compiled by the Institute for Women's Policy Research.

New Hampshire's rankings and grades for each of the composite indices were calculated by combining data on indicators of women's status in each of the five areas. These data were used to compare women in New Hampshire with women in each of the 50 states and the District of Columbia. In addition, they were used to evaluate women's status in the state in comparison with women's ideal status (for more information on the methodology for the composite indices and grades, see Appendix II).

New Hampshire joins Connecticut, Maine, Massachusetts, Rhode Island, and Vermont as part of the New England region. Among these six states, New Hampshire ranks average to low. The state ranks third on three composites: political participation, employment and earnings, and reproductive rights. It ranks fourth on two composites: economic autonomy and health and well-being.

As part of New England, New Hampshire shares in a generally high standard of living. The cost of living is generally also thought to be relatively high among the New England states and is not adequately controlled for in these measures of women's status. In addition, New Hampshire is much less ethnically diverse than the rest of the United States, with minorities making up less than 3 percent of women

in the state, compared with 27 percent for the nation as a whole. In some areas of the country, factors such as discrimination against minority women substantially lower a state's indicators, such as women's median income. The vast majority of New Hampshire's women, however, do not face these obstacles. As a result, some indicators here may both be higher than in other states with more diverse populations and may simultaneously mask some of the real problems facing minority women in New Hampshire.

New Hampshire has the tenth smallest population in the United States. While New Hampshire has experienced less population growth in recent years than the nation as a whole, it has experienced more growth than the five other states in the New England region. While the distribution of family types is similar in New Hampshire to the United States as a whole, the state has a lower percentage of female-headed households with children. Finally, New Hampshire has a large proportion of women living in rural areas compared with other states (see Appendix I).

Political Participation

New Hampshire is one of only three states in the nation with a female governor, and a relatively high proportion of the state legislature is made up of women. As a result, the state ranks high on this composite index, at eighth in the nation. Rates of voter registration and voter turnout are only slightly higher than that of the nation as a whole, however, and rank New Hampshire 25th and 27th, respectively. New Hampshire lacks a women's caucus in the state legislature. Finally, despite relatively high levels of women in elected office, the state's women still do not hold a proportional number of political offices, as women constitute just over 30 percent of the legislature and none of the state's congressional delegation. Like all states, New Hampshire could improve greatly on measures of political participation. Thus the state received a C+ on the political participation composite index.

Employment and Earnings

New Hampshire's ranking on the employment and earnings composite index (14th) reflects scores in the top third on three of the component indicators of this index. Women in New Hampshire earn more, are more likely to participate in the labor force, and are more likely to work in managerial and professional positions than women in the nation as a whole. In contrast, the ratio of their earnings compared to men's is low, ranking only 34th in the nation. Because New Hampshire's men earn substantially more than its women, despite a high ranking relative to women in other states on some indicators, the state earned a C+ on employment and earnings.

A substantial proportion, about 74.2 percent, of women with children under six years of age in New Hampshire currently participates in the workforce. New Hampshire's parents increasingly need adequate and affordable child care, a policy demand not yet adequately addressed in New Hampshire or the United States as a whole. In an economic era when all able or available parents generally work for pay to support their children, public policies lag far behind reality.

Economic Autonomy

New Hampshire ranked tenth on IWPR's composite index of economic autonomy and does fairly well on measures of women's health insurance coverage (fifth), educational attainment (ninth), and poverty levels (fifth). However, New Hampshire is well behind other states when it comes to women's business ownership, ranking 40th in the nation, and the growth of women's business ownership from 1987-92 is lower than the average for the country. Moreover, despite the state's higher rankings, almost 12 percent of women are uninsured and almost 9 percent live in poverty. New Hampshire's need for improvement is reflected in its grade of B- on the economic autonomy composite index. Finally, not all women in New Hampshire share in the state's economic security, and women's access to the state's resources vary for urban and rural populations as well as for women from different racial and ethnic backgrounds.

Reproductive Rights

New Hampshire women have relatively high levels of access to the reproductive rights and resources identified as important, and as a result the state ranked 13th on this composite index. New Hampshire allows full access to abortion without parental consent or waiting periods, and it requires health insurance companies to provide contraceptive coverage. The state does not, however, provide public funding for abortions, mandate that health insurance companies cover infertility treatments, or require sex education in schools. Like most states, New Hampshire does not offer adequate reproductive freedom to women, and thus the state received a grade of B- on this indicator.

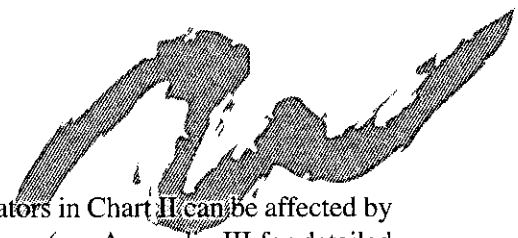
Health and Well-Being

New Hampshire's rank of 19th on the health and well-being composite index encompasses a wide range of scores on each of the component indicators. Women in New Hampshire have the lowest incidence of chlamydia in the country and rank among the top ten states for low incidences of diabetes and AIDS. On the other hand, New Hampshire's women fare particularly badly when it comes to rates of mortality from lung cancer (44th), breast cancer (43rd), and heart disease (30th). This combination of very good and very poor health indicators in New Hampshire results in an overall grade of B-. Finally, women in New Hampshire lack policies mandating insurance coverage of cervical cancer screenings and osteoporosis screenings. These policies would increase women's access to important health-related resources.

Conclusion

New Hampshire illustrates both the advances and limited progress achieved by women in the United States. While women in New Hampshire and the United States as a whole are seeing important changes in their lives and in their access to political, economic and social rights, they by no means enjoy equality with men, and they still lack many of the legal guarantees that would allow them to achieve that equality. Women in New Hampshire and the nation as a whole would benefit from stronger enforcement of equal opportunity laws, better political representation, adequate and affordable child care, and other policies that would help improve their status.

Women's Resources and Rights Checklist



The Fourth World Conference on Women, held in Beijing in September 1995, heightened awareness of women's status around the world and pointed to the importance of government action and public policy for the well-being of women. At the conference, representatives of 189 countries, including the United States, unanimously adopted the Beijing Declaration and Platform for Action, which pledged their governments to action on behalf of women. The Platform for Action outlines critical issues of concern to women and remaining obstacles to women's advancement.

In the United States, the President's Interagency Council on Women continues to follow up on U.S. commitments made at the Fourth World Conference on Women. According to the Council (2000), many of the laws, policies and programs that already exist in the United States meet the goals of the Platform for Action and support the rights of women identified in the Platform. Women in the United States enjoy access to relatively high levels of resources and gender equality compared with women around the world. In some other areas, however, the United States and many individual states have an opportunity to better support women's rights.

Chart II, the Women's Resources and Rights Checklist, provides an overview of the policies supporting women's rights and the resources available to women in New Hampshire. This list derives from ideas presented in the Platform for Action, including the need for policies that help prevent violence against women, promote women's economic equality, alleviate poverty among women, improve their physical, mental, and reproductive health and well-being, and enhance their political power. The rights and resources outlined in the Women's Resources and Rights Checklist fall under several categories: protection from violence, access to income support (through welfare and child support collection), women-friendly employment protections, legislation protecting sexual minorities, reproductive rights, and institutional representation of women's concerns.

Many of the indicators in Chart II can be affected by state policy decisions (see Appendix III for detailed explanations of the indicators). As a result, the Women's Resources and Rights Checklist provides a measure of New Hampshire's commitment to policies designed to help women achieve economic, political, and social well-being. In New Hampshire, women enjoy many of the rights identified with women's well-being, although they lack others. The state receives a total score of 13 out of 28 possible measures presented in the Women's Resources and Rights Checklist.

Violence Against Women

New Hampshire lacks all of the policies and provisions identified in this report that can help curtail violence and protect victims. The state has not adopted domestic battery laws that supplement assault statutes. Creating a separate offense for domestic battery allows enhanced penalties for repeat offenders and equal treatment for victims of domestic violence, since victims of domestic violence are often treated less seriously than victims of other kinds of assault (Miller, 1999a). A total of 30 states have adopted this type of law. New Hampshire also does not legislatively require domestic violence training among new police recruits to ensure that police are aware of state laws, the prevalence and significance of domestic violence, and the resources available to victims (Miller, 1999a). Thirty-one states and the District of Columbia require domestic violence training by statute. Although New Hampshire has not adopted such a statute, the New Hampshire Police Standards and Training Council includes such training in its program for new recruits, including four-hour courses in Domestic Violence, Stalking Investigation, and Law; Domestic Violence Dynamics; Victim/Witness Relations; and Sexual Assault/Rape Protocols (State of New Hampshire, Police Standards & Training Council, 2000).

Chart II.
Women's Resources and Rights Checklist

	Yes	No	Other Information	Total Number of States with Policy (of 51) or U.S. Average
Violence Against Women				
Is domestic violence a separate criminal offense in New Hampshire?		✓		30
Does New Hampshire law require domestic violence training of new police recruits?		✓	Required by Police Standards & Training Council	32
Domestic violence and sexual assault spending per person:			$1.39	$1.34
Is a first stalking offense a felony in New Hampshire?		✓		10
Does New Hampshire law require sexual assault training for police and prosecutors?		✓	Required by Police Standards & Training Council	10
Child Support				
Percent of single-mother households receiving child support or alimony:			44%	34%
Percent of child support cases with orders for collection in which support was collected:			49.5%	39.2%
Welfare Policies				
Does New Hampshire extend TANF benefits to children born or conceived while a mother is on welfare?	✓			27
Does New Hampshire allow receipt of TANF benefits up to or beyond the 60-month federal time limit?	✓		60-month limit	30
Does New Hampshire allow welfare recipients at least 24 months before requiring participation in work activities?[1]		✓		23
Does New Hampshire provide transitional child care under TANF formore than 12 months?[2]	✓			33
Has New Hampshire's TANF plan been certified or submitted for certification under the Family Violence Option or made other provisions for victims of domestic violence?	✓		Submitted for certification	40
In determining welfare eligibility, does New Hampshire disregard the equivalent of at least 50 percent of earnings from a full-time, minimum wage job?	✓			25
Average TANF benefit in New Hampshire, 1997-98:			$417.12	$358.08
Employment/Unemployment Benefits				
Is New Hampshire's minimum wage higher than the federal level as of March 2000?		✓		11
Does New Hampshire have mandatory temporary disability insurance?		✓		5
Does New Hampshire provide Unemployment Insurance benefits to:				
Low-wage workers?		✓		12
Workers seeking part-time jobs?		✓		9
Workers who leave their jobs for certain circumstances ("good cause quits")?	✓			23

Chart II continued

	Yes	No	Other Information	Total Number of States with Policy (of 51) or U.S. Average
As of July 2000, has New Hampshire proposed policies allowing workers to use Unemployment Insurance for paid family leave?	✓			0 Enacted; 13 Proposed
Has New Hampshire implemented adjustments to achieve pay equity in its state civil service?		✓		20
Sexual Orientation and Gender Identity				
Does New Hampshire have civil rights legislation prohibiting discrimination on the basis of sexual orientation and/or gender identity?	✓			19
Does New Hampshire have a Hate Crimes law covering sexual orientation?	✓			24
Has New Hampshire avoided adopting a ban on same-sex marriage?	✓			20
Reproductive Rights				
Does New Hampshire allow access to abortion services:				
Without mandatory parental consent or notification?	✓			9
Without a waiting period?	✓			33
Does New Hampshire provide public funding for abortions under any or most circumstances if a woman is eligible?		✓		15
Does New Hampshire require health insurers to provide comprehensive coverage for contraceptives?	✓			11
Does New Hampshire require health insurers to provide coverage of infertility treatments?		✓		10
Does New Hampshire allow the non-legal parent in a gay/lesbian couple to adopt his/her partner's child?[3]			No case has been tried	21
Does New Hampshire require schools to provide sex education?		✓		18
Institutional Resources				
Does New Hampshire have a Commission for Women?	✓			39
Total Policies[4]	**14**	**13**		**28 possible**

See Appendix III for a detailed description and sources for the items on this checklist.

[1] New Hampshire imposes immediate work requirements, but allows 26 weeks of job search followed by 26 weeks of work activities.

[2] New Hampshire has no limit for families below 190% of poverty.

[3] Most states that allow such adoptions do so as the result of court decisions. In New Hampshire, no case has yet been tried.

[4] Policies in the "yes" and "no" columns do not add up to 28 because some of New Hampshire's policies have mixed evaluations and thus fall in the "other" column.

Compiled by the Institute for Women's Policy Research.

Focus on Sexual Assault in New Hampshire

Sexual assault is a growing problem in New Hampshire, and the number of sexual assault survivors seeking services is steadily increasing. According to the New Hampshire Department of Justice, in 1996, 439 women who were raped sought services at a crisis center. These numbers increased in 1997 and 1998 to 538 and 578, respectively. For 1999, 559 sexual assault survivors sought services at crisis centers. The number of female victims of incest or child sexual assault seeking services has also risen, from 102 in 1996 to 159 in 1997 and 183 in 1999. Crisis centers have also seen reports of sexual harassment increase by one-third between 1996 and 1999 (Palmer, 1999).

The 1998 New Hampshire Behavioral Risk Factors Surveillance System Study reports the following:

- More than 15 percent of women report unwanted sexual touching or sexual abuse.
- Of women who experience unwanted sexual touching or sexual abuse, more than 50 percent report at least one incident of forced sex after their 18th birthday.
- More than 60 percent of sexual assaults reported in the study occurred at the hands of a present or former intimate partner (Powers, 1998).

Despite increases in the number of victims seeking services, sexual violence remains one of the most underreported and underaddressed crimes in our society. In New Hampshire, as in the United States as a whole, there is a need for educational campaigns designed to increase awareness around and prevent violence against women, as well as for policies that encourage reporting of violence and that prioritize the needs of victims.

To this end, New Hampshire has created the Governor's Commission on Domestic and Sexual Violence, which is charged with increasing awareness of and enhancing government responses to domestic and sexual violence.

In addition to domestic violence policies, many states also have provisions related to crimes such as stalking, harassment, and sexual assault. In ten states, a first stalking offense is considered a felony, while in 23 others stalking can be classified as either a felony or a misdemeanor, depending on circumstances such as use of a weapon or prior convictions. Straight felony status is considered preferable because it usually leads to quicker arrest, since otherwise police must investigate the level of seriousness of the stalking in determining probable cause (U.S. Department of Justice, Office of Justice Programs, Violence Against Women Grants Office, 1998). In New Hampshire, stalking is never a

felony. In addition, ten states have legislative provisions requiring training on sexual assault for police and prosecutors. New Hampshire does not have this kind of law, although it does provide training on stalking laws and investigation, as described above.

In fiscal year 1994-95, New Hampshire administered $1.39 of state and federal funds for domestic violence and sexual assault programs per person in the state, five cents above the U.S. average of $1.34. Of this money, state funds comprised 53 percent and federal funds comprised 47 percent. Of its state funds, New Hampshire spent 92 percent on domestic violence programs and 8 percent on sexual assault programs. Of the state's federal funds, 66 percent was spent on domestic violence programs and 34 percent on sexual assault programs. Investing in programs to decrease the prevalence of domestic battery and sexual assault, as well as to provide services to victims, is important to reducing both types of crimes and to helping victims rebuild their lives (for more on these issues, see "Focus on Sexual Assault in New Hampshire").

Child Support

Many mother-headed households experience low wages and poverty, and child support or alimony is one way to supplement their depressed incomes. In the United States, approximately 34 percent of female-headed households receive some level of child support or alimony. In New Hampshire, 44 percent receive such support, ten percentage points above the national average.

According to the U.S. Department of Health and Human Services Office of Child Support Enforcement, 55 percent of all child support cases that go to trial are granted a support order by a judge. However, child support is collected in only 39.2 percent of cases with orders (or about 22 percent of all child support cases). The enforcement efforts made by state and local agencies can affect the extent of collections (Gershenzon, 1993). Of all child support cases with orders for collection in New Hampshire, child support was collected in 49.5 percent. This proportion is well above the average for the United States as a whole. IWPR research shows that child support can make a substantial difference in low-income families' lives by lifting many out of poverty. Among nonwelfare, low-income families with child support agreements, poverty rates would increase by more than 30 percent without their child support income (IWPR, 1999).

Welfare Policies

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) enacted the most sweeping changes to the federal welfare system since it was established in the 1930s. PRWORA ended entitlements to federal cash assistance, replacing the Aid to Families with Dependent Children (AFDC) program with the Temporary Assistance for Needy Families (TANF) program. Where AFDC provided minimal guaranteed income support for all eligible families (most frequently those headed by low-income single mothers), TANF benefits are restricted to a five-year lifetime limit and are contingent on work participation after 24 months. TANF funds are distributed to states in the form of block grants, and states are free to devise their own eligibility rules, participation requirements and sanction policies within the federal restrictions.

Within federal restrictions, states have adopted widely divergent TANF plans. The provisions of their welfare programs can have important ramifications on the economic security of low-income residents, the majority of whom are women and children. These policies affect the ability of welfare recipients to receive training and education for better-paying jobs, to leave family situations involving domestic violence and other circumstances, and simply to support their families during times of economic hardship. Given existing federal restrictions, New Hampshire has adopted TANF policies that are relatively supportive of women.

New Hampshire has not adopted a "Family Cap," which would limit or eliminate TANF benefits to children born or conceived while a mother receives welfare. As of August 1999, 24 states have Child Exclusion policies, or Family Caps. Of these states, two have a modified Family Cap and therefore give

partial increases in benefits for additional children. Twenty-six states and the District of Columbia do not have any type of Family Cap (U.S. Department of Health and Human Services, Administration for Children and Families, 1999c).

New Hampshire's time limit for receiving TANF benefits is the maximum it can be under federal regulations. In New Hampshire, recipients are limited to 60 months, while the average for all states is just over 46 months. Twenty-seven states and the District of Columbia have a time limit of 60 months (the maximum allowed under federal law). Four states have no lifetime limits for individuals complying with TANF requirements. Of these four, two supplement federal funds with state monies, and two have other kinds of restrictions on receipt after 24 months (U.S. Department of Health and Human Services, Administration for Children and Families, 1999c).

Federal law requires nonexempt residents to participate in work activities within two years of receiving cash assistance. States have the option of establishing stricter guidelines, and many have elected to do so. In 20 states, including New Hampshire, nonexempt recipients are required to engage in work activities immediately under TANF. Within its definition of work activities, however, New Hampshire allows 26 weeks of job search. Six states require work within less than 24 months. Twenty-two states and the District of Columbia require recipients to work within 24 months or when determined able to work, whichever comes first. In one state, Arizona, work requirements are evaluated on an individual basis (U.S. Department of Health and Human Services, Administration for Children and Families, 1999c). New Hampshire's requirement that welfare recipients begin work immediately makes it difficult for them to upgrade their skills through education and training. The state's failure to invest in women's capacity to support themselves may doom them to a lifetime of low earnings.

PRWORA also replaced former child care entitlements with the Child Care and Development Fund, which consolidated funding streams for child care and provided new child care funds to states. This new system requires that states use no less than 70 percent of the new funds to provide child care assistance to several types of families: those receiving TANF, those transitioning away from welfare through work activities, and those at risk of becoming dependent on TANF (U.S. Department of Health and Human Services, Administration for Children and Families, 1999c). In addition to these funds, many states use TANF funds or additional state funds to provide child care services. States also have substantial discretion over designing their child care programs, including how long they provide child care services to families. Currently, while all states provide a minimum of twelve months of child care to families transitioning away from welfare, 33 states, including New Hampshire, extend child care beyond twelve months. New Hampshire extends child care services with no time limit to all families living below 190 percent of the poverty line. Expanded child care services are a crucial form of support for working families, especially single mothers, and are critical to ensuring families' self-sufficiency.

As of August 1999, 27 states and the District of Columbia were recognized by the U.S. Department of Health and Human Services, Administration for Children and Families, as having adopted the Family Violence Option, which allows victims of violence to be exempted from work requirements, lifetime time limits, or both as part of state TANF plans (U.S. Department of Health and Human Services, 1999c). Another five states are in the process of developing screening and counseling standards, and seven others have adopted exemptions for domestic violence but have not received certification. The eleven other states have not applied for or received the optional certification and have not adopted other language. New Hampshire has applied for certification under the Family Violence Option.

PRWORA also gave states increased flexibility in how they treat earnings in determining income eligibility for TANF applicants. One standard for measuring the generosity of state rules is whether they disregard 50 percent or more of the earnings of a full-time, minimum wage worker. New Hampshire has a relatively generous policy on how it treats earnings in determining TANF eligibility. Generous earnings disregards can help ease the transition away from welfare for women and their families as they strive for self-sufficiency.

In the United States as a whole, in the period from October 1997 to September 1998, over three million families received an average cash assistance benefit of $358.08 per month. In New Hampshire, the average monthly benefit was $417, somewhat above the national average (U.S. Department of Health and Human Services, Administration for Children and Families, 1999b).

Even states with relatively generous welfare policies do not always provide welfare recipients adequate opportunities to take advantage of the resources available to them, often because of poor implementation of state TANF plans. For example, welfare recipients are not always aware of the benefits that are available to them, such as child care, Food Stamps or Medicaid, especially after they lose cash assistance under TANF (Schumacher and Greenberg, 1999; Ku and Garrett, 2000). In addition, they may not be aware of policies such as Family Violence exemptions or other regulations allowing them to extend their eligibility for receiving benefits. Through rigorous training of caseworkers, an emphasis on informing welfare recipients of their rights, and other policies, states can work to ensure that welfare recipients are able to take full advantage of the economic and support services available to them.

Employment/Unemployment Benefits

Employment policies and protections are crucial to helping women achieve economic self-sufficiency and to providing them a safety net during periods of unemployment. New Hampshire lacks many employment policies that would be supportive of women.

The minimum wage is particularly important to women because they constitute the majority of low-wage workers. Recent research by IWPR and the Economic Policy Institute found that women would be a majority of the workers affected by a one-dollar increase in the minimum wage (Bernstein, Hartmann, and Schmitt, 1999). As of March 2000, ten states and the District of Columbia had minimum wage rates higher than the federal level of $5.15. Six states had minimum wage rates lower than the federal level (but the federal level generally applies to most employees in these states). Seven states had no minimum wage law, and 27 states had state minimum wages equal to the federal level. New Hampshire maintains the same minimum wage as the federal level (U.S. Department of Labor, 1999).

Temporary Disability Insurance (TDI) is also an important resource for women because it provides partial income replacement to employees who leave work because of an illness or accident unrelated to their jobs. In the five states with mandated programs (California, Hawaii, New Jersey, New York and Rhode Island), employees and/or their employers pay a small percentage of the employee's salary into an insurance fund and, in return, employees are provided with partial wage replacement if they become ill or disabled. Moreover, in states with TDI programs, women workers typically receive eight to twelve weeks of partial wage replacement for maternity leave through TDI (Hartmann, Yoon, Spalter-Roth and Shaw, 1995). New Hampshire does not require mandatory TDI. Failure to require mandatory TDI coverage leaves many women, especially single mothers, vulnerable in case of injury or illness.

Unemployment Insurance (UI) provides workers and their families a safety net during periods of unemployment. In order to receive UI, potential recipients must meet several eligibility requirements. IWPR research has shown that nearly 14 percent of unemployed women workers are disqualified from receiving UI by two earnings criteria, more than twice the rate for unemployed men (see Appendix III for more details on UI requirements; Yoon, Spalter-Roth and Baldwin, 1995). States typically set eligibility standards for UI and can enact policies that are more or less inclusive and more or less generous to claimants. In New Hampshire, UI policies are relatively harmful to women. Eligibility requirements generally disqualify the majority of low-wage workers, and policies do not cover workers seeking part-time employment. Because women are more likely than men to seek part-time work, the failure to cover workers seeking part time work disproportionately harms women. New Hampshire law does allow "good cause quits" in some circumstances. An unemployed worker must prove that he or she left a job for good cause attributable to the

employer in order to collect. However, most compelling or necessitous personal circumstances do not qualify a worker for benefits. The only exception is when a worker must leave a job for reasons related to being a victim of domestic violence (New Hampshire, 1999b).

Finally, New Hampshire has considered legislation that would allow women to use UI to provide benefits during work absences covered under the Family and Medical Leave Act. While women currently cannot do so in any state, as of July 2000, such policies have been proposed in 13 states. In addition, the Department of Labor recently issued a ruling allowing states to provide partial wage replacement under the unemployment compensation program on a voluntary, experimental basis to parents who take leave or who otherwise leave employment following the birth or adoption of a child. The new regulations were issued in June of 2000 and took effect in August. To implement them, state legislatures must adopt a plan allowing this use of UI.

Some states have implemented pay equity remedies, which are policies designed to raise the wages of jobs undervalued at least partly because of the sex or race of the workers who hold those jobs. By 1997, 20 states had implemented programs to raise the wages of workers in female-dominated jobs in their states' civil services (National Committee on Pay Equity, 1997). A study by IWPR found that for states that implemented pay equity remedies, the remedies improved female/male wage ratios (Hartmann and Aaronson, 1994). New Hampshire has not implemented policies within its state civil service to achieve pay equity.

Sexual Orientation and Gender Identity

New Hampshire has several polices that would provide lesbians and other sexual minorities access to the same rights that other citizens have. Eighteen states and the District of Columbia have adopted civil rights statutes prohibiting discrimination on the basis of sexual orientation. New Hampshire has adopted a civil rights statute prohibiting discrimination against gay, lesbian, and bisexual residents. In addition, 23 states and the District of Columbia have passed laws creating enhanced penalties for perpetrators of hate crimes committed against victims because of their sexual orientation. New Hampshire has passed a hate crime bill that addresses crimes against gay, lesbian and bisexual residents. New Hampshire also has not specifically prohibited same-sex marriage. Thirty-one states have banned same-sex marriage. Only one state, Vermont, has expressly allowed gay and lesbian couples to take advantage of the same rights and benefits extended to married couples under state law, through the passage of a "civil union" act. Vermont's law was signed in April 2000 and allows gay and lesbian couples to claim benefits such as inheritance rights, property rights, tax advantages, and the authority to make medical decisions for a partner, once they register as a civil union.

Reproductive Rights

While indicators concerning reproductive rights and family planning resources are covered in more detail later in the report, they also represent crucial components of any list of desirable policies for women. Overall, in New Hampshire, women have relatively high levels of access to abortion, contraception, and other family planning resources, although the state still lacks many policies important to reproductive freedom. Such access can allow women to make careful, informed, and independent decisions about childbearing, which can in turn have a significant impact on their lives and well-being and the lives and well-being of their children.

Institutional Resources

Finally, since New Hampshire has a state commission for women, it has one form of representation that might help create more women-friendly policies in the state (see the section on Political Participation for more details). A total of 39 states currently have state-level commissions for women.

Conclusion

In order for women in New Hampshire to achieve more equality and greater well-being, the state should adopt the policies from the Women's Resources and Rights Checklist it still lacks. Although this list does not encompass all the policies necessary to guarantee equality, it represents a sample of exemplary women-friendly provisions. Each of the policies also reflects the goals of the Beijing Declaration and Platform for Action by addressing issues of concern to women and obstacles to women's equality. Thus these rights and resources are important for improving women's lives and the well-being of their families.

Political Participation

Political participation allows women to influence the policies that affect their lives. By voting, running for office, and taking advantage of other avenues for participation, women can make their concerns, experiences and priorities visible in policy decisions. Recognizing the lack of equity in political participation and leadership throughout the world, the Beijing Declaration and Platform for Action cites ensuring women equal access to avenues for participation and decision-making as a major objective. This section presents data on several aspects of women's involvement in the political process in New Hampshire: voter registration and turnout, female state and federal elected and appointed representation, and women's state institutional resources.

Over the past few decades, a growing gender gap in attitudes among voters—the tendency for women and men to vote differently—suggests that women's political preferences at times differ from men's (Conway, Steuernagel and Ahern, 1997). Women, for example, tend to support funding for social services and child care as well as measures combating violence against women more than men do. Many women also stress the importance of issues like education, health care and reproductive rights. Because women are often primary care providers in families, these issues can affect women's lives profoundly.

Political participation allows women to demand that policymakers address these and other priorities. Voting is one way for them to express their concerns. Women's representation in political office also gives them a more prominent voice. In fact, regardless of party affiliation, female officeholders are more likely than male ones to support women's agendas (Center for American Women and Politics [CAWP], 1991). In addition, legislatures with larger proportions of female elected officials tend to address women's issues more often and more seriously than those with fewer female representatives (Dodson, 1991; Thomas, 1994). Finally, representation through institutions such as women's

Chart III.
Political Participation: National and Regional Ranks

Indicators	National Rank* (of 50)	Regional Rank* (of 6)	Grade
Composite Political Participation Index	**8**	**3**	**C+**
Women's Voter Registration (percent of women 18 and older who reported being registered to vote in 1992 and 1996)[a]	25	5	
Women's Voter Turnout (percent of women 18 and older who reported voting in 1992 and 1996)[a]	27	6	
Women in Elected Office Composite Index (percent of state and national elected officeholders who are women, 2000)[b, c, d]	9	3	
Women's Institutional Resources (number of institutional resources for women in New Hampshire, 2000)[e, f]	31	5	

See Appendix II for methodology.
* The national rank is of a possible 50, because the District of Columbia is not included in this ranking. The regional rankings are of a maximum of six and refer to the states in the New England Region (CT, ME, MA, NH, RI, VT).
Source: [a] U.S. Department of Commerce, Bureau of the Census, 1993; 1998b; [b] CAWP, 1999a; 1999c; 1999d; 1999e; [c] Council of State Governments, 1998; [d] Compiled by IWPR based on Center for Policy Alternatives, 1995; [e] CAWP, 1998; [f] Compiled by IWPR based on National Association of Commissions on Women, 1997.
Calculated by the Institute for Women's Policy Research.

commissions or women's legislative caucuses can both provide ongoing channels for expressing women's concerns and make policymakers more accessible to women, especially when those institutions work closely with women's organizations (Stetson and Mazur, 1995).

Overall, women in New Hampshire fare relatively well when compared with women in the United States as a whole. At eighth in the nation, the state ranks among the top ten on the political participation composite index, although its rankings for individual indicators vary greatly. Women in New Hampshire rank 25th and 27th in voter registration and turnout, respectively, and 31st in institutional resources. However, New Hampshire ranks 9th out of all 50 states when it comes to the number of women in elected office (see Chart III). New Hampshire also ranks third among the six New England states on the political participation composite index.

Despite its high overall rankings, New Hampshire's performance suggests that for indicators of political participation, the state still has room for improvement. Many eligible women do not vote or register to vote, for example. In addition, despite having a female governor, less than one-third of all state elected and appointed officials and no members of the state's congressional delegation are women. Finally, while New Hampshire has a commission on women, the state lacks a women's legislative caucus in either the Senate or Assembly.

Since, like most states, New Hampshire could improve significantly on most indicators of political participation, the state received a grade of C+ for women's political participation. Women throughout the country and in New Hampshire need better representation within the political process.

Voter Registration and Turnout

Voting is one of the most fundamental ways Americans express their political needs and interests. Through voting, citizens choose leaders to represent them and their concerns. Recognizing this, early women's movements made suffrage one of their first goals. Ratified in 1920, the Nineteenth Amendment established U.S. women's right to vote, and in November of that year, about eight million out of 51.8 million women voted for the first time (National Women's Political Caucus, 1995). African American and other minority women, however,

Table 1.
Voter Registration for Women and Men in New Hampshire and the United States

	New Hampshire		United States	
	Percent	Number	Percent	Number
1996 Voter Registration*[a]				
Women	71.9	329,000	67.3	67,989,000
Men	71.4	289,000	64.4	59,672,000
1992 Voter Registration*[b]				
Women	71.9	309,000	69.3	67,324,000
Men	67.9	288,000	66.9	59,254,000
Number of Unregistered Women Eligible to Vote, 1996[c]	N/A	99,000	N/A	23,775,000
Percent and Number of Public Assistance Recipients Registered under the National Voter Registration Act, 1996[c]	N/A**	N/A**	14.1	1,312,000

* Percent of all women and men aged 18 and older who reported registering, based on data from the 1993 and 1997 November Supplements of the Current Population Survey. These data are self-reports and tend to overstate actual voter registration.
** New Hampshire is exempt from the National Voter Registration Act.
Source: [a] U.S. Department of Commerce, Bureau of the Census, 1998b; [b] U.S. Department of Commerce, Bureau of the Census, 1993; [c] HumanSERVE, 1996.
Compiled by the Institute for Women's Policy Research.

Table 2.
Women's and Men's Voter Turnout in New Hampshire and the United States

	New Hampshire		United States	
	Percent	Number	Percent	Number
1996 Voter Turnout*[a]				
Women	58.8	269,000	55.5	56,108,000
Men	61.6	249,000	52.8	48,909,000
1992 Voter Turnout*[b]				
Women	65.4	281,000	62.3	60,554,000
Men	63.8	270,000	60.2	53,312,000

* Percent of all women and men aged 18 and older who reported voting, based on data from the 1993 and 1997 November Supplements of the Current Population Survey. These data are self-reports and tend to overstate actual voter turnout.

Source: [a] U.S. Department of Commerce, Bureau of the Census, 1998b; [b] U.S. Department of Commerce, Bureau of the Census, 1993.

Compiled by the Institute for Women's Policy Research.

were denied the right to vote in many states until the Voting Rights Act of 1965 was passed. Even after women of all races were able to exercise their right to vote, many candidates and political observers did not take women voters seriously. Instead, they assumed women would either ignore politics or simply vote like their fathers or husbands (Carroll and Zerrilli, 1993).

Neither prediction came true. Women now register and vote slightly more often than men. By 1996, almost 68 million women, or 67.3 percent of those eligible, reported being registered to vote, compared with nearly 60 million or 64.4 percent of eligible men (see Table 1). New Hampshire's voter registration rates are slightly above the national rates for both men and women. In New Hampshire, 71.9 percent of women reported being registered to vote in the November 1996 elections, while 71.4 percent of men did.

Women voters have constituted a majority of U.S. voters since 1964. In 1996, 53 percent of voters were women while in 1992, 54 percent were. New Hampshire has higher voter turnout than the nation as a whole. In 1992, 65.4 percent of New Hampshire women reported voting, and 58.8 percent reported voting in 1996 (see Table 2). New Hampshire ranks 27th among all the states but last in the new England region for women's voter turnout in the 1992 and 1996 elections combined (because many of the larger states have low levels of voter turnout, the national rate is lower than the median rate for all states; thus several states with higher voter turnout than the nation as a whole rank below the midpoint for all states). Notably, voter turnout dropped substantially for both sexes in the nation as a whole between 1992 and 1996. New Hampshire women's voter turnout fell substantially in 1996, and New Hampshire was one of the few states in which women's voter turnout was lower than men's in that year. However, it did remain slightly higher than turnout for men and women in the United States as a whole. Overall, compared with other Western democracies, voter turnout is relatively low for both sexes in the United States.

Minority men and women in the United States generally vote at lower rates than white men and women. In 1996, 54.8 percent of white men and 57.2 percent of white women voted, compared with 46.6 percent of African American men, 53.9 percent of African American women, 24.2 percent of Hispanic men, and 29.3 percent of Hispanic women (U.S. Department of Commerce, Bureau of the Census, 1998b). Separate data for minority men and women are not available at the state level for any state, and in New Hampshire, voting data are not available for minority groups at all. In the nation as a whole, lower levels of voter turnout among minority men and women can mean that their interests and concerns are less well represented in the political process.

Over the years, most states in the United States have developed relatively complicated systems of voter

registration. Voting has typically required advance registration in a few specified locations, and this system is historically a major cause of low U.S. voting rates (Wolfinger and Rosenstone, 1980). Two groups most underserved by it are the poor and persons with disabilities, and voting itself is more difficult for people with disabilities because of problems such as inadequate transportation to the polls.

Effective as of January 1995, the National Voter Registration Act (NVRA) required states to allow citizens to register to vote when receiving or renewing a driver's license or applying for AFDC, Food Stamps, Medicaid, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and disability services. Under the new welfare system, applicants for TANF and related programs continue to have the opportunity to register to vote when seeking welfare benefits. By 1996, the NVRA successfully enrolled or updated voting addresses for over eleven million people, including 1.3 million through public assistance agencies (see Table 1). As of 1996, 14.1 percent of eligible public assistance recipients were registered to vote through public assistance offices. Women in New Hampshire, however, have not benefited from the NVRA since the state is exempt from it, due to the state's policy of on-site, same-day registration (United States, 1993; New Hampshire, 2000a). Overall, nearly 24 million eligible women remain unregistered in the United States, and almost 99,000 of them live in New Hampshire.

Elected Officials

Although women constitute a minority of elected officials at both the national and state levels, their presence has grown steadily over the years. As more women hold office, women's issues are becoming more prominent in legislative agendas (Thomas, 1994). Nine women served in the 1999-2000 U.S. Senate (106th Congress). Women also filled 56 of the 435 seats in the 106th U.S. House of Representatives (not including Eleanor Holmes Norton, the nonvoting delegate from the District of Columbia, and Donna Christian-Green, the nonvoting delegate from the Virgin Islands). Women of color filled only 20 House seats and no Senate seats, and only one openly lesbian woman served in Congress. Women from New Hampshire filled none of the state's four possible seats in the U.S. House and Senate, leading to rates below the national average (see Table 3).

Table 3.
Women in Elected and Appointed Office in New Hampshire and the United States, 2000

	New Hampshire	United States
Number of Women in Statewide Executive Elected Office[a,b]	1	91
Women of Color[c]	0	6
Number of Women in the U.S. Congress		
U.S. Senate[d]	0 of 2	9 of 100
Women of Color[c]	0	0
U.S. House[e]	0 of 2	56 of 435
Women of Color[c]	0	20
Number of Women Running for the U.S. Congress, 1998[f,g]		
U.S. Senate	0 of 2	10 of 79
U.S. House	1 of 4	121 of 779
Percent of State Legislators Who Are Women[h]	31.8%	22.4%
Percent of Women in Appointed Office[i]	25.9%	29.8%

* These figures refer to candidates running for congresssional seats in the general election and exclude those running in primaries.

Source: [a] CAWP, 1999a; [b] Council of State Governments, 1998; [c] CAWP, 1999f; [d] CAWP, 1999e; [e] CAWP, 1999d; [f] CAWP, 1999f; [g] Federal Election Commission, 1998a, 1998b; [h] CAWP, 1999c; [i] Center for Women in Government, 1998.

Compiled by the Institute for Women's Policy Research.

At the same time, of 50 governors nationwide, only three are women, and New Hampshire boasts one. Women's proportion of the state legislature is also relatively high (31.8 percent of the legislature, compared with a 22.4 percent average for the nation). Women have reached leadership positions within New Hampshire's state legislature; both the speaker of the House and Senate president are women (Ramer, 1999; Concord Monitor, 1996). In addition, New Hampshire has a female Supreme Court Justice (New Hampshire, 2000b). On the other hand, as of October 1999, women constituted only 25.9 percent of top-level public appointees with policymaking responsibilities who were appointed by the current governor in New Hampshire; the national average is 29.8 percent.

Based on its proportion of women in elected office, New Hampshire ranks ninth in the nation and third in the New England region for women in elected office. Its relatively high ranking despite proportionately low levels of women's representation illustrates the lack of political power women have attained in elected office in the country as a whole.

Research on women as political candidates suggests that they generally win elected office at similar rates to men, but far fewer women run for office (National Women's Political Caucus, 1994). In 1998, 121 women out of 779 total candidates (15.5 percent) ran for office in the U.S. House of Representatives, while ten women of 79 total candidates (12.7 percent) ran for office in the U.S. Senate. In New Hampshire, only one woman ran for a seat in the U.S. House or Senate in the 1998 general election (CAWP, 1999b; FEC 1998a, 1998b). At one female candidate out of a total of six, New Hampshire's proportion of women running for Congress was close to average at 16.7 percent.

For women to win their proportionate share of political offices in the near term, the number and percentage of seats they hold must increase much more quickly than they did during the 1990s. Policies and practices that might encourage women to run for office—including those that would help them challenge incumbents—can be integral to increasing women's political voice (Burrell, 1994). Such policies include campaign finance reform, recruitment of female candidates by political parties, and fair and equal media treatment for male and female candidates.

Institutional Resources

Women's institutional resources can play an important role in providing information about women's issues and attracting the attention of policymakers and the public to women's political concerns. They can also serve as an access point for individual women and women's groups to express their interests to public officials. Thus such institutions can ensure that women's issues remain on the political agenda. New Hampshire has a state-level, government-appointed commission for women, the New Hampshire Commission on the Status of Women, but lacks a women's caucus in either the Assembly or the Senate (see Table 4). In the country as a whole, 39 states have state-level commissions for women and 34 have women's caucuses. Fifteen states have both a commission for women and caucuses in each house of the state legislature.

Table 4.
Institutional Resources for Women in New Hampshire

	Yes	No	Total, United States
Does New Hampshire have a:			
Commission for Women?[a]	✓		39
Legislative Caucus in the State Legislature?[b]			34
Assembly?		✓	
Senate?		✓	

Source: [a] Compiled by IWPR, based on National Association of Commissions on Women, 1997. [b] CAWP, 1998.
Compiled by the Institute for Women's Policy Research.

Employment and Earnings

Because earnings are the largest component of income for most families, earnings and economic well-being are closely linked. Noting the historic and ongoing inequities between women's and men's economic status, the Beijing Declaration and Platform for Action stresses the need to promote women's economic rights. Its recommendations include improving women's access to employment, eliminating occupational segregation and employment discrimination, and helping men and women balance work and family responsibilities. This section surveys several aspects of women's economic status by examining the following topics: women's earnings, the female/male earnings ratio, women's earnings by educational attainment, labor force participation, unemployment rates, and the industries and occupations in which women work.

Families often rely on women's earnings to remain out of poverty (Cancian, Danziger and Gottschalk, 1993; Spalter-Roth, Hartmann and Andrews, 1990). Moreover, women's employment status and earnings have grown in importance for the overall well-being of women and their families as demographic and economic changes have occurred. Men, for example, experienced stagnant or negative real wage growth during the 1980s and the early portion of the 1990s. At the same time, more married-couple families now rely on both husbands' and wives' earnings to survive. In addition, more women head households alone, and more women are in the labor force.

Women in New Hampshire ranked 14th in the nation and third in the New England region on the employment and earnings composite index (see Chart IV). The state ranked in the top third on indicators of women's labor force participation (8th), percent of women in managerial and professional occupations (15th), and women's median annual income (17th). However, New Hampshire ranks just

Chart IV.
Employment and Earnings: National and Regional Ranks

Indicators	National Rank* (of 51)	Regional Rank* (of 6)	Grade
Composite Employment and Earnings Index	**14**	**3**	**C+**
Women's Median Annual Earnings (for full-time, year-round workers, aged 16 and older, 1997)[a]	17	4	
Ratio of Women's to Men's Earnings (median annual earnings of full-time, year-round women and men workers aged 16 and older, 1997)[a]	34	5	
Women's Labor Force Participation (percent of all women, aged 16 and older, in the civilian non-institutional population who are either employed or looking for work, 1998)[b]	8	1	
Women in Managerial and Professional Occupations (percent of all employed women, aged 16 and older, in managerial or professional specialty occupations, 1998)[b]	15	3	

See Appendix II for methodology.
* The national rank is out of a possible 51 including the 50 states and the District of Columbia. The regional rankings are of a maximum of six and refer to the states in the New England Region (CT, ME, MA, NH, RI, VT).
Source: [a] Economic Policy Institute, 2000; [b] U.S. Department of Labor, Bureau of Labor Statistics, 1999c. Calculated by the Institute for Women's Policy Research.

above the bottom third of all states in the ratio of women's to men's earnings, at 34th of 51.

Despite its relatively high ranking on three of the four indicators, women in New Hampshire do not enjoy economic parity with men. Like women in most states, New Hampshire women lag significantly behind men in their wages and labor force participation. As a result, New Hampshire received a grade of C+ on the employment and earnings index.

Women's Earnings

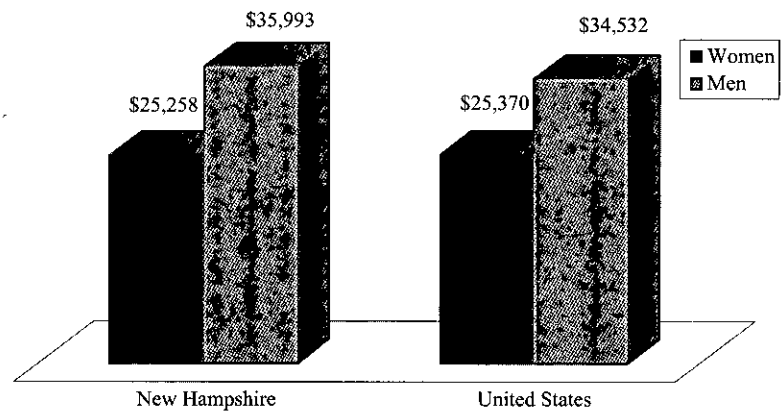
New Hampshire women working full-time, year-round have about the same median annual earnings as women in the United States as a whole ($25,258 and $25,370, respectively; see Figure 1). However, median annual earnings for men in New Hampshire are higher than in the United States as a whole ($35,993 and $34,532, respectively). The median annual earnings for women in New Hampshire rank fourth in the New England region and 17th in the nation. Women in the District of Columbia rank the highest with earnings of $30,495.

Between 1989 and 1997, women in New Hampshire saw their median annual earnings decrease by three percent in real terms. Two other states in the New England region, Vermont and Massachusetts, also experienced negative growth in women's earnings, 1.6 and 1.9 percent, respectively, while women's wages in Rhode Island, Maine and Connecticut increased by 2.9, 2.0 and 0.7 percent, respectively (data not shown; all growth rates are calculated for earnings that have been adjusted to remove the effects of inflation; EPI, 2000; IWPR, 1995a).

Unfortunately, the data set used to estimate state-level women's earnings does not provide enough cases to reliably estimate earnings separately for women of different races and ethnicities. National data show, however, that in 1997 the median annual earnings of African American women were $22,378 and those of Hispanic women were $19,269, substantially below that of non-Hispanic white women, who earned $26,319. The earnings of Asian American women were the highest of all groups at $28,214 (median earnings of full-time, year-round women workers aged 15 years and over; U.S. Department of Commerce, Bureau of the Census, 1999c; all data converted to 1998 dollars). Earnings for Native American women are not available between decennial Census years, but in 1989, their earnings for year-round, full-time work were only 84 percent of white women's earnings (U.S. Department of Commerce, Bureau of the Census, 1990).

In addition, a national survey by the Census Bureau showed that in 1994-95 the median monthly income of women with disabilities was only 80 percent of the income of women with no disability (for female full-time workers 21-64 years of age; U.S. Department of Commerce, Bureau of the Census, 1995).

Figure 1.
Median Annual Earnings of Women and Men Employed Full-Time/Year-Round in New Hampshire and the United States, 1997 (1998 Dollars)



For women and men aged 16 and older. See Appendix II for methodology.
Source: Economic Policy Institute, 2000.
Compiled by the Institute for Women's Policy Research.

Focus on Regional Economic Disparities in New Hampshire

The status of women in New Hampshire varies significantly by region of the state. Thus, state level data can mask regional differences among New Hampshire's women. However, few data revealing those trends exist. Those that do, though, reveal interesting trends. In New Hampshire, disparities in economic well being—from town to town and from region to region—are a defining state characteristic.

One analysis of child health and well being, *KIDS COUNT New Hampshire 2000*, divided the state into five economic clusters, based not on geographic proximity but on economic conditions (Children's Alliance of New Hampshire, 2000). It found that from 1989-96, per capita income increased statewide by 18.8 percent. However, not everyone benefited from the state's economic well-being. Per capita income in the poorest clusters was 67 percent less in 1996 than it was in the wealthiest clusters (Children's Alliance of New Hampshire, 2000).

Moreover, while average annual wages in the state rose 14.4 percent from 1994-97, outpacing the cost of living, average wages in some areas of New Hampshire rose only 7.5 percent, a full percentage point less than increases in the consumer price index. A woman living in Conway (in the north of the state) would need to work three average-paying jobs to earn the same income as a woman working two average-paying jobs in Nashua (in the southern part of the state; Children's Alliance of New Hampshire, 2000).

These differences in economic well-being have profound implications for women and their families. Many indicators of family well-being are closely tied to economics. Births to women who have not graduated from high school, for example, are strongly connected to family poverty, and the rate of such births is four times higher in the poorest communities than in the wealthiest (Children's Alliance of New Hampshire, 2000). Births to teen mothers also have profound links with poverty for the life of the teen as well as of her new child. Rates of teen births are also four times higher in the poorest communities than in the wealthiest. And births to single mothers, also closely correlated with poverty, are three times as common in the poorest communities than in the wealthiest, making up one in every three births in the state (Children's Alliance of New Hampshire, 2000).

Because of these disparities, the boom economy in one part of the state means little to the woman or family struggling to survive on below-average state wages in another area; competitive benefits offered in a hot job market in the technology belt mean little to a mother lacking health insurance while working several low paying jobs; and extensive after-school programs in affluent communities offer little to children who are unsupervised after school while their parents are working extra hours to make ends meet.

When regional differences are understood, when resources are targeted to areas of highest need, and when economic issues are understood as family issues, the status of women in New Hampshire as a whole will earn high marks. As a result, it is important for policymakers, researchers, and advocates for women in the state to push for better data collection and analysis that would elucidate the importance and consequences of geographic disparities.

Finally, the data used to calculate women's earnings did not allow analysis of regional differences among New Hampshire women (for more detail see Focus on Economic Disparities in New Hampshire).

The Wage Gap

The Wage Gap and Women's Relative Earnings

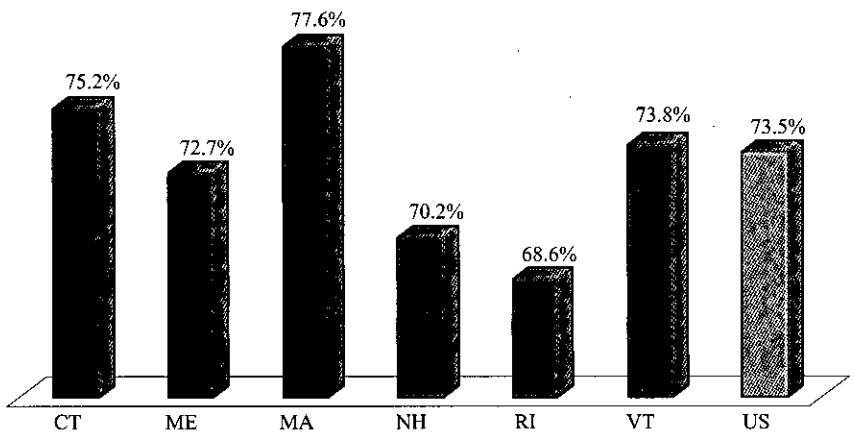
In the United States, women's wages historically lag behind men's. In 1997, the median wages of women who worked full-time, year-round were only 73.5 percent of men's (based on calculations from three years of pooled data). In other words, women earned about 74 cents for every dollar earned by men.

In contrast, women in New Hampshire earned about 70.2 percent of what men in New Hampshire earned in 1997. Therefore, compared with the earnings ratio for the nation as a whole, New Hampshire women experience less earnings equality with men (see Figure 2). As a result, New Hampshire ranks 34th in the nation for the ratio of women's to men's earnings for full-time, year-round work. In contrast, the District of Columbia has the highest earnings ratio at 85.7 percent. Compared with other states in the New England region, New Hampshire ranks fifth. Massachusetts ranks first, with a 77.6 percent wage ratio, and Rhode Island ranks last, with a 68.6 percent wage ratio. Unfortunately, the wage gap remains large all over the United States, and especially in New Hampshire.

Narrowing the Wage Gap

Throughout the 1960s and 1970s, the ratio of women's earnings to men's in the United States remained fairly constant at around 60 percent. During the 1980s, however, women made progress in narrowing the gap between men's earnings and their own. Women increased their educational attainment and their time in the labor market and entered better-paying occupations in large numbers, partly because of equal opportunity laws. At the same time, however, adverse economic trends such as declining wages in the low-wage sector of the labor market began to make it more difficult to close the gap, since women still tend to be concentrated at the low end of the earnings distribution. If women had not increased their relative skill levels and work experience as much as they did during the 1980s, those adverse trends might have led to a widening of the gap rather than the significant narrowing that did occur (Blau and Kahn, 1994).

Figure 2.
Ratio of Women's to Men's Full-Time/Year-Round Median Annual Earnings in States in the New England Region, 1997



For women and men aged 16 and older. See Appendix II for methodology.
Source: Economic Policy Institute, 2000.
Compiled by the Institute for Women's Policy Research.

One factor that probably also helped to narrow the earnings gap between women and men is unionization. Women have increased their share of union membership, and being unionized tends to raise women's wages relatively more than men's. Recent research by IWPR found that union membership raises women's weekly wages by 38.2 percent and men's by 26.0 percent (data not shown; Hartmann, Allen and Owens, 1999). In New Hampshire, the wages of all

unionized women were 30.7 percent higher than those of nonunionized women. Unionization also raises the wages of women of color relatively more than the wages of non-Hispanic white women and the wages of low earners relatively more than the wages of high earners (Spalter-Roth, Hartmann and Collins, 1993). In the United States as a whole, unionized minority women earned 38.6 percent more than nonunionized ones (Hartmann, Allen and Owens, 1999).

Unfortunately, part of the narrowing in the wage gap that occurred during the 1980s and 1990s was due to a fall in men's real earnings. According to research done by IWPR, less than half (47.8 percent) of the narrowing of the national female/male earnings gap between 1979 and 1997 was due to women's rising real earnings, while more than half (52.2 percent) was due to men's falling real earnings. The slowdown in real earnings growth for women during the later portion of this period is even more disturbing. From 1989 to 1997, more than two-thirds (71.5 percent) of the narrowing of the gap was due to the fall in men's real earnings.

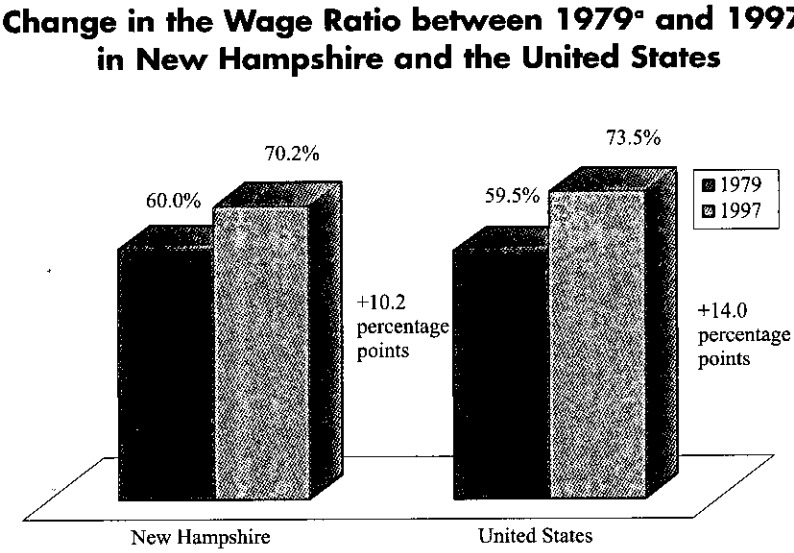
New Hampshire fell behind the United States as a whole in increasing women's annual earnings relative to men's between 1979 and 1997 (see Figure 3). In New Hampshire, the annual earnings ratio increased by only 10.2 percentage points compared with an increase of 14.0 percentage points in the United States.

Weekly earnings data provide an interesting comparison to annual earnings figures. Unlike annual earnings data, the weekly data released by the Bureau of Labor Statistics (BLS) do not include earnings from self-employed workers, approximately 6 percent of the labor force. Thus, because they are more complete, the annual earnings statistics are used in IWPR's employment and earnings composite indicator. In 1997, women in New Hampshire earned 76.1 percent of men's weekly earnings for full-time work. This ratio indicates that New Hampshire ranks above the national median (16th in the nation) in this ratio of female-male median weekly earnings, far above its ranking based on annual earnings (34th). The difference may be related to New Hampshire's relatively high level of self-employed female workers, who often earn less than other women and substantially less than self-employed men, or to the nature of part-year work in New Hampshire. Women who work during selected periods of the year, for example, may have higher earnings during those weeks, bringing up weekly earnings figures, but they are not included in the full-time, full-year annual earnings data. According to the weekly data series, the District of Columbia ranked first in the ratio of women's to men's weekly earnings at 97.1 percent (Council of Economic Advisors, 1998).

Earnings and Earnings Ratios by Educational Levels

Between 1979 and 1997, women with higher levels of education in both New Hampshire and the United

Figure 3.
Change in the Wage Ratio between 1979[a] and 1997[b] in New Hampshire and the United States



For women and men aged 16 and older. See Appendix II for methodology.
Source: [a] IWPR, 1995a; [b] Economic Policy Institute, 2000.
Compiled by the Institute for Women's Policy Research.

States saw their median annual earnings increase more than women with lower levels of educational attainment. As Table 5 shows, the annual earnings for women in New Hampshire increased from 9.7 percent (in constant dollars) for women with less than a high school education to 26.7 percent for those with a four-year college education.

On the other hand, the gap between women's earnings and men's earnings (as measured by the female/male earnings ratio) narrowed more quickly for women with less education in the period from 1979 to 1997, indicating that men with less education fared even worse in the labor market than women. Women with the lowest educational attainment (less than high school completion) experienced an increase in their wages relative to men's of 28.9 percent, while those with more than a college education experienced a loss of 9.9 percent in relation to men's earnings.

Despite the narrowed wage gap, the low earnings of women with less education make it especially important that all women have the opportunity to increase their education. For example, many welfare recipients lack a high school diploma or further education, yet in many cases they are encouraged or required to leave the welfare rolls in favor of immediate employment. These single mothers may be consigned to a lifetime of low earnings if they are not allowed the opportunity to complete high school and acquire a few years of education beyond high school (IWPR, 1997). As Table 5 shows, women with some college, who have completed college, or who have postgraduate training have much higher earnings than those without, and their earnings have generally been growing more rapidly.

Labor Force Participation

One of the most notable changes in the U.S. economy over the past four decades has been the rapid rise in women's participation in the labor force. Between 1965 and 1998, women's labor force participation increased from 39 to 60 percent (these data reflect the proportion of the civilian noninstitutional population aged 16 and older who are employed or looking for work; U.S. Department of Labor, Bureau of Labor Statistics, 1999c). Women now make up nearly half of the U.S. labor force at 46.2 percent of all workers (full-time and part-time combined). According to projections by the Bureau of Labor Statistics, women's share of the labor force will continue to increase, growing from 46 to 48 percent between 1998 and 2008 (U.S. Department of Labor, Bureau of Labor Statistics, 1999a).

In 1998, 66.1 percent of women in New Hampshire were in the labor force, compared with 59.8 percent of women in the United States, earning New Hampshire the rank of eighth in the nation. Men's labor force participation rate in New Hampshire was also higher than the rate for men in the United States as a whole (see Figure 4).

Table 5.
Women's Earnings and the Earnings Ratio in New Hampshire by Educational Attainment, 1979 and 1997 (1998 Dollars)

	Women's Median Annual Earnings 1997[a]	Percent Change in Real Earnings 1979[b] and 1997[a]	Female/Male Earnings Ratio, 1997[a]	Percent Change in Earnings Ratio, 1979[b] and 1997[a]
Educational Attainment				
Less than 12th Grade	$19,712	+9.7	86.0%	+28.9
High School Only	$22,938	+18.7	71.5%	+16.5
Some College	$26,198	+16.6	73.4%	+17.4
College	$31,581	+26.7	65.3%	+10.1
College Plus	$35,720	+22.3	58.5%	-9.9

For women and men working full-time year-round.
Source: [a] Economic Policy Institute, 2000; [b] IWPR, 1995a.
Calculated by the Institute for Women's Policy Research.

Unemployment and Personal Income Per Capita

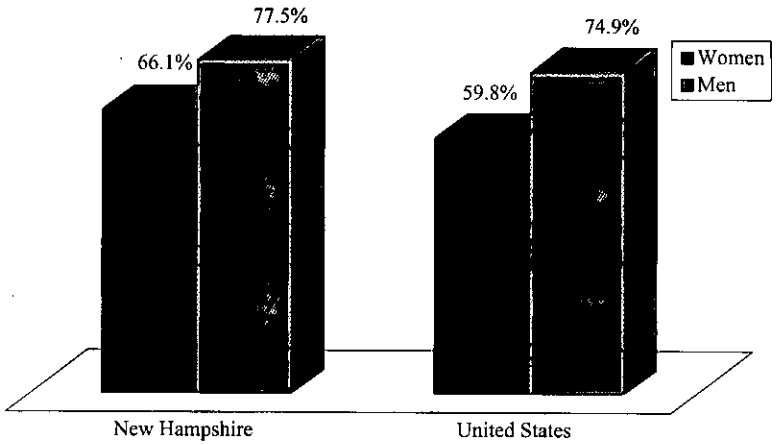
In New Hampshire, a much smaller percent of workers is unemployed than in the nation as a whole. In 1998, the unemployment rate in New Hampshire was 3.0 percent for women and 2.8 percent for men, compared with the nation's 4.6 percent for women and 4.4 percent for men (see Figure 5).

While New Hampshire experienced considerably lower than average unemployment rates in 1998, they experienced rates that were even further below the national average during the 1980s. As a result, personal income per capita in New Hampshire grew more quickly than it did for the nation between 1980 and 1998 (51.9 percent versus 36.3 percent; see Table 6). From 1990 to 1998, as New Hampshire's unemployment rate fell (along with the national average), income per capita in New Hampshire grew 1.7 percentage points faster than the nation.

Part-Time and Full-Time Work

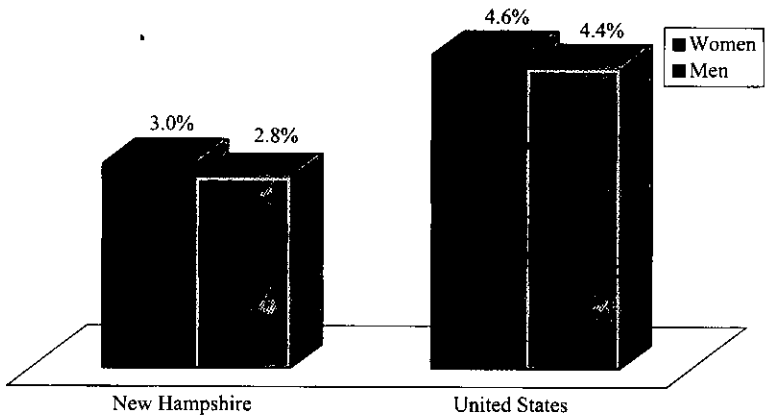
New Hampshire's female labor force is less likely to work full-time (66.9 percent versus 70.7 percent) and much less likely to be unemployed than women nationally, and as a result the percent of the female workforce in New Hampshire employed part-time is larger than the national average (30.2 versus 24.8 percent; see Table 7). Within the part-time category, the percent of women in the labor force who are "involuntary" part-time employees—that is, they would prefer

Figure 4.
Percent of Women and Men in the Labor Force in New Hampshire and the United States, 1998



For women and men in the civilian non-institutional population, aged 16 and older.
Source: U.S. Department of Labor, Bureau of Labor Statistics, 1999c, Tables 1 and 12.
Compiled by the Institute for Women's Policy Research.

Figure 5.
Unemployment Rates for Women and Men in New Hampshire and the United States, 1998



For women and men in the civilian non-institutional population, aged 16 and older.
Source: U.S. Department of Labor, Bureau of Labor Statistics, 1999c.
Compiled by the Institute for Women's Policy Research.

full-time work were it available—is somewhat smaller in New Hampshire than in the United States (1.9 percent and 2.3 percent, respectively). In contrast, a larger proportion of New Hampshire's female labor force is working part-time voluntarily compared with the United States as a whole (26.3 percent in New Hampshire and 20.8 percent, respectively). This pattern reflects national trends, in which involuntary part-time work correlates highly with unemployment rates (Blank, 1990). Thus the low unemployment rate corresponds with a low rate of involuntary part-time employment.

Workers are considered involuntary part-time workers if, when interviewed, they state that their reason for working part-time (fewer than 35 hours per week) is slack work—usually reduced hours at one's normally full-time job, unfavorable business conditions, reduced seasonal demand, or inability to find full-time work. Many reasons for part-time work, including lack of child care, are not considered involuntary by the Bureau of Labor Statistics, since workers must indicate they are available for full-time work to be considered involuntarily employed part-time. This definition, therefore, likely understates the extent to which women would prefer to work full-time.

Table 6.
Personal Income Per Capita for Both Men and Women in New Hampshire and the United States, 1998

	New Hampshire	United States
Personal Income Per Capita, 1998	**$29,022**	**$26,412**
Personal Income Per Capita, Percent Change*:		
Between 1990 and 1998	+15.4	+13.7
Between 1980 and 1990	+31.6	+19.9
Between 1980 and 1998	+51.9	+36.3

* In constant dollars.
Source: U.S. Bureau of Economic Analysis, 1999.
Calculated by the Institute for Women's Policy Research.

Table 7.
Full-Time, Part-Time and Unemployment Rates for Women and Men in New Hampshire and the United States, 1998

	New Hampshire		United States	
	Female Labor Force	Male Labor Force	Female Labor Force	Male Labor Force
Total Number in the Labor Force	**308,000**	**344,000**	**63,714,000**	**73,959,000**
Percent Employed Full-Time	66.9	87.5	70.7	85.5
Percent Employed Part-Time*	30.2	9.6	24.8	10.2
Percent Voluntary Part-Time	26.3	8.1	20.8	8.2
Percent Involuntary Part-Time	1.9	0.9	2.3	1.4
Percent Unemployed	3.0	2.8	4.6	4.4

For men and women aged 16 and older.
* Percent part-time includes workers normally employed part-time who were temporarily absent from work the week of the survey. Those who were absent that week are not included in the numbers for voluntary and involuntary part-time. Thus, these two categories do not add to the total percent working part-time.
Source: U.S. Department of Labor, Bureau of Labor Statistics, 1999c, Tables 1, 12, and 13.
Calculated by the Institute for Women's Policy Research.

Labor Force Participation of Women by Race/Ethnicity

According to analysis of data from the Current Population Survey from 1996-98, 66.8 percent of women of all races aged 16 and older in New Hampshire were in the labor force in 1997, a rate substantially higher than in the United States as a whole (see Table 8; see Appendix II

Table 8.
Labor Force Participation of Women in New Hampshire and the United States by Race/Ethnicity, 1997

Race/Ethnicity	New Hampshire		United States	
	Number of Women in Labor Force	Percent in Labor Force	Number of Women in Labor Force	Percent in Labor Force
All Races	**311,000**	**66.8**	**64,027,000**	**60.1**
White*	298,000	66.2	47,124,000	60.2
African American*	N/A	N/A	8,317,000	63.4
Hispanic	N/A	N/A	5,771,000	55.8
Asian American/ Other*	N/A	N/A	2,815,000	59.8

For women aged 16 and older.
*Non-Hispanic.
Hispanics may be of any race.
N/A = Not available.
Source: Economic Policy Institute, 2000.
Since the numbers and percentages in this table are based on three years of pooled data for data years 1996-98, they differ slightly from official labor force participation rates published by the U.S. Department of Labor, Bureau of Labor Statistics for 1997. See Appendix II for details on the methodology.
Compiled by the Institute for Women's Policy Research.

for details on the methodology used for the 1996-98 Current Population Survey data presented in this report). The labor force participation rate for white women was higher in New Hampshire than in the United States as a whole (66.2 percent compared with 60.2 percent; see Table 8). Data for Hispanic, African American, Native American and Asian American women in New Hampshire are not available. However African American women historically have had a higher national labor force participation rate than white and Hispanic women and did so in 1997. Hispanic women traditionally have the lowest average participation rates among women, and in 1997 only 55.8 percent of Hispanic women in the United States were in the workforce. Separate data were not available for Asian American, Native American, or women of other races or ethnicities for 1997. However, in 1990, Asian American women had the highest participation rate (60.2 percent) of women in the United States. The national labor force participation rate for Native American women was 55.4 percent in 1990 (Population Reference Bureau, 1993).

Labor Force Participation of Women by Age

Workforce participation varies across the life cycle. The highest participation generally occurs between ages 25 and 44, which are also generally considered the prime earning years. Table 9 shows the relationship between labor force participation and age for women in New Hampshire and in the United States as a whole. Women in New Hampshire generally have higher labor force participation rates than their U.S. counterparts. Nationally, the highest rate occurs between ages 35 to 44, with just over 77 percent of these women working. In New Hampshire, in contrast, the highest level of labor force participation of women occurs between ages 45 to 54, with 85 percent in the workforce (compared with 76.3 percent in the United States as a whole). Young women in their teens (16-19 years), many of whom are attending school, are much less likely to participate in the labor market than any other age group except the pre-retirement and retired cohorts. In New Hampshire, 62.4 percent of female teenagers reported being in the labor force, considerably higher than the reported 52.7 percent for female teens in the United States as a whole.

As women near retirement age, they are much less likely to work than younger women. In the United States, women aged 55-64 have a labor force participation rate of only 51.6 percent. In New Hampshire, 64.2 percent of these women are in the workforce. In addition, data for women aged 65 and older demonstrate that women over 65 in New Hampshire work at slightly higher rates than do women over 65 in the nation as a whole (11.7 and 9.0 percent, respectively).

Table 9.
Labor Force Participation of Women in New Hampshire and the United States by Age, 1997

Age Groups	New Hampshire		United States	
	Number of Women in Labor Force	Percent in Labor Force	Number of Women in Labor Force	Percent in Labor Force
All Ages	**311,000**	**66.8**	**64,027,000**	**60.1**
Ages 16-19	21,000	62.4	4,046,000	52.7
Ages 20-24	24,000	79.1	6,420,000	73.0
Ages 25-34	68,000	81.6	15,087,000	76.6
Ages 35-44	88,000	80.5	17,352,000	77.3
Ages 45-54	72,000	85.0	13,440,000	76.3
Ages 55-64	29,000	64.2	6,005,000	51.6
Over 65	9,000	11.7	1,677,000	9.0

For women aged 16 and older.
Source: Economic Policy Institute, 2000.
Since the numbers and percentages in this table are based on three years of pooled data for data years 1996-98, they differ slightly from official labor force participation rates published by the U.S. Department of Labor, Bureau of Labor Statistics for 1997. See Appendix II for details on the methodology.
Compiled by the Institute for Women's Policy Research.

Labor Force Participation of Women with Children

Mothers represent the fastest growing group in the U.S. labor market (Brown, 1994). In 1998, 59 percent of women with children under age one were in the labor force, compared with 31 percent in 1976 (U.S. Department of Commerce, Bureau of the Census, 2000). In general, the workforce participation rate for women with children in the United States tends to be higher than the rate for all women (70.3 percent versus 60.1 percent; EPI, 2000). This is partially explained by the fact that the overall labor force participation rate is for all women aged 16 and older; thus both teenagers and retirement-age women are included in the statistics even though they have much lower rates of labor force participation. Mothers, in contrast, tend to be in age groups with higher labor force participation rates. In New Hampshire, 74.7 percent of women with children under age 18 are in the workforce, compared with 66.8 percent of all women in New Hampshire. Women with children are also more likely to engage in labor market activity in New Hampshire than in the United States as a whole (74.7 percent versus 70.3 percent; see Table 10).

Table 10.
Labor Force Participation of Women with Children in New Hampshire and the United States, 1997

	New Hampshire	United States
	Percent in the Labor Force	Percent in the Labor Force
Women with Children		
Under Age 18*	74.7	70.3
Under Age 6*	74.2	64.1

For women aged 16 and older.
* Children under age 6 are also included in children under 18.
Source: Economic Policy Institute, 2000.
Compiled by the Institute for Women's Policy Research.

Child Care and Other Caregiving

The high and growing rates of labor force participation of women with children suggest that the demand for

child care is also growing. Many women report a variety of problems finding suitable child care (affordable, good quality and conveniently located), and women use a wide variety of types of child care. These arrangements include doing shift work to allow both parents to take turns providing care; bringing a child to a parent's workplace; working at home; using another family member (usually a sibling or grandparent) to provide care; using a babysitter in one's own home or in the babysitter's home; using a group child care center; or leaving the child unattended (U.S. Department of Commerce, Bureau of the Census, 1996b).

As full-time work among women has grown, so has the use of formal child care centers, but child care costs are a significant barrier to employment for many women. Child care expenditures use up a large percentage of earnings, especially for lower-income mothers. For example, among single mothers with family incomes within 200 percent of the poverty level, the costs for those who paid for child care amount to 19 percent of the mother's earnings on average. Among married mothers at the same income level, child care costs amount to 30 percent of the mother's earnings on average (although the costs of child care are similar for both types of women, the individual earnings of married women with children are less on average than those of single women with children; IWPR, 1996).

As more low-income women are encouraged or required (through welfare reform) to enter the labor market, the growing need for affordable child care must be addressed. Child care subsidies for low-income mothers are essential to enable them to purchase good quality child care without sacrificing their families' economic well-being. Currently, these subsidies exist in all states, but they are often inadequate; many poor women and families do not receive them. Recent data show that nationally, only 10 percent of those children potentially eligible for child care subsidies under federal rules actually receive subsidies under the federal government's Child Care and Development Fund. In New Hampshire, a slightly lower proportion, 9 percent, of these children do (see Table 11). In addition, New Hampshire maintains stricter criteria for eligibility for receiving child care subsides than required by federal law. If state income eligibility limits were equal to the federal maximum, 71,600 children would be eligible for subsidies, while in New Hampshire, only about 38 percent of that number, about 27,000 children, are eligible under existing state eligibility policies. These stricter limits can make it more difficult for many women, especially single mothers, to enter the labor market. Clearly, many New Hampshire families in need of economic support for child care are not receiving it (for more information on child care, see Focus on Child Care in New Hampshire).

In addition to caring for children, many women provide care for friends and relatives who experience long-term illness or disability. Although few data on caregiving exist, recent research suggests that about a quarter of all households in the United States are giving or have given care to a relative or friend in the past year, and over 70 percent of those

Table 11.
Percent of Eligible Children Receiving CCDF* Subsidies in New Hampshire and the United States, 1998

	New Hampshire	United States
Eligibility**		
Number of Children Eligible under Federal Provisions	71,600	14,749,300
Number of Children Eligible under State Provisions	27,000	9,851,100
Receipt		
Number and Percent of Children Eligible under Federal Law Receiving Subsidies in the State	6,390 9%	1,530,500 10%

*Child Care and Development Fund (CCDF).
**Children eligible under federal provisions" refers to those children with parents working or in education or training who would be eligible for CCDF subsidies if state income eligibility limits were equal to the federal maximum. Many states set stricter limits and therefore the pool of eligible children is smaller under state provisions.
Source: U.S. Department of Health and Human Services, Administration for Children and Families, 1999a. Compiled by the Institute for Women's Policy Research.

Focus on Child Care in New Hampshire

A shortage of affordable, high quality child care in New Hampshire presents special challenges for working parents and businesses alike. The New Hampshire Business Commission on Child Care and Early Childhood Education, established in 1998 by Governor Jeanne Shaheen, has recently recommended that the state implement policies and programs to lower the cost of child care while improving quality and expanding access (Governor's Business Commission on Child Care and Early Childhood Education, 1998).

Demand and Access

In 1997, 74 percent of children under the age of 14 had dual working parents. Of these, 60 percent needed care outside the home (Women's Fund of New Hampshire, 1998). That same year, New Hampshire had only enough licensed child care slots for 32 percent of the children needing care (Women's Fund of New Hampshire, 1998). In coming years, an estimated 6,500 additional children will need child care as a result of welfare reform (Shapiro, 1998).

In addition, access to specialized types of child care is scarce or nonexistent in some areas of the state. Second- and third-shift care, infant care, after-school programs, and back-up care are difficult if not impossible to find in certain regions (Governor's Business Commission on Child Care and Early Childhood Education, 1998).

Finally, fewer than half of New Hampshire's preschoolers are in licensed child care centers (Packard Foundation, 1997).

Cost

The average New Hampshire family with children in child care spends 18 percent of its income on child care. Low income families in the state spend as much as 25 percent of their income on child care (Packard Foundation, 1997). Meanwhile, New Hampshire's relatively strict income criteria have cut eligibility for federal child care subsidies to families by 62 percent. In 1998, of the 71,600 New Hampshire children who qualified for subsidies under federal provisions, only 9 percent, or fewer than 6,400 children, actually received aid through the state (see Table 1.1).

Quality

Although required to undergo special training and education, licensed child care professionals receive exceptionally low wages and limited benefits. Employee turnover in the field runs as high as 41 percent in some child care programs (Kagan and Cohen, 1997). High employee turnover and inexperienced staff, both of which can be partially attributed to poor compensation, are the chief causes of poor quality child care (Governor's Business Commission on Child Care and Early Education, 1998).

Employee Productivity and Costs to Businesses

In a recent survey, 25 percent of parents reported having to switch jobs or move from full-time to part-time work due to child care responsibilities. As a result, New Hampshire companies lose up to $24 million per year in child care-related absenteeism (Wallner, 1998).

Conclusions

All of these issues and data point to a clear need for policies guaranteeing affordable, high quality child care for parents in the state, for the sake of fairness, children, and the state's economic well-being.

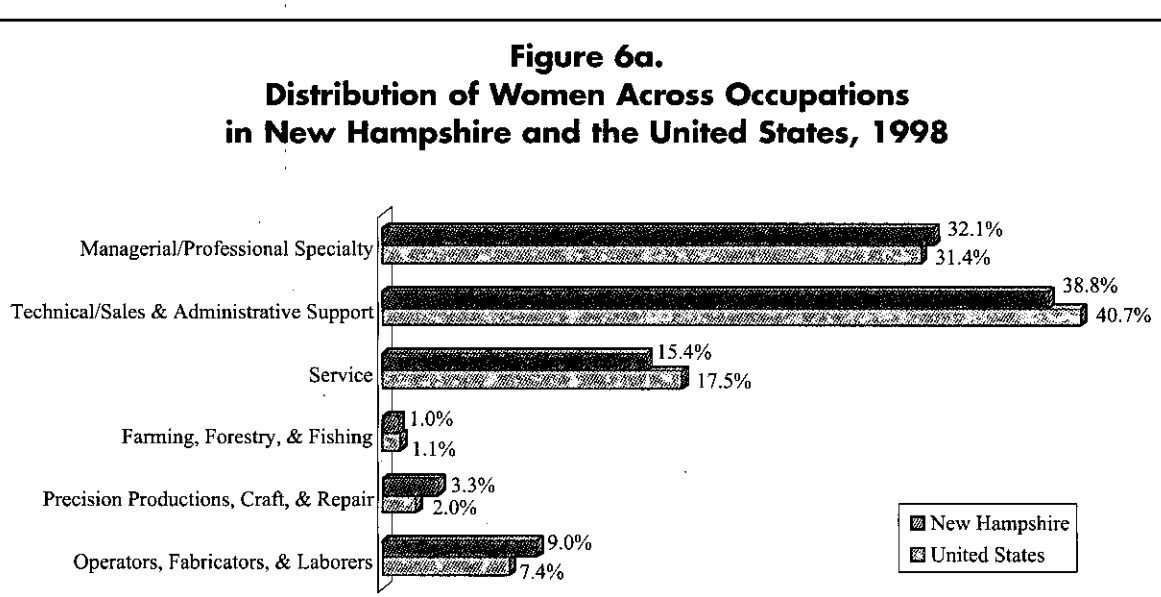
giving care are female. Caregivers on average provide just under 18 hours a week of care, and many report giving up time with other family members; giving up vacations, hobbies, or other activities; and making adjustments to work arrangements for caregiving (National Alliance for Caregiving and American Association of Retired Persons, 1997). Like mothers of young children, other types of caregivers experience shortages of time, money and other resources, and they too require policies designed to lessen the burden of long-term care. Nonetheless, few such policies exist, and this kind of caregiving remains an issue for state and national policymakers to address.

Occupation and Industry

The distribution of women in New Hampshire across occupations is similar to the distribution found in the United States as a whole. In the United States, technical, sales and administrative occupations provide 40.7 percent of all jobs held by women (see Figure 6a). This is similar to New Hampshire, where 38.8 percent of women are employed in this area. Women in New Hampshire are slightly less likely to work in service occupations (15.4 percent versus 17.5 percent) and slightly more likely to work as operators, fabricators and laborers (9 percent versus 7.4 percent), or in precision production, craft, and repair (3.3 percent versus 2.0 percent) than women in the nation as a whole. The proportion of women in New Hampshire working in managerial and professional specialty occupations is slightly higher than women in the nation (32.1 percent versus 31.4 percent). As a result, New Hampshire ranks 15th in the nation and third in the New England region for the proportion of its female labor force employed in professional and managerial occupations.

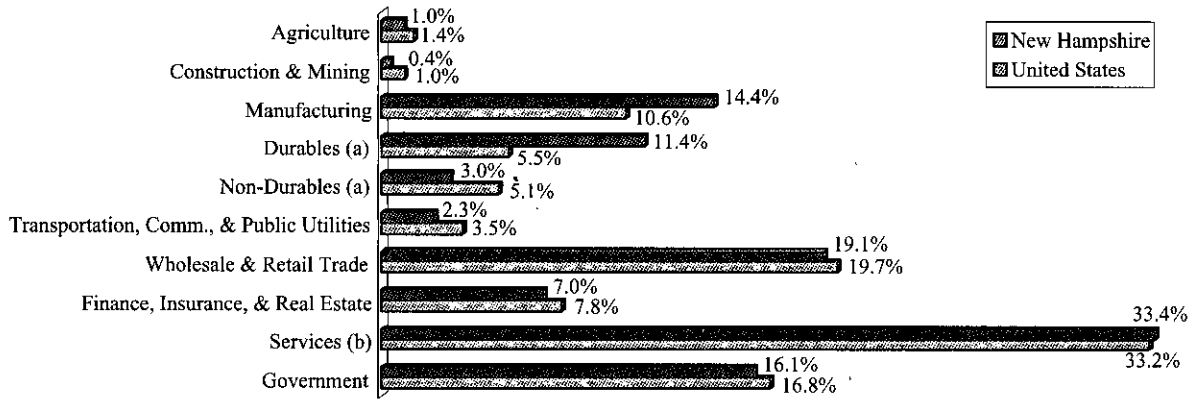
Unfortunately, even when women work in the higher-paid occupations, such as managers, they earn substantially less than men. A national IWPR (1995b) study shows that women managers are unlikely to be among top earners in managerial positions. If women had equal access to top-earning jobs, 10 percent of women managers would be among the top 10 percent of earners for all managers; however, only 1 percent of women managers have earnings in the top 10 percent. In fact, only 6 percent of women had earnings in the top fifth. Similarly, a Catalyst (1999) study showed that only 3.3 percent (77) of the highest-earning high-level executives in Fortune 500 companies were women as of 1999.

Figure 6a.
Distribution of Women Across Occupations in New Hampshire and the United States, 1998



For employed women aged 16 and older.
Source: U.S. Department of Labor, Bureau of Labor Statistics, 1999c, Table 15.
Compiled by the Institute for Women's Policy Research.

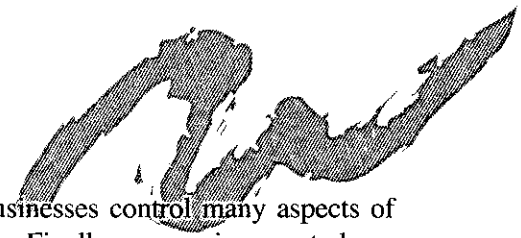
Figure 6b.
Distribution of Women Across Industries in New Hampshire and the United States, 1998



For employed women aged 16 and older.
Percents do not add up to 100 percent because 'self-employed' and 'unpaid family workers' are excluded.
(a) Durables and non-durables are included in manufacturing.
(b) Private household workers are included in services.
Source: U.S. Department of Labor, Bureau of Labor Statistics, 1999c, Table 17.
Compiled by the Institute for Women's Policy Research.

The distribution of women in New Hampshire across industries is also similar in many ways to that of the United States as a whole (see Figure 6b). In New Hampshire, 33.4 percent of all women are employed in the service industries (including business, professional and personnel services), while 33.2 percent are in the United States. About 19.7 percent of employed women in the United States work in the wholesale and retail trade industries, and a similar proportion, 19.1 percent, of women in New Hampshire work in these industries. About 16.8 percent of the nation's women work in government, compared with 16.1 percent of women in New Hampshire. Similarly, the percent of women who work in the finance, insurance and real estate (F.I.R.E.) industry is comparable to that of women in the United States as a whole (7.0 percent and 7.8 percent, respectively). The largest difference between women in New Hampshire and the United States is evident in manufacturing. New Hampshire women are substantially more likely to work in the manufacturing industries, especially durables, than women in the United States (14.4 percent versus 10.6 percent for all manufacturing; 11.4 percent versus 5.5 percent for durables).

Economic Autonomy



While labor force participation and earnings are significant in helping women achieve financial security, many additional issues affect their ability to act independently, exercise choice and control their lives. The Beijing Declaration and Platform for Action stresses the importance of adopting policies and strategies that ensure women equal access to education and health care, provide women access to business networks and services, and address the needs of women in poverty. This section highlights several topics important to women's economic autonomy: health insurance coverage, educational attainment, women's business ownership and female poverty.

Each of these issues contributes to women's lives in distinct if interrelated ways. Access to health insurance plays a role in determining the overall quality of health care for women in a state and governs the extent of choice women have in selecting health care services. Educational attainment relates to economic autonomy in many ways: through labor force participation, hours of work, earnings, childbearing decisions and career advancement. Women who own their own businesses control many aspects of their working lives. Finally, women in poverty have limited choices. If they receive public income support, they must comply with legislative regulations enforced by their caseworkers. They do not have the economic means to travel freely. In addition, they often do not have access to the skills and tools necessary to improve their economic situation.

New Hampshire ranks tenth among all the states on the composite index measuring economic autonomy (see Chart V). States in the New England region generally rank high on these indicators, as New Hampshire ranks fourth out of six states in the region. The state ranks near the top of all states on three of the four individual indicators in the composite: on women's health insurance coverage and women living above poverty, New Hampshire ranks fifth, and the state ranks ninth in women's educational attainment. However, New Hampshire does less well compared to other states when it comes to women's business ownership, ranking 40th in the nation. Within its region, New Hampshire's best rank is on poverty, where it ranks first; it ranks

Chart V.
Economic Autonomy: National and Regional Ranks

Indicators	National Rank* (of 51)	Regional Rank* (of 6)	Grade
Composite Economic Autonomy Index	**10**	**4**	**B-**
Percent with Health Insurance (among nonelderly women, 1997)[a]	5	2	
Educational Attainment (percent of women aged 25 and older with four or more years of college, 1990)[b]	9	4	
Women's Business Ownership (percent of all firms owned by women, 1992)[c]	40	4	
Percent of Women Above Poverty (percent of women living above the poverty threshold, 1997)[d]	5	1	

See Appendix II for methodology.
*The national rank is of a possible 51 including the 50 states and the District of Columbia. The regional rankings are of a maximum of six and refer to the states in the New England Region (CT, ME, MA, NH, RI, VT).
Source: [a] Employee Benefit Research Institute, 1999; [b] Population Reference Bureau, 1993; [c] U.S. Department of Commerce, Bureau of the Census, 1996a; [d] Economic Policy Institute, 2000.
Calculated by the Institute for Women's Policy Research.

second on the percent of women with health insurance and fourth on the remaining two indicators.

On most of the indicators of economic autonomy, women have far less access than men to the resources identified as important, even in a state that ranks highly. Throughout the country, men are more likely to have a college education, own a business, and live above the poverty line than are women. Although women generally do have health insurance at rates higher than men, largely because of public insurance like Medicaid, the rates of uninsured men and women are both growing. Trends in New Hampshire do not diverge from these basic patterns. As a result, the state received a grade of B- on the economic autonomy composite index.

Access to Health Insurance

Women in New Hampshire are much more likely than women in the nation as a whole to have health insurance. In New Hampshire, 11.8 percent of women, compared with 18.5 percent in the United States, are not insured (see Table 12). Thus among all the states, New Hampshire ranks fifth in the nation and second in the New England region for the proportion of women insured.

On average, women and men in New Hampshire have much more access to employer-based health insurance than women and men in the United States as a whole (73.9 percent compared to 66.4 percent for women; 75.4 percent compared to 67.4 percent for men). While women in New Hampshire are about as likely as women in the United States as a whole to receive health insurance from employers in their own name (41.1 percent versus 40.1 percent), a much higher proportion of New Hampshire women receive employer-based health insurance as dependents. In New Hampshire, 32.8 percent of all women receive employer-based insurance this way compared with 26.4 percent for women in the nation as a whole. In the United States as a whole, women tend to have health insurance coverage from public sources, such as Medicaid, at higher rates than men. In New Hampshire, the rate of publicly insured women is slightly less than the U.S. rate (11.0 percent in New Hampshire and 12.5 percent in the United States), but still higher than the rate for men in the state (11.0 percent versus 6.8 percent).

Education

In the United States, women have made steady progress in achieving higher levels of education. Between 1980 and 1998, the percent of women in the United States with a high school education or more increased by about one-fifth, and as of 1998, comparable percentages of women and men had completed a high school education (82.9 percent of women and 82.7 percent of men). During the same period, the percent of women with four or more years of college increased by three-fifths, from 13.6 percent in 1980 to 22.4 percent in 1997 (compared with 26.5 percent of men in 1997), bringing women closer to

Table 12.
Percent of Women and Men without Health Insurance and with Different Sources of Health Insurance in New Hampshire and the United States, 1997

	New Hampshire		United States	
	Women	Men	Women	Men
Number	363,875	370,913	85,132,000	81,458,000
Percent Uninsured	11.8	15.1	18.5	21.0
Percent with Employer-Based Health Insurance	73.9	75.4	66.4	67.4
Own Name	41.1	57.0	40.1	54.9
Dependent	32.8	18.5	26.4	12.5
Percent with Public Insurance	11.0	6.8	12.5	8.7
Percent with Individually-Purchased Insurance	6.5	5.5	6.4	5.8

Women and men ages 18 to 64; numbers do not add to 100 percent because some people have more than one source of health insurance.
Source: Employee Benefit Research Institute, 1999.
Compiled by the Institute for Women's Policy Research.

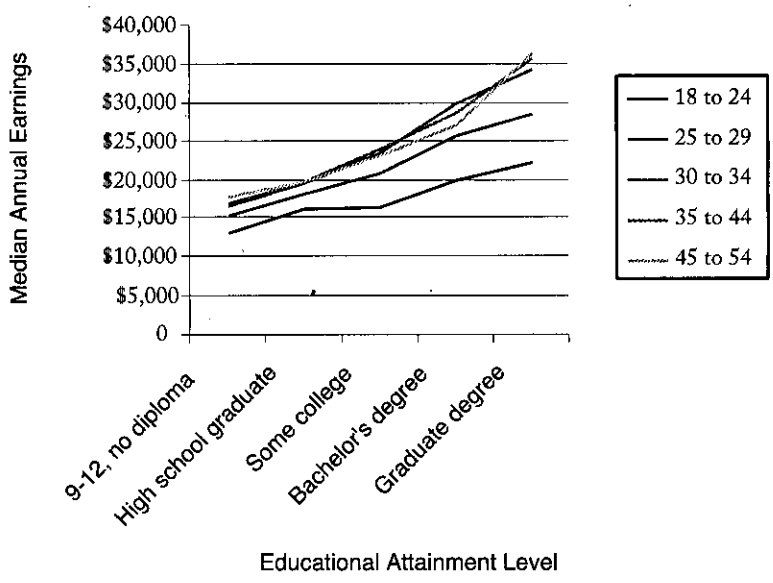
Focus on Education in New Hampshire

Education may be the most important predictor of women's economic well-being throughout their adult lives. In New Hampshire, each additional level of education that women reach translates into a 10 to 25 percent increase in their earnings (see Illustration 1; U.S. Department of Education, National Center for Education Statistics, 1998).

Education is therefore particularly important for women on welfare and those transitioning to work. However, only 3 percent of New Hampshire welfare recipients are engaged in post-secondary education (Broshek, 2000). To address this, New Hampshire could spend a portion of its Temporary Assistance for Needy Families (TANF) dollars to expand access to post-secondary education. The state could also reconsider its welfare reform policies, which have minimized the role of post-secondary education by emphasizing work rather than education and training. Because skills and educational credentials typically lead to higher wages, it is critical that New Hampshire do more to allow low-income women an opportunity to obtain post-secondary education.

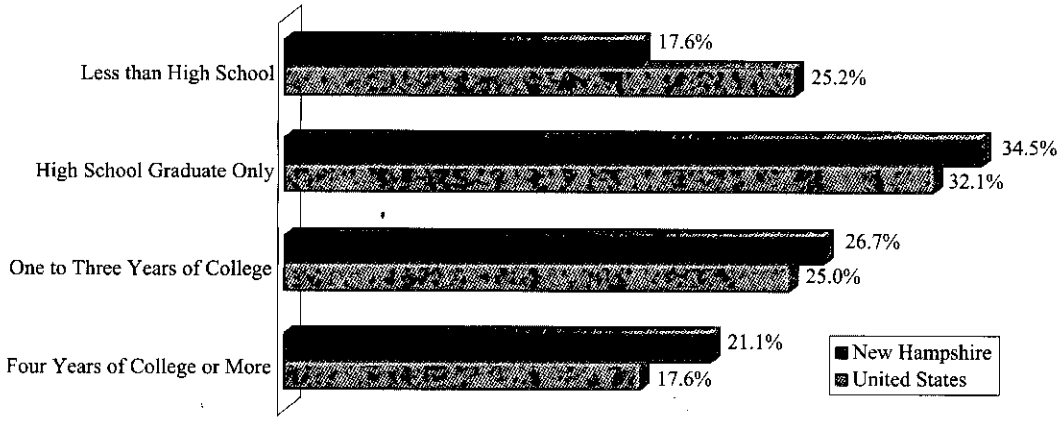
In addition, New Hampshire has not done enough to collect data about girls, women, and education. There are no data to indicate the proportion of girls who are dropouts, are in gifted and talented programs, are considered at-risk, have Individual Education Programs (IEPs), or are special needs students. These data would deepen understanding of the real picture of education for New Hampshire women and girls.

Focus Box Illustration 1.
Median Annual Earnings by Educational Attainment and Age in New Hampshire, 1990



Source: U.S. Department of Education, National Center for Education Statistics, 1998.

Figure 7.
Educational Attainment of Women Aged 25 and Older in New Hampshire and the United States, 1990



Source: Population Reference Bureau, 1993.
Compiled by the Institute for Women's Policy Research.

closing the education gap (U.S. Department of Commerce, Bureau of the Census, 1998a, 1998c).

In general, women in New Hampshire tend to have considerably more college experience than women in the nation. In 1990, 47.8 percent of women in New Hampshire had more than a high school education, compared with 42.6 percent of women in the United States as a whole (see Figure 7). In New Hampshire, at 26.7 percent, the proportion of women with one to three years of college was 1.7 percentage points higher than the national average, while the percent of women with four or more years of college, at 21.1 percent, was about 3.5 percentage points higher than the national average. In turn, the proportion of women older than 25 in New Hampshire without high school diplomas was much smaller than that of women in the United States (17.6 percent and 25.2 percent, respectively; for more details, see Focus on Education in New Hampshire).

Women Business Owners and Self-Employment

Owning a business can bring women increased control over their working lives and create important financial opportunities for them. It can encompass a wide range of arrangements, from owning a corporation, to consulting, to engaging in less lucrative activities such as child care provision. Overall, both the number and proportion of businesses owned by women have been growing.

Between 1987 and 1992, the number of women-owned businesses grew 38.7 percent in New Hampshire, lower than the 43.1 percent growth of women-owned businesses in the United States as a whole (for purposes of comparability over time, these data exclude Type C corporations; for a definition of Type C corporations, see Appendix II). By 1992, women owned 31,492 firms in New Hampshire and women-owned businesses employed 34,138 people (see Table 13). Comparable to the United States as a whole, in New Hampshire, 54.3 percent of women-owned firms were in the service industries and the next highest proportion (18.9 percent) was in retail trade (see Figure 8). Business receipts of women-owned businesses in New Hampshire rose by 79.8 percent (in constant dollars) between 1987 and 1992. This growth is lower than the increase of 87 percent in business receipts for women-owned firms nationally but dramatically higher than the 34.9 percent increase for all firms in the United States during the same time period, also adjusted for inflation (data not shown).

In 1992, the U.S. Bureau of the Census reported that women owned more than 6.4 million firms nationwide, employing over 13 million people and generating $1.6 trillion in business revenues (unlike the figures in Table 13, these numbers include all women-owned businesses, including Type C corporations; U.S. Department of Commerce, Bureau of the Census, 1996a). Projecting women's business growth rates forward from 1987 to 1992 and including Type C corporations, the National Foundation for Women Business Owners (NFWBO) estimates the 1999 number of women-owned firms for New Hampshire to be 47,600 of the more than 9.1 million estimated for the United States as a whole (NFWBO, 1999).

Table 13.
Women-Owned Firms in New Hampshire and the United States, 1992

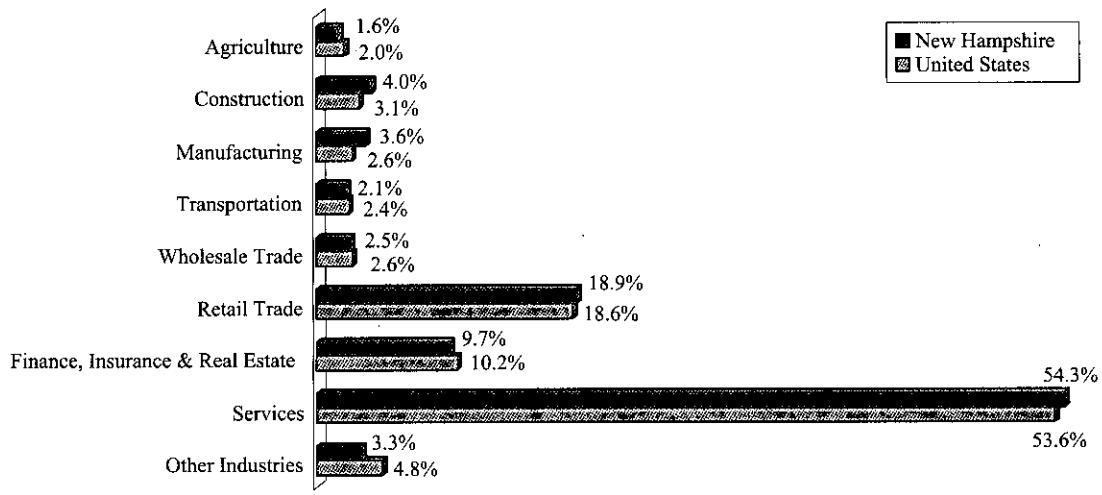
	New Hampshire	United States
Number of Women-Owned Firms*	**31,492**	**5,888,883**
Percent of All Firms that Are Women-Owned	32.2%	34.1%
Percent Increase, 1987-1992	38.7%	43.1%
Total Sales & Receipts (in billions, 1992 dollars)	**$4.1**	**$642.5**
Percent Increase (in constant dollars), 1987-1992	79.8%	87.0%
Number Employed by Women-Owned Firms	**34,138**	**6,252,029**

* For reasons of comparability between 1987 and 1992, these statistics do not include data on Type C corporations; see Appendix II.

Source: U.S. Department of Commerce, Bureau of the Census, 1996a.
Compiled by the Institute for Women's Policy Research.

Like women's business ownership, self-employment for women (one kind of business ownership) has also been rising over recent decades. In 1975, women represented one in every four self-employed workers in the United States, and in 1998 they were approximately one in two. The decision to become

Figure 8.
Distribution of Women-Owned Firms Across Industries in New Hampshire and the United States, 1992



Source: U.S. Department of Commerce, Bureau of the Census, 1996a.
Compiled by the Institute for Women's Policy Research.

self-employed is influenced by many factors. An IWPR study shows that self-employed women tend to be older and married, have no young children, and have higher levels of education than the average. They are also more likely to be covered by another person's health insurance (Spalter-Roth, Hartmann and Shaw, 1993). Self-employed women are more likely to work part-time, with 42 percent of married self-employed women and 34 percent of nonmarried self-employed women working part-time (Devine, 1994).

Unfortunately, most self-employment is not especially well-paying for women, and about half of self-employed women combine this work with another job, either a wage or salaried job or a second type of self-employment (for example, babysitting and catering). In 1986-87 in the United States as a whole, women who worked full-time, year-round at only one type of self employment had the lowest median hourly earnings of all full-time, year-round workers ($5.38); those with two or more types of self-employment with full-time schedules earned somewhat more ($6.33 per hour). In contrast, those who held only one full-time, year-round wage or salaried job earned the most ($11.59 per hour at the median; all figures in 1998 dollars). Those who combined wage and salaried work with self-employment had median earnings that ranged between these extremes. Many low-income women package earnings from many sources in an effort to raise their family incomes (Spalter-Roth, Hartmann and Shaw, 1993).

Moreover, some self-employed workers are independent contractors, a form of work that can be largely contingent, involving temporary or on-call work without job security, benefits, or opportunity for advancement. Even when working primarily for one client, independent contractors may be denied the fringe benefits (such as health insurance and employer-paid pension contributions) offered to wage and salaried workers employed by the same client firm. The average self-employed woman who works full-time, year-round at just one type of self-employment has health insurance an average of only 1.7 months a year, while full-time wage and salaried women average 9.6 months a year (those who lack health insurance entirely are also included in the averages; Spalter-Roth, Hartmann and Shaw, 1993).

Overall, however, recent research finds that the rising earnings potential of women in self-employment compared with wage and salary work explains most of the upward trend in the self-employment of married women between 1970 and 1990. This suggests that the growing movement of women into self-employment represents an expansion in their opportunities (Lombard, 1996). Women in New Hampshire are more likely to be self-employed than women in the United States. In 1997, 7.7 percent of working women in New Hampshire were self-employed, compared with 6.1 percent of women nationwide (U.S. Department of Labor, Bureau of Labor Statistics, 1995).

Women's Economic Security and Poverty

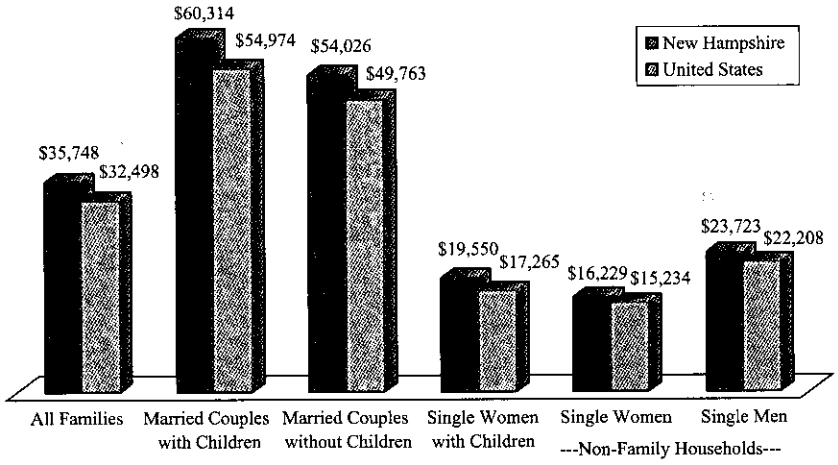
As women's responsibility for their families' economic well-being grows, the continuing wage gap and women's prevalence in low-paid, female-dominated occupations impede their ability to ensure their families' financial security, particularly for single mothers. In the United States, the median family income for households comprised of single women with children was $17,265 in 1997, while that for married couples with children was $54,974 (see Figure 9). Figure 9 also shows that household income was slightly higher on average for all family types in New Hampshire than in the United States as a whole, including families headed by single women with children (data for single men with children are not included because sample sizes were too low to accurately estimate income or poverty for these families).

In addition, in 1997 the proportion of women in poverty in New Hampshire was lower than that of women in the United States: 8.9 percent and 13.1 percent, respectively (see Figure 10). Thus New Hampshire ranks fifth in the nation and first of the six states in its region for women living above poverty.

Since New Hampshire is a high-income state, and many high-income states also have high costs of living, New Hampshire's low rate of poverty may understate hardship in the state. To measure hardship in wealthier countries, many researchers use one-half median family income as an indicator of families'

access to adequate social and economic resources (Miringoff and Miringoff, 1999; Smeeding, 1997). Because median family income varies by state, this measure is more sensitive to variations in cost or standard of living than the federal poverty line, which is the same for all states. Figure 10 also shows the proportion of women living under one-half median income in the state and in the United States as a whole.

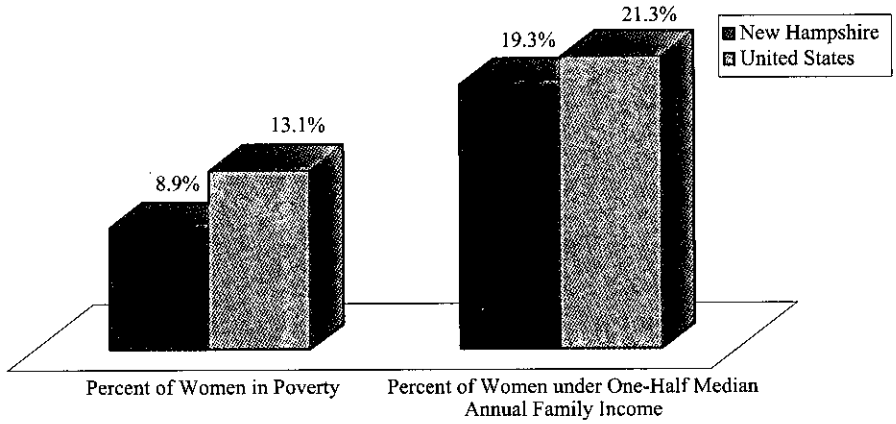
Figure 9.
Median Annual Income for Selected Family Types and Single Women and Men, in New Hampshire and the United States, 1997 (1998 dollars)



Source: Economic Policy Institute, 2000.
Compiled by the Institute for Women's Policy Research.

Overall, this measure shows much higher rates of hardship than the poverty rate does. In the United States, the proportion of women living in families with income under one-half median income was 21.3 percent, much higher than the percent of women living in families with income below the federal poverty line (13.1 percent). In New Hampshire, 19.3 percent of women were living under one-half median family income in 1997, a much higher rate of hardship than the poverty rate among women in New Hampshire. Nevertheless, the percent of women living under one-half median family income in New Hampshire is 2.0 percentage points lower than that for the nation as a whole, indicating that women in New Hampshire do fare slightly better than women nationally in terms of family income. However, they do not fare as much better as the difference between the U.S.-New Hampshire poverty rates (4.2 percentage points) would suggest.

Figure 10.
Percent of Women Living in Poverty and Living under One-Half Median Annual Family Income in New Hampshire and the United States, 1997



Source: Economic Policy Institute, 2000.
Compiled by the Institute for Women's Policy Research.

Focus on Housing in New Hampshire

A lack of available and affordable housing poses a significant problem for many of New Hampshire's citizens. According to the National Low Income Housing Coalition's calculations, based on Fair Market Rent[1] data and income distributions of renter households, 45 percent of renters in New Hampshire are unable to afford Fair Market Rent for a two bedroom unit ($683; Dolbeare, 1999).

Using the standard of affordability established by Congress and the Department of Housing and Urban Development (HUD), which assumes affordable housing costs to be 30 percent of an individual's income, the National Low Income Housing Coalition calculated that to afford the statewide median rent for a two-bedroom apartment, a minimum wage worker in New Hampshire would need to work 102 hours per week. Alternatively, a wage earner working 40 hours per week, 52 weeks per year would need to earn $13.14 per hour, $7.99 above New Hampshire's minimum wage, to afford the statewide median rent for a two-bedroom apartment (Dolbeare, 1999).

Affordable[1] and available housing should be a priority in New Hampshire. Increased housing subsidies and a living wage are integral to ensuring that each New Hampshire family has an affordable home.

[1] The U.S. Department of Housing and Urban Development (HUD) uses the 1990 Census, the Bureau of the Census' 1995 American Housing Survey, and telephone surveys of individual FMR areas to calculate FMRs. FMRs are used by HUD to calculate the Section 8 Housing Assistance Payment Programs and are gross rent estimates that include shelter rent and the cost of utilities except telephones. The level at which FMRs are set is expressed as a percentile point (currently gross rent paid by the 40th percentile of movers to standard housing) within the rent distribution of housing units in an area.

Along with New Hampshire's lower overall rate of female poverty, the poverty rate for single women with children is considerably lower than the nationwide rate (30.3 percent and 41.0 percent, respectively). In New Hampshire and in the nation as a whole, single women with children experience much higher levels of poverty than any other family type (see Figure 11). Moreover, even these high rates of poverty probably understate the degree of hardship among these families, especially among those with working mothers. While counting non-cash benefits would reduce their poverty rates, adding the cost of child care for working mothers would increase the calculated poverty rates both in New Hampshire and the nation (Renwick and Bergmann, 1993). Child care costs were not included at all in family expenditures when federal poverty thresholds were developed. However, for the country as a whole, single parents who do not work have basic cash needs at about 64 percent of the poverty line, while those who work have basic cash needs from 113 to 186 percent of the poverty line, depending on the number and ages of their children. Overall, the net effect of this under- and over-estimation of poverty was a significant underestimation, and Renwick and Bergmann estimate a 1989 national poverty rate of 47 percent, compared with an official estimate of 39 percent, for single-parent families (Renwick and Bergmann, 1993). Poverty rates for low-income, married-couple families would also be much higher if child care costs were included (Renwick, 1993).

Another factor contributing to poverty among all types of households is the wage gap. Recent IWPR research found that in the nation as a whole, narrowing the wage gap, and thus raising women's wages to a level equal to those of men with similar qualifications, would cut the poverty rate among married women and single mothers in half. In New Hampshire, poverty among single-mother households would also drop by about half if the wage gap

were eliminated (Hartmann, Allen and Owens, 1999). As a result, while eliminating the wage gap would not completely eliminate poverty or hardship—especially for women and men in low-wage jobs—pay equity provisions would help many women support their families.

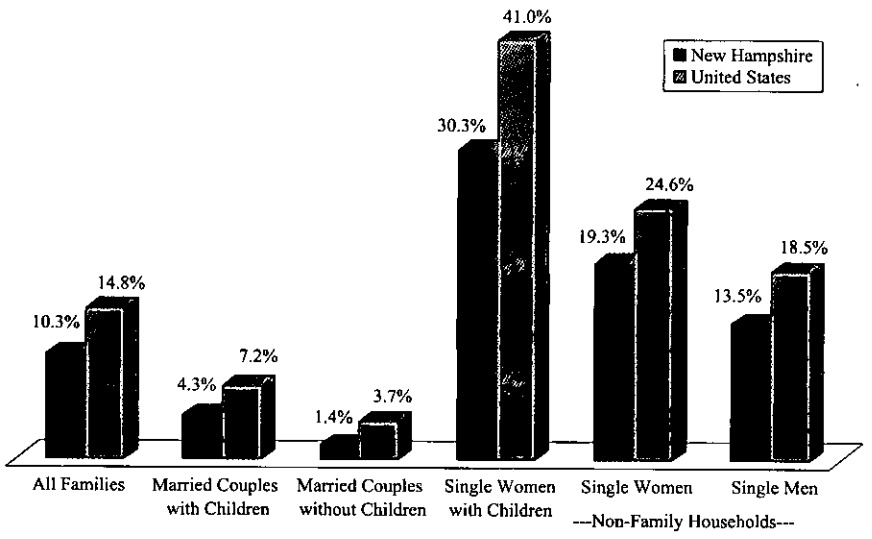
Finally, despite the overall growth in women's earnings and a strong economy, in most states—including both high and low earnings states—inequality among families is growing. Research by the Economic Policy Institute notes that in the nation as a whole in 1996-98, the income of the average family in the top 20 percent of families was 10.6 times the income of the average family in the bottom 20 percent. This represents a substantial increase from 1978-80, when families in the top 20 percent had about 7.4 times as much income as those in the bottom 20 percent. In New Hampshire, families in the top 20 percent received 8.8 times as much income as those in the bottom 20 percent in 1996-98, indicating slightly lower income inequality than in the nation as a whole (Bernstein, McNichol, Mishel and Zahradnik, 2000). In 1978-80, New Hampshire families in the top 20 percent received 5.6 percent times the income of those in the bottom 20 percent. Thus the inequality ratio increased by 3.2 percentage points in New Hampshire, the same as in the nation as a whole.

State Safety Nets for Economic Security

The amount of cash welfare benefits varies widely from state to state. Figure 12 compares the size of New Hampshire's average welfare benefit with one-half median family income in the state, as a measure of how well the state's welfare safety net helps poor women achieve an acceptable standard of living. Obviously, the poverty of many families is not alleviated by welfare alone, and many families also receive Food Stamps or other forms of noncash benefits. Still, research shows that, even adding the value of noncash benefits, many women remain poor (U.S. Department of Commerce, Bureau of the Census, 1997b). In New Hampshire as in all of the United States, TANF cash benefits are substantially below one-half median income. Although New Hampshire's cash benefits are slightly above the national average ($5,005 versus $4,279 per year), benefits are only 28.4 percent of one-half median income in the state. This level is comparable to the nation as a whole, however, since the national benefit level is 26.0 percent of one-half median income nationally.

New Hampshire does a worse than average job of providing a safety net for unemployed women. While a smaller proportion of women is unemployed in New Hampshire (3.0 percent) than in the nation as a whole (4.6 percent; see Table 7), a larger proportion of unemployed women goes without benefits. The percent of unemployed women in New

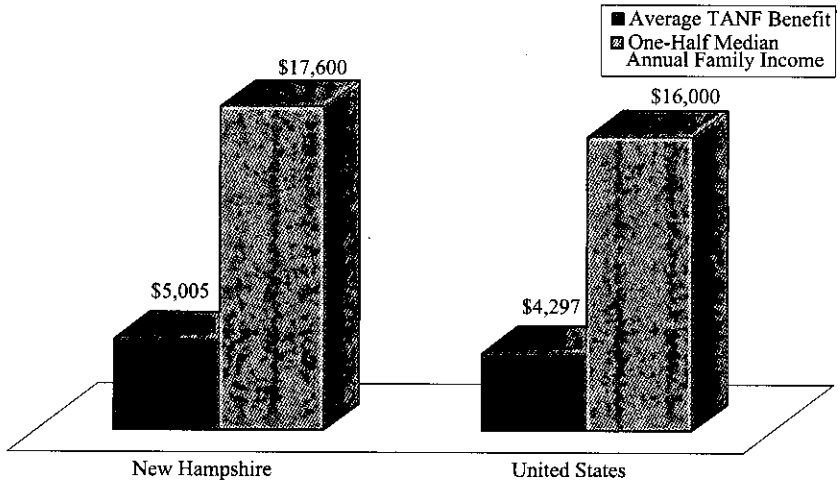
Figure 11.
Poverty Rates for Selected Family Types and Single Men and Women in New Hampshire and the United States, 1997



Source: Economic Policy Institute, 2000.
Compiled by the Institute for Women's Policy Research.

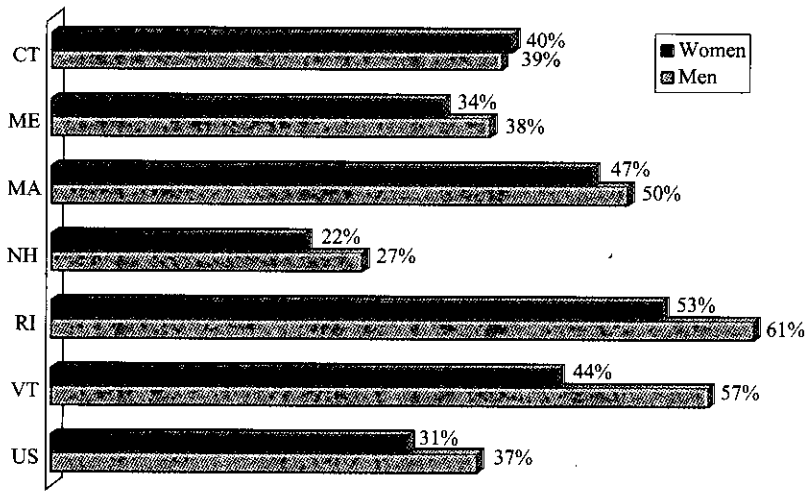
Hampshire receiving unemployment insurance benefits is lower in New Hampshire than in the United States as a whole and is by far the lowest in its region (see Figure 13). The same is true for unemployed men in New Hampshire: the percent of unemployed men is lower, and the rate of unemployment insurance benefit receipt is lower in New Hampshire than in the nation. Finally, in New Hampshire, as in most states in New England, the rate of unemployment insurance benefit receipt for women is lower than that for men. Of states in New England, only in Connecticut is women's receipt of unemployment insurance higher than men's (40 percent versus 39 percent).

Figure 12.
Average Annual TANF Benefit[a] and One-Half Median Annual Family Income[b] in New Hampshire and the United States, 1997



Source: [a] U.S. Department of Health and Human Services, Administration for Children and Families, 1999b; [b] Economic Policy Institute, 2000.
Compiled by the Institute for Women's Policy Research.

Figure 13.
Percent of Unemployed Women and Men with Unemployment Insurance in the New England States and the United States, 1997



Source: U.S. Department of Labor, Employment and Training Administration, Unemployment Insurance Service, 1999.
Compiled by the Institute for Women's Policy Research.

Reproductive Rights

This section provides information on state policies concerning abortion, contraception, gay and lesbian adoption, infertility, and sex education. It also presents data on fertility and natality, including births to unmarried and teenage mothers. Issues pertaining to reproductive rights and health can be controversial. Nonetheless, 189 countries, including the United States, adopted by consensus the Platform for Action from the U.N. Fourth Conference on Women. This document stresses that reproductive health includes the ability to have a safe, satisfying sex life, to reproduce, and to decide if, when and how often to do so (U.N. Fourth World Conference on Women, 1995). The document also stresses that adolescent girls in particular need information and access to relevant services.

In the United States, the 1973 Supreme Court case *Roe v. Wade* defined reproductive rights for federal law to include both the legal right to abortion and the ability to exercise that right at different stages of pregnancy. However, state legislative and executive bodies are continually in battle over legislation relating to access to abortion, including parental consent and notification, mandatory waiting periods and public funding for abortion. The availability of providers also affects women's ability to access abortion. Because of ongoing efforts in many states and at the national level to win judicial or legislative changes that would outlaw or restrict women's access to abortion, the stances of governors and state legislative bodies are critically important.

Reproductive issues encompass other policies as well. Laws requiring health insurers to cover contraception and infertility treatments allow insured women to exercise choice in deciding when and if to have children. Policies allowing gay and lesbian couples to adopt their partners' children give them a fundamental family planning choice. Finally, sex education for high school students can provide them with the information they need to make educated choices about sexual activity.

The reproductive rights composite index shows that New Hampshire, which ranks third in its region and 13th in the nation, has some important protections of women's reproductive rights and resources when compared with other states (see Chart VI, Panel A). However, women in the state still lack access to other resources. New Hampshire's grade of B- on the reproductive rights index reflects the gap between the ideal status of women's reproductive rights and resources and their actual status within the state.

Access to Abortion

Mandatory consent laws require minors to gain the consent of one or both parents before a physician can perform an abortion procedure, while notification laws require they notify one or both parents of the decision to have an abortion. As of January 2000, of the 42 states with consent or notification

Chart VI. Panel A.
Reproductive Rights: National and Regional Ranks

	National Rank* (of 51)	Regional Rank* (of 6)	Grade
Composite Reproductive Rights Index	13	3	B-

See Appendix II for methodology.
* The national rank is of a possible 51 including the 50 states and the District of Columbia. The regional rankings are of a maximum of six and refer to the states in the New England Region (CT, ME, MA, NH, RI, VT).
Calculated by the Institute for Women's Policy Research.

laws on the books, 32 enforce their laws. Of these 32 states, 15 enforce notification laws and 17 enforce consent laws. In states with notification or consent laws, 37 allow for a judicial bypass if the minor appears before a judge and provides a reason that parental notification would place an undue burden on the decision to have an abortion. Three states provide for physician bypass, and two allow minors to petition for either a judicial or physician bypass. Of the 32 states that enforce consent and notification laws, only Idaho and Utah have no bypass procedure. As of January 2000, New Hampshire allows access to abortion services without mandatory parental consent or notification (see Chart VI, Panel B; NARAL and NARAL Foundation, 2000).

Waiting-period legislation mandates that a physician cannot perform an abortion until a certain number of hours after his or her patient is notified of her options in dealing with a pregnancy. Waiting periods range from one to 72 hours. Of the 18 states with mandatory waiting periods as of January 2000, 14

Chart VI. Panel B.
Components of the Reproductive Rights Composite Index

	Yes	No	Other Information	Total Number of States with Policy (of 51) or U.S. Average
Does New Hampshire allow access to abortion services:				
Without mandatory parental consent or notification?[a]	✓			9
Without a waiting period?[a]	✓			33
Does New Hampshire provide public funding for abortions under any or most circumstances if a woman is eligible?[a]		✓		15
What percent of New Hampshire women live in counties with an abortion provider?[b]			74%	68%
Is New Hampshire's state government pro-choice?[c]				
Governor	✓			15
Senate	✓			13
Assembly	✓			7 of 49
Does New Hampshire require health insurers to provide comprehensive coverage for contraceptives?[a]	✓			11
Does New Hampshire require health insurers to provide comprehensive coverage for infertility treatments?[d]		✓		10
Does New Hampshire allow the non-legal parent in a gay/lesbian couple to adopt his/her partner's child?*[e]			No case has been tried	21
Does New Hampshire require schools to provide sex education?[a]		✓		18

* Most states that allow such adoption do so as the result of court decisions. In New Hampshire no case has yet been tried.

Source: [a] NARAL and NARAL Foundation, 2000; [b] Henshaw, 1998; [c] NARAL and NARAL Foundation, 1999; [d] Stauffer and Plaza, 1999; [e] National Center for Lesbian Rights, 1999.

Compiled by the Institute for Women's Policy Research.

states (with waiting periods ranging from one to 24 hours) enforce their laws. New Hampshire does not have a law mandating a waiting period (NARAL and NARAL Foundation, 2000).

Public funding for abortion for women who qualify can be instrumental in reducing the financial obstacles to abortion for low-income women. In some states, public funding for abortions is available only under specific circumstances, such as rape or incest, life endangerment to the woman, or limited health circumstances of the fetus. Fifteen states fund abortions in all or most circumstances. New Hampshire is one of 29 states that do not provide public funding for abortions under any circumstances other than those required by the federal Medicaid law, which are when the pregnancy results from reported rape or incest or when the pregnancy threatens the life of the woman (NARAL and NARAL Foundation, 2000).

The percent of women living in counties with abortion providers measures the availability of abortion services to women. This proportion ranges from 16 to 100 percent across the states. As of 1996, in the bottom three states, 20 percent or fewer women live in counties with at least one provider, while in the top six states, more than 90 percent of women live in counties with at least one (Henshaw, 1998). At 74 percent of women in counties with a provider, New Hampshire's proportion falls in the top third of all states. In contrast, only 50 percent of counties in New Hampshire have abortion providers. Thus, while the majority of women live in counties with abortion providers, for those women in rural counties without a provider, access can be problematic. In 41 states, more than half of all counties have no abortion provider, and in 21 states more than 90 percent of counties have none (Henshaw, 1998).

Debates over reproductive rights frequently involve potential restrictions on women's access to abortion and contraception, and the stances of elected officials play an important role in the success or failure of these efforts. To measure the level of support for or opposition to potential restrictions, the National Abortion and Reproductive Rights Action League (NARAL) examined the votes and public statements of governors and members of state legislatures. NARAL determined whether these public officials would support restrictions on access to abortion and contraception, including (but not limited to) provisions concerning parental consent, mandatory waiting periods, prohibitions on Medicaid funding for abortion and bans on certain abortion procedures. NARAL also gathered official comments from governors' offices and conducted interviews with knowledgeable sources involved in reproductive issues in each state (NARAL and NARAL Foundation, 1999). For this study, governors and legislators who would support restrictions on abortion rights are considered anti-choice, and those who would oppose them are considered pro-choice. New Hampshire's state government is generally pro-choice, with the majority of members in the Senate and Assembly as well as the governor supporting a women's right to choose.

Other Family Planning Policies and Resources

About 49 percent of traditional health plans do not cover any reversible method of contraception such as the pill or IUD. Others will pay for one or two types but not all five types of prescription methods—the pill, implants, injectables, IUDs and diaphragms. About 38 percent of HMOs cover all five prescription methods (Gold and Daley, 1994). Controversy about contraceptive coverage is leading lawmakers in many states to introduce bills that would require health insurers to cover contraception. Eleven states, including New Hampshire, require all private insurers to provide comprehensive contraceptive coverage (see Chart VI, Panel B). Seven states have provisions requiring partial coverage for contraception. In five of these states, insurance companies must offer at least one insurance package that covers some or all prescription birth control methods. One state, Minnesota, requires coverage of all prescription drugs, including contraceptives, and another, Texas, requires insurers with coverage for prescription drugs to cover oral contraceptives (NARAL and NARAL Foundation, 2000).

Infertility treatments can also widen the reproductive choices open to women and men, but they are often prohibitively expensive, especially when they are not covered by insurance. In ten states, legislatures have passed measures requiring insurance

companies to pay for infertility treatments and in three states, insurance companies must offer at least one package with infertility coverage to their policyholders. In New Hampshire, insurance companies are not required to cover infertility treatments at all (Stauffer and Plaza, 1999).

State courts currently hold considerable power to determine what legally constitutes lesbian and gay families, because there is no comprehensive federal law concerning their reproductive rights.

Courts have exercised this power in many ways, including allowing or denying lesbians and gays to legally adopt their partners' children, or second-parent adoption. Second-parent adoption provides legal rights to nonlegal parents in same-sex relationships that legal parents take for granted. These rights include (but are not limited to) custodial rights in the case of divorce or death and the right to make health care decisions for the child. Court rulings in 21 states specifically allow second-parent adoption to lesbians and gays. In 15 of those states, lower courts have approved a petition to adopt; in five states, high or appellate courts have prohibited discrimination; and in one state, the state supreme court has prohibited discrimination against gays or lesbians in second-parent adoption cases. In five states, courts have ruled against second-parent adoption. Because many of the rulings have been issued from lower-level courts, there is room for them, both in favor of and against second-parent adoption, to be overturned by courts at a higher level. In addition, courts in the remaining 24 states have not ruled on a case involving second-parent adoption, creating a sense of ambiguity for lesbian and gay families. Only one state, Florida, has specifically banned second-parent adoption through state statute. In New Hampshire, no case has been tried regarding the right of a non-legal parent in a gay/lesbian couple to adopt his/her partner's child (National Center for Lesbian Rights, 1999). More favorably, in 1999, New Hampshire repealed its law prohibiting adoption and foster care by gay or lesbian parents (New Hampshire, 1999a).

Sexuality education is crucial to giving young women and men the knowledge they need to make informed decisions about their sexual activity and to avoid unwanted pregnancy. In 18 states, schools are required to provide sex education. Of those 18, nine states require that sex education programs teach abstinence and also provide students information about contraception. Three states require that sex education programs teach abstinence but do not require that schools provide information about contraception (NARAL and NARAL Foundation, 2000). New Hampshire does not mandate sex education.

Fertility, Natality, and Infant Health

Current trends in the United States reveal a decline in the birth rate for all women, in part due to women's tendency to marry and give birth later in life. In 1998, the median age for women at the time of their first marriage was 25.0 years, while as of 1994, the median age at first birth was 23.8 years (U.S. Department of Commerce, Bureau of the Census, 1999a; National Center for Health Statistics, 1997). Fertility rates in New Hampshire are lower than in the nation as a whole. Table 14 shows 52.4 live births per 1,000 women aged 15-44 in New Hampshire and 65.0 births per 1,000 women aged 15-44 in the United States in 1997.

Table 14 also shows 4.3 infant deaths per 1,000 births in New Hampshire, a rate substantially lower than that for the United States as a whole, at 7.2 infant deaths per 1,000. Infant mortality also affects white and African American communities in the United States at very different rates. In the United States as a whole respective rates are 6.0 for white infants and 14.2 for African American infants. While data for minorities in New Hampshire are not available, the state's rate of 4.3 infant deaths for white infants is quite low relative to that of white infants in the country as a whole.

Low birth weight (5 lbs., 8 oz.) among babies also affects different racial and ethnic groups at different rates. In New Hampshire, the percent of low-weight births is 5.8 among white infants and 8.8 among Hispanic infants. No data are available for the proportion of low birth weight babies among African Americans in New Hampshire. In the United States as a whole, in 1997, the percent of low-weight births among white infants was 6.5; for Hispanic infants, 6.4; and for African American infants, 13.1. In the

country as a whole, disparities in both infant mortality and low birth weight rates between African Americans and whites are growing. These differences are probably related to a variety of factors, including disparities in socioeconomic status, nutrition, maternal health, and access to prenatal care, among others (U.S. Department of Health and Human Services, Public Health Service, 2000).

For all women, women's access to prenatal care can be crucial to health during pregnancy and to lowering the risk of infant mortality and low birth weights (U.S. Department of Health and Human Services, Public Health Service, 2000). In the country as a whole, about 82.5 percent of women begin prenatal care in their first trimester of pregnancy, while 89.6 percent of women in New Hampshire do. However, use of prenatal care varies by race. In the United States as a whole, 84.7 percent of white women use prenatal care in the first trimester, while 72.3 percent of African American and 73.7 percent of Hispanic women do. In New Hampshire, 89.8 percent of white women, 78.0 percent of African American women, and 77.9 percent of Hispanic women use first trimester prenatal care.

Births to teenage mothers can make it difficult for them to achieve an adequate standard of living by limiting their choices about education and employment (The Alan Guttmacher Institute, 1994; U.S. Department of Health and Human Services, Public Health Service, 2000). In 1997, births to teenage mothers accounted for a lower proportion of all births in New Hampshire (7.8 percent) than they did nationally (12.8 percent). Births to unmarried mothers also accounted for a smaller proportion of all births in New Hampshire than they did nationally (23.8 percent compared with 32.4 percent).

Table 14.
Fertility, Natality, and Infant Health, 1997

	New Hampshire	United States
Fertility Rate in 1997 (live births per 1,000 women aged 15-44)[a]	**52.4**	**65.0**
Infant Mortality Rate in 1997 (deaths of infants under age one per 1,000 live births)[b]	**4.3**	**7.2**
Among Whites	4.3	6.0
Among African Americans	N/A	14.2
Percent of Low Birth Weight Babies (less than 5 lbs. 8 oz.), 1997[a]	**5.8%**	**7.5%**
Among Whites	5.8%	6.5%
Among African Americans	N/A	13.1%
Among Hispanics	8.8%	6.4%
Percent of Mothers Beginning Prenatal Care in the First Trimester of Pregnancy, 1997[a]	**89.6%**	**82.5%**
Among Whites	89.8%	84.7%
Among African Americans	78.0%	72.3%
Among Hispanics	77.9%	73.7%
Births to Teenage Women (aged 15-19 years) as a Percent of All Births, 1997[c]	**7.8%**	**12.8%**
Births to Unmarried Women as a Percent of All Births, 1997[c]	**23.8%**	**32.4%**

N/A = Not Available.

Source: [a] National Center for Health Statistics, 1999a; [b] National Center for Health Statistics, 1999b; [c] U.S. Department of Commerce, Bureau of the Census, 1999e.

Compiled by the Institute for Women's Policy Research.

Health and Well-Being

Health is a crucial factor in women's overall well-being. Health problems can seriously impair women's quality of life as well as their ability to care for themselves and their families. Illness can be costly and painful and can interrupt daily tasks people take for granted. The healthier the inhabitants of an area are, the better their quality of life, and the more productive those inhabitants are likely to be. As with other resources described in this report, women in the United States vary in their access to health-related resources. To ensure equal access, the Beijing Declaration and Platform for Action stresses the need for strong prevention programs, research and information campaigns targeting all groups of women, and adequate and affordable quality health care.

This section focuses on the quality of health of women in New Hampshire. The composite index of women's health and well-being ranks the states on several indicators, including mortality from heart disease, breast cancer and lung cancer; the incidence of diabetes, chlamydia, and AIDS; women's mental health status and mortality from suicide; and

Chart VII.
Health and Well-Being: National and Regional Ranks

Indicators	National Rank* (of 51)	Regional Rank* (of 6)	Grade
Composite Health and Well-Being Index	**19**	**4**	**B-**
Average Annual Mortality Rate Among Women from Heart Disease (per 100,000, 1995)[a]	30	5	
Average Annual Mortality Rate Among Women from Lung Cancer (per 100,000, 1991-95)[b]	44	5	
Average Annual Mortality Rate Among Women from Breast Cancer (per 100,000, 1991-95)[b]	43	4	
Percent of Women Who Have Ever Been Told They Have Diabetes (1998)[c]	8	2	
Average Annual Incidence Rate of Chlamydia Among Women (per 100,000, 1997)[d]	1	1	
Average Annual Incidence Rate of AIDS Among Women (per 100,000 adolescents and adults, July 1998 through June 1999)[e]	10	3	
Average Number of Days per Month on which Women's Mental Health Is Not Good (1998)[c]	36	6	
Average Annual Mortality Rate Among Women from Suicide (per 100,000, 1995-97)[f]	35	4	
Average Number of Days per Month on which Women's Activities Are Limited by Their Health (1998)[c]	19	3	

See Appendix II for methodology.

* The national rank is of a possible 51 including the 50 states and the District of Columbia. The regional rankings are of a maximum of six and refer to the states in the New England Region (CT, ME, MA, NH, RI, VT).

Source: [a] Centers for Disease Control, National Center for Chronic Disease Prevention and Health Promotion, 1998; [b] American Cancer Society, 1999; [c] Centers for Disease Control, National Center for Chronic Disease Prevention and Health Promotion, 1999a; [d] Centers for Disease Control, Division of STD Prevention, 1998; [e] U.S. Department of Health and Human Services, Public Health Service, 1999; [f] Centers for Disease Control, National Center for Injury Prevention and Control, 2000b.

Calculated by the Institute for Women's Policy Research.

limitations on women's everyday activities. Because research links women's health and well-being to their ability to access the health care system (Mead, Witkowski and Hartmann, forthcoming), this section also presents information on women's use of preventive services, health-related behaviors and state-level policies concerning women's health issues. Information on women's access to health insurance is presented earlier in this report.

Although women on average live longer than men—79 years for women compared with 73 years for men in the United States in 1998—women suffer from more nonfatal acute and chronic conditions and are more likely to live with disabilities and suffer from depression. In addition, women have higher rates of health service use, physician visits, and prescription and nonprescription drug use than men (Mead, Witkowski and Hartmann, forthcoming).

Women's overall health status is closely connected to many of the other indicators in this report, including women's poverty status, access to health insurance, and reproductive rights and family planning. As a result, it is important to consider women's health as imbedded in and related to their political, economic, and social status (National Women's Law Center, FOCUS on the Health of Women at the University of Pennsylvania Medical Center, and Lewin Group, forthcoming). For example, women's health is significantly influenced by their socioeconomic status. Many studies find direct and indirect relationships between income, education and work status, and health. Poor, uneducated women with few work opportunities are more likely to be unhealthy. Women with low incomes, little education and no jobs also face significant problems accessing the health care system, which indirectly influences their health status (Mead, Witkowski and Hartmann, forthcoming). On the other hand, research shows that women's employment has a positive effect on health. Studies suggest the link may result both because work provides health benefits to women and because healthier women "self-select" to work (Hartmann, Kuriansky and Owens, 1996). Finally, research suggests that across the states, women's mortality rates, cause-specific death rates and mean days of activity limitations due to health are highly correlated with their political participation and with a smaller wage gap (Kawachi, Kennedy, Gupta and Prothrow-Stith, 1999).

New Hampshire ranks 19th of all states and fourth in its region on indicators of women's health and well-being. The state fares particularly poorly on mortality from lung cancer (ranked 44th) and breast cancer (ranked 43rd), as well as on mortality from heart disease (ranked 30th). However, New Hampshire ranks exceptionally high on indicators of sexually transmitted diseases, ranking first in the country for the lowest incidence of chlamydia and tenth for the incidence of AIDS. Overall, New Hampshire ranks about average for indicators of women's health.

New Hampshire's grade of B- on the health and well-being index reflects the difference between women's actual health status in the state and national goals concerning their health status, including goals set by the U.S. Department of Health and Human Services in its Healthy People 2010 program (see Appendix II for a discussion of the composite methodology).

Mortality and Incidence of Disease

Heart disease has been the leading cause of death for both women and men of all ages in the United States since 1970. It is the second leading cause of death among women aged 45-74, following all cancers combined (but is the leading cause when cancers are examined separately). It remains the leading cause of death for women aged 75 and over even when all cancers are combined (National Center for Health Statistics, 1996). Since many of the factors contributing to heart disease, including high blood pressure, smoking, obesity and inactivity, can be addressed by changing women's health habits, states can contribute to decreasing rates of death from heart disease by raising awareness of the risk factors and how to modify them. In addition, states can help by implementing policies that facilitate access to health care professionals and preventive screening services. Women in New Hampshire experience mortality from heart disease at rates slightly higher than the median mortality rate for all states (93.3 and 90.9 per 100,000 population, respectively; see

Table 15) and ranks 30th among all states on this indicator. Notably, men's mortality from heart disease is much higher in New Hampshire and in the country as a whole at 187.4 and 174.4 per 100,000 population respectively (data not shown). Like women's, men's mortality rate from heart disease in New Hampshire is higher than the median for the United States.

Mortality from heart disease also varies greatly by race in New Hampshire and the United States as a whole. As Figure 14 shows, mortality rates from heart disease are generally much higher among African American women than among white women, while Asian American women have the lowest rates of mortality from heart disease. In the United States, the mortality rate from heart disease for 1991-95 among all women 35 and older was 401 deaths per 100,000 women (these data differ from those in Table 15, which presents 1995 mortality rates for women of all ages). For African American women, it was much higher, at 553 deaths per 100,000, while for white women it was 388. For Hispanic women, the rate was only 265 deaths per 100,000, and it was even lower, at 221 and 259, for Asian American and Native American women, respectively. In New Hampshire, the mortality rate of white women was about the same as the rate for the state as a whole. Unfortunately, data for mortality from heart disease were not available for other racial and ethnic groups in New Hampshire.

Table 15.
Components of the Health and Well-Being Composite Index

Indicator	New Hampshire	United States
Average Annual Mortality Rate Among Women from Heart Disease (per 100,000), 1995[a]	**93.3**	**90.9***
Average Annual Mortality Rate Among Women from Lung Cancer (per 100,000), 1991-95[b]	**38.0**	**33.3**
Among White Women[c]	37.9	33.8
Among African American Women[c]	34.5	32.7
Average Annual Mortality Rate Among Women from Breast Cancer (per 100,000), 1991-95[b]	**28.3**	**26.0**
Among White Women[c]	28.6	25.6
Among African American Women[c]	27.9	31.5
Percent of Women Who Have Ever Been Told They Have Diabetes (1998)[d]	**3.7%**	**5.3%***
Average Annual Incidence Rate of Chlamydia Among Women (per 100,000), 1997[e]	**108.3**	**335.8**
Average Annual Incidence Rate of AIDS Among Women (per 100,000 adolescents and adults), July 1998 through June 1999[f]	**1.4**	**9.4**
Average Number of Days of Poor Mental Health Among Women, 1998[d]	**3.8**	**3.5***
Average Annual Mortality Rate Among Women from Suicide (per 100,000), 1995-97[g]	**4.4**	**3.9**
Average Number of Days of Limited Activities Among Women, 1998[d]	**3.4**	**3.6***

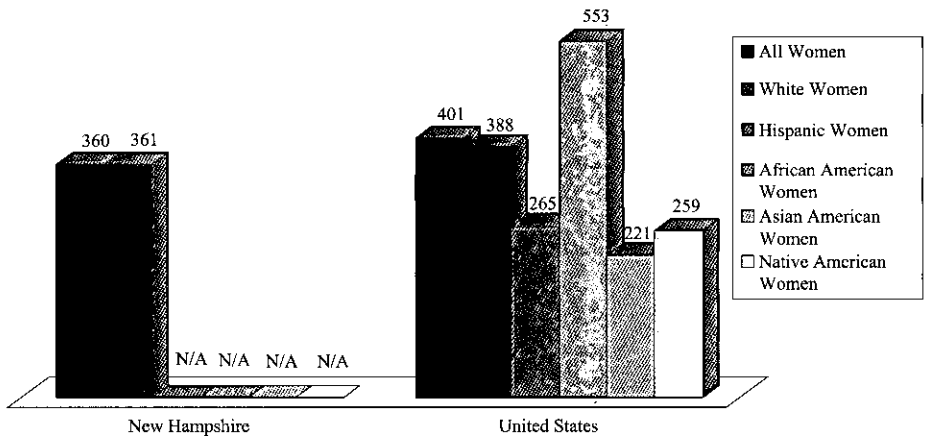
* Median rate for the 50 states and the District of Columbia.

Source: [a] Centers for Disease Control, National Center for Chronic Disease Prevention and Health Promotion, 1998; [b] American Cancer Society, 1999; [c] American Cancer Society, 2000; [d] Centers for Disease Control, National Center for Chronic Disease Prevention and Health Promotion, 1999a; [e] Centers for Disease Control, Division of STD Prevention, 1998; [f] U.S. Department of Health and Human Services, Public Health Service, 1999; [g] Centers for Disease Control, National Center for Injury Prevention and Control, 2000b.

Compiled by the Institute for Women's Policy Research.

Cancer is the leading cause of death for women aged 45-74, and women's lung cancer, the leading cause of death among cancers, in particular is on the rise. Among women nationally, the incidence of lung cancer doubled and the death rate rose 182 percent between the early 1970s and early 1990s (National Center for Health Statistics, 1996). Like heart disease, lung cancer is closely linked with cigarette smoking. State public awareness efforts on the link between cancer and smoking can be crucial to lowering lung cancer incidence and mortality. In New Hampshire, average mortality from lung cancer is 38.0 per 100,000 women, above the national rate of 33.3 per 100,000 women. As a result, New Hampshire ranks 44th in the nation and fifth of six in its region on this indicator. In addition, in New Hampshire as in the nation as a whole, mortality from lung cancer is higher among white women than among African American women. In New Hampshire, 37.9 white women per 100,000 die from lung cancer each year, while 34.5 African American women do. Nationally, 33.8 white women and 32.7 African American women per 100,000 die annually from lung cancer.

Figure 14.
Average Annual Mortality Rates among Women from Heart Disease in New Hampshire and the United States, 1991-95*



* Average annual mortality rates (deaths per 100,000) for women aged 35 years and older. Data for Hispanics are also included within the data on each of the four categories of race. Data for Native American, Asian American, African American, and Hispanic women are not available for New Hampshire. Data differ from those provided in Table 15, which are for women of all ages for 1995.

Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2000.

Compiled by the Institute for Women's Policy Research.

Among cancers, breast cancer is the second-most common cause of death for U.S. women. Approximately 175,000 new invasive cases of breast cancer are expected in 1999 (American Cancer Society, 1999). Breast cancer screening is crucial not just for detecting breast cancer but also for reducing breast cancer mortality. Consequently, health insurance coverage, breast cancer screenings, and public awareness of the need for screenings are all important issues to address as states attempt to diminish death rates from the disease. New Hampshire's rate of mortality from breast cancer is relatively high, at 28.3 per 100,000 population, compared with the national rate of 26.0 per 100,000 population. Like lung cancer rates, breast cancer rates vary by race. Nationally, the mortality rate from breast cancer is 25.6 per 100,000 white women and 31.5 per 100,000 African American women. In New Hampshire, mortality from breast cancer is 28.6 per 100,000 white women but 27.9 per 100,000 African American women. Thus, while breast cancer mortality is higher among African American women than white women in the nation as a whole, it is slightly lower among African American women in New Hampshire.

People with diabetes are two to four times more likely to develop heart disease or stroke, blindness, kidney disease, and other serious health conditions than those without it, and women with diabetes have the same risk of heart disease as men (Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 1999b). Rates of diabetes vary tremendously by race, with African Americans, Hispanics, and

American Indians experiencing much higher rates than white men and women (Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 1999b). The overall risk of diabetes can be decreased by lowering the level of obesity and by improving health habits in a state. In New Hampshire, 3.7 percent of women have been diagnosed with diabetes at some point in their lifetime, a rate considerably lower than the median rate for all states, 5.3 percent. At eighth, New Hampshire ranks relatively high on this indicator of women's health.

Sexually transmitted diseases (STDs) are a common threat to younger women's health. As with many other health problems, education, awareness, and proper screening can be key to limiting the spread of STDs and diminishing the health impact associated with them. One of the more common STDs among women is chlamydia, which affects over 436,000 women in the United States. Chlamydia is often asymptomatic, as up to 85 percent of women who have it manifest no symptoms. Nonetheless, chlamydia can lead to Pelvic Inflammatory Disease (PID), which is a serious threat to female reproductive capacity (U.S. Department of Health and Human Services, Public Health Service, 2000). As a result, screening for chlamydia is important to women's reproductive health. In New Hampshire, chlamydia affects 108.3 women per 100,000 population, a rate substantially lower than that for the United States as a whole, 335.8 women per 100,000 population. As a result, New Hampshire does better than all other states, ranking first in the nation on this indicator of women's health status.

Finally, the incidence of HIV and AIDS in women is one of the fastest growing threats to their health, especially among younger women. In fact, the original gap between the incidence of AIDS in women and men is diminishing quickly. While in 1985 the incidence of AIDS-related illnesses among men was 13 times more than for women, by 1998-99 men had fewer than four times as many AIDS-related illnesses as women. The proportion of people with AIDS who are women is likely to continue rising, since a higher proportion of HIV cases are women: in 1998-99, 23 percent of AIDS cases were women, while 32 percent of HIV cases were women (U.S. Department of Health and Human Services, Public Health Service, 1999). Moreover, the majority of the AIDS burden falls on minority women: in 1998, 63 percent of women diagnosed with AIDS were African American, while over 18 percent were Hispanic (U.S. Department of Health and Human Services, Public Health Service, 1999). Unfortunately, state-by-state data for minority women were not available. However, overall New Hampshire has a substantially lower incidence rate of AIDS than the nation as a whole, at 1.4 and 9.4 per 100,000 population respectively. For men the AIDS incidence rate is also substantially lower in New Hampshire, at 8.2 cases per 100,000 population in New Hampshire and 33.2 cases in the United States as a whole for men (data not shown; U.S. Department of Health and Human Services, Public Health Service, 1999).

Mental Health

Women experience certain psychological disorders, such as depression, anxiety, panic disorders, and eating disorders, at higher rates than men. However, they are less likely to suffer from substance abuse and conduct disorder than men are. Overall, about half of all women aged 15-54 experience symptoms of psychological disorders at some point in their lives (National Center for Health Statistics, 1996). However, because of stigmas associated with psychological disorders and their treatment, many go untreated. In addition, while many health insurance policies cover some portion of alcohol and substance abuse programs, many do not adequately cover treatments of psychological disorders. These treatments, however, are integral to helping patients achieve good mental health.

In New Hampshire, women's self-reported evaluations indicate that women experience an average of 3.8 days per month on which their mental health is not good (see Table 15 and Chart VII), earning the state a national rank of 36th. Nationally, the median rate for all states is 3.5 days per month of poor mental health. In contrast, men's rate of poor mental health is slightly below the national median at 2.1 and 2.4 days, respectively (data not shown). In New Hampshire, men's lower rate of poor mental health compared with women's mirrors national trends: in the nation as a whole, the median rate for women is

over 1 day more than it is for men (3.5 and 2.4 days per month, respectively).

One of the most severe public health problems related to psychological disorders is suicide. In the United States as a whole, 1.3 percent of all deaths occur from suicide, about the same number of deaths as from AIDS (National Institute of Mental Health, 1999). Women are much less likely than men to commit suicide, with four times as many men as women dying by suicide. However, women are twice as likely to attempt suicide as men are, and a total of 500,000 suicide attempts are estimated to have occurred in 1996. In addition, in 1997, suicide was the fourth leading cause of death among women aged 14-24 and 35-44, the sixth leading cause of death among women aged 25-34, and the eighth leading cause of death among women 45-54 (Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2000a). Among women in the United States, the annual rate of mortality from suicide is 3.9 per 100,000 population. In New Hampshire, the rate of death by suicide among women is higher, at 4.4. As a result, New Hampshire ranks 35th in the nation and fourth in the New England region on this indicator of women's health status.

While risk factors for suicide often occur in combination, research indicates that 90 percent of men and women who kill themselves are experiencing depression, substance abuse, or another diagnosable psychological disorder (National Institute of Mental Health, 1999). As a result, policies that extend and expand mental health services to those who need them can help potential suicide victims. According to the National Institute of Mental Health, the most effective programs prevent suicide by addressing broader mental health issues, such as stress and substance abuse (National Institute of Mental Health, 1999).

Limitations on Activities

Women's overall health status strongly affects their ability to carry out everyday tasks, provide for their families, fulfill their goals, and live full and satisfying lives. Illness, disability and generally poor health can obstruct their ability to do so. Women's self-evaluation of the number of days in a month on which their activities were limited by their health status measures the extent to which women are unable to perform the tasks they need and want to complete. Among all states, the median is 3.6; in New Hampshire, the average number of days of limited activities for women is slightly lower, at 3.4 (see Table 15). The state ranks 19th on this indicator. For men, the rate in New Hampshire (2.8 days per month) is also lower than the median rate for all states (3.5 days per month; data not shown).

Preventive Care and Health Behaviors

Women's health status is affected tremendously by their use of early detection measures, preventive health care, and good personal health habits. In fact, preventive health care, healthy eating and exercise, as well as elimination of smoking and heavy drinking, can help women avoid many of the diseases and conditions described above. Table 16 presents data on women's use of preventive care, early detection resources, and good health habits in New Hampshire. Generally, women in New Hampshire use preventive care resources at rates slightly above national levels. Of women over age 50, 71.6 percent have had a mammogram within the past two years and 75.1 percent over age 18 have been screened for cholesterol in the past five years, rates higher than the median numbers for all states. New Hampshire women have usage rates of pap tests near the median for all states (84.2 percent versus 84.9 percent).

In addition, women in New Hampshire engage in good health habits at relatively high levels compared with women in the nation as a whole. While the percent of adult women in New Hampshire who smoke (21.0 percent) is near the median for all states, women in New Hampshire are more likely to participate in physical activity, more likely to eat the recommended amount of fruits and vegetables, and less likely to drink chronically than women in other states (drinking chronically entails 60 or more alcoholic beverages a month; see Table 16).

Table 16.
Preventive Care and Health Behaviors

	New Hampshire	United States*
Preventive Care		
Percent of Women Aged 50 and Older Who Have Had a Mammogram in the Past Two Years, 1998[a]	71.6	67.8
Percent of Women Aged 18 and Older Who Have Had a Pap Smear in the Past Three Years, 1998[a]	84.2	84.9
Percent of Women Aged 18 and Older Who Have Been Screened for Cholesterol in the Past Five Years, 1995[b]	75.1	68.2
Health Behaviors		
Percent of Women Who Smoke (100 or more cigarettes in their lifetime and who now smoke everyday or some days), 1998[a]	21.0	20.8
Percent of Women Who Report Chronic Drinking (60 or more alcoholic beverages during the previous month), 1995[b]	0.4	0.7
Percent of Women Who Report No Leisure-Time Physical Activity During the Past Month, 1998[a]	25.8	29.9
Percent of Women Who Do Not Eat 5 or More Servings of Fruits or Vegetables per Day, 1998[a]	66.1	72.2

* National rates are median rates for the 50 states and the District of Columbia.

Source: [a] Centers for Disease Control, National Center for Chronic Disease Prevention and Health Promotion, 1999a; [b] Centers for Disease Control, 1997.

Compiled by the Institute for Women's Policy Research.

Women are particularly affected by resource allocations to Medicaid programs since more women than men live in poverty and, consequently, over 50 percent more women receive Medicaid benefits than men (U.S. Department of Health and Human Services, Health Care Financing Administration, 1999a). In New Hampshire, more women than men receive health insurance from public sources (11 percent versus 6.8 percent; see Table 12). During the 1990s, states gained increased autonomy in setting eligibility and benefit levels for Medicaid programs, and as a result their spending varied substantially. Table 17 shows the level of Medicaid spending per adult enrollee in New Hampshire ("adults" are generally defined as nondisabled people aged 18-64, although some states extend "adult" to cover some

State Health Policies and Resources

State policies can contribute to women's health status in significant ways. Because poverty is closely associated with poor health among women, policies allocating resources to Medicaid programs to help low-income men and women cover health-related expenses are critical for improving health and well-being.

Table 17.
Medicaid Spending and Domestic Violence and Sexual Assault Spending Per Person in New Hampshire and the United States

	New Hampshire	United States
Medicaid Spending Per Adult Enrollee, 1997[a]	**$1,985**	**$1,874**
Domestic Violence and Sexual Assault Services and Prevention Spending Per Capita, 1994-95[b]	**$1.39**	**$1.34**

Source: [a] Urban Institute, 1999; [b] Centers for Disease Control, National Center for Injury Prevention and Control, 1997.

Compiled by the Institute for Women's Policy Research.

Focus on Violence against Women in New Hampshire

The New Hampshire Department of Justice reports that crisis centers in New Hampshire have seen a leveling in the number of female domestic violence victims seeking assistance, from 7,742 in 1997, to 7,147 in 1998, and 7,159 in 1999 (Palmer, 1999). However, violence against women in New Hampshire continues to be a serious public health issue. In 1998, the New Hampshire Behavioral Risk Factors Surveillance System Study reported the following facts:

- Women and men are about equally likely to have experienced physical violence of any type in the last twelve months, but women are twice as likely to sustain injuries requiring medical attention.
- Among women, more than 85 percent of serious injuries resulting from physical violence take place in the home.
- More than 50 percent of women experiencing serious physical violence are assaulted by an intimate partner or former intimate partner.
- Of women who are seriously injured as a result of physical violence, more than 28 percent receive no treatment for their injuries. More than 42 percent are treated in emergency rooms, while 14 percent seek treatment at their doctor's office or through a health clinic (Powers, 1998).

Violence in the home also remains a serious public health issue for children. The differential in violence rates for males and females begins with children. According to the Youth Risk Behavior Survey, of 1,703 New Hampshire high school students polled in 1999:

- Eleven percent report at least one incident that involved feeling it was unsafe to go home.
- Among high school students, 1.4 percent reported needing to seek alternate safe housing options more than six times.
- Students who feel less safe at home have consistently lower grades, indicating a direct correlation between a safe home and school performance.
- Girls were more likely than boys to be victims of physical, sexual, emotional and verbal abuse.
- Girls were twice as likely as boys to report needing counseling and were often unable to obtain it.
- Girls were nearly twice as likely as boys to consider suicide (Johnson, 1999).

These statistics clearly demonstrate a need for increased awareness concerning violence against women and for increased resources for victims, including both adults and children.

younger people, such as pregnant teens or mothers classified as head-of-household). In 1997, at $1,985, New Hampshire's spending was above the average among all states, $1,874 per adult enrollee. Adequate financial support for their health care needs can be integral to the health status of low-income women and their families. State and federal policy should also ensure that as men and women move away from welfare and into the workforce, they do not lose access to health insurance.

Domestic violence and stalking can also affect women's physical health and mental well-being significantly. Very little reliable data on rates of violence against women exist, however, because many incidences of violence go unreported. Women who suffer from domestic violence, stalking, and other crimes often need appropriate services to help them make the transition from a violent and unhealthy situation to an independent and stable life. Still, state spending related to violence against women varies tremendously. Table 17 shows that New Hampshire's funding for domestic violence and stalking programs is $1.39 per person in the state, five cents above the national average of $1.34 (for more detail see Focus on Violence Against Women in New Hampshire). Of this money, state funds comprised 53 percent and federal funds comprised 47 percent. Of its state funds, New Hampshire spent 92 percent on domestic violence programs and 8 percent on sexual assault programs. Of its federal funds, 66 percent was spent on domestic violence programs and 34 percent on sexual assault programs.

Studies show that the quality of insurance coverage significantly affects women's access to certain health resources and, consequently, their health (Mead, Witkowski and Hartmann, forthcoming). In order to advance women's and men's access to adequate health-related resources, many states have passed policies governing health care coverage by insurance companies for their policyholders. These policies include required coverage for preventive screenings for cervical cancer and osteoporosis; laws allowing women to choose a specialist in obstetrics and gynecology as their primary care physician or allowing direct access to one without referral; and mandates for coverage of mental health services. In addition, some states have mastectomy stay laws, requiring insurance companies to cover inpatient care for defined periods following a mastectomy. Overall, while New Hampshire has a few state insurance mandates important to women, it still lacks several significant policies (see Table 18). In particular, women in the state would benefit from insurance mandates covering screenings for cervical cancer and osteoporosis and inpatient care after a mastectomy.

Table 18.
State Health Insurance Mandates in New Hampshire, 1999

	Yes	No	Total, United States (of 51)
Does New Hampshire require insurance companies to...			
Cover screenings for cervical cancer?[a]		✓	23
Cover screenings for osteoporosis?[a]		✓	7
Cover inpatient care for a defined period after a mastectomy?[a]		✓	19
Allow women to identify a specialist in obstetrics and gynecology as their primary care physician or allow direct access to one?[a]	✓		37
Cover or offer at least one policy covering mental health services at the same level as other health services?[b]	✓		20

Source: [a] Stauffer and Plaza, 1999. [b] Delaney, 1999.
Compiled by the Institute for Women's Policy Research.

Conclusions and Policy Recommendations

Women in New Hampshire, like women in the nation as a whole, have made a great deal of progress in recent decades. Women are more educated, more active in the workforce, and have made important strides in narrowing the wage gap. Yet women still face substantial and persistent obstacles to attaining equality in these and other areas. This report demonstrates, above all else, that for activists and policymakers, improving the quality of life for all New Hampshire residents by eliminating the inequities that exist between the state's women and men remains a challenge.

A variety of policy changes could be implemented to help women attain greater equality in all areas of life:

- Women in New Hampshire will benefit more from the state's strong economy if the minimum wage is raised, programs to increase the growth of living-wage jobs are developed, and efforts are made to eliminate the wage gap. In addition, more progress should be made in New Hampshire for women to access capital. Policies that enhance the opportunity for women to own businesses should include greater recognition of banks, especially in rural areas of the state, that increase access for women who seek loans to start or develop their own businesses.

- New Hampshire should recognize that education is the key to economic self-sufficiency for women. By fostering educational attainment among low-income women, the state can help these women become more fully attached to the labor force, thereby increasing their families' economic self-sufficiency. New Hampshire Employment Program rules need to allow more types of educational experiences to count as work experience and to allow TANF recipients and other low-income women broader access to post-secondary education and to loans that can help them attain that education.

- Women workers will benefit if there is greater availability of adequate and affordable child care and expanded eligibility for child care subsidies. Also, initiatives that promote employment flexibility, family-friendly work environments, and paid parental and dependent leave policies can help parents better balance work and family.

- Although New Hampshire's racial, ethnic and immigrant communities are small compared to national populations, these populations are growing. As the diversity of New Hampshire's population increases, it is necessary to ask how women are represented in the changing demographics. Without accurate data on diverse women's needs, the state will continue to provide inadequate and inappropriate services, particularly in housing, employment, child care, access to health care, and education, to populations of women that may need the most assistance. To get a more realistic appraisal of the diverse needs of New Hampshire's women, the state needs more comprehensive data collection mechanisms to monitor and assess the current status of the state's immigrant and minority women. To date, these data sources or mechanisms are inadequate.

- New Hampshire faces an ongoing challenge to provide women access to the reproductive resources and medical care that will enable healthy and purposeful decisions about childbearing and motherhood. While this state has historically respected women's reproductive privacy by rejecting legal restrictions that would limit access to abortion care, reproductive health policies continue to be controversial and require constant safeguarding. Women's lives and health will be greatly improved if New Hampshire devotes additional resources to preventing the need for abortion by supporting policies that reduce the incidence of unintended pregnancy. Policymakers and activists can meet

this challenge by allocating increased funding to family planning services and by encouraging comprehensive sexuality education for teens. Women's reproductive autonomy cannot be fully achieved until financial and legal barriers to access to infertility treatments or abortion care for low-income women are removed.

- Women's physical safety must be safeguarded, through greater emphasis on and sustained funding for public awareness and preventive programs combating violence against women. Policies should encourage interventions in violent relationships by multiple social systems while protecting victims' rights. Stronger laws for domestic violence, sexual assault, and stalking are needed. However, thorough enforcement of laws on the books, with emphasis on respecting the rights, safety, and dignity of survivors of domestic and sexual violence, is equally essential. Judicial and police training must educate officials about the unique characteristics and prevalence of this kind of crime.

- Women in New Hampshire are more likely than women in many New England states and in the nation to die from a chronic disease such as heart disease, lung cancer, and breast cancer (the three leading causes of death for women in the United States). They are also more likely to suffer from certain mental health disorders. Women's physical and mental well-being can be enhanced through public awareness programs about the risk factors for fatal illness and policies that encourage early detection and preventive care.

- Although during the 1999-2000 legislative session New Hampshire enjoyed the historic accomplishment of becoming the first state in the nation with women serving simultaneous terms as Governor, Speaker of the House, and Senate President, the state has never had a woman serve on its congressional delegation. And, while 31.8 percent of the state's legislature is comprised of women—a number higher than the national average—that percentage is far lower than the full share of the female population. Because women's participation in politics gives women a more prominent voice, increasing their number in the New Hampshire and U.S. legislature will bring important issues of concern, including those in this report, to the forefront of policy debates.

National policies also remain important in improving women's status in the states and in the country as a whole. IWPR recommends the following national policies:

- The federal minimum wage, federal equal employment opportunity legislation, and federal health and safety standards are all critical in ensuring minimum levels of decency and fairness for women workers.

- Because union representation correlates strongly with higher wages for women and improved pay equity, benefits and working conditions, federal laws that protect and encourage unionization efforts would assist women workers.

- Policies such as paid family leave could be legislated nationally as well as at the state level through, for example, mandatory insurance or the establishment of an employee pay-in system.

- Because most income redistribution occurs at the national level, federal legislation on taxes, entitlements and income security programs (such as the Earned Income Tax Credit, Social Security, Medicaid, Medicare, Food Stamps and welfare) will continue to profoundly affect women's lives and should take women's needs and interests into account.

In most cases, both state and national policies lag far behind the changing realities of women's lives.

IWPR's series of reports on *The Status of Women in the States* establishes baseline measures for the status of women in the 50 states and the District of Columbia. In accordance with IWPR's purpose—to meet the need for women-centered, policy-relevant research—these reports describe women's lives and provide the tools to analyze the policies that can and do affect them.

The New Hampshire Advisory Committee

Appendix I
Basic Demographics

This Appendix includes data on different populations within New Hampshire. Statistics on age, the sex ratio and the elderly female population are presented, as are the distribution of women by race/ethnicity and family types and information on women in prisons. These data present an image of the state's

Appendix Table 1.
Basic Demographic Statistics for New Hampshire and the United States

	New Hampshire	United States
Total Population, 1998[a]	**1,185,048**	**270,298,524**
Number of Women, All Ages[b]	602,079	138,252,197
Sex Ratio (women to men, aged 18 and older)[b]	1.06:1	1.08:1
Median Age of All Women[b]	36.2	36.3
Proportion of Women Over Age 65[b]	13.8%	14.6%
Distribution of Women by Race and Ethnicity, All Ages, 1995[c]		
White*	97.3%	73.0%
African American*	0.5%	12.8%
Hispanic**	1.0%	9.8%
Asian American*	1.0%	3.6%
Native American*	0.2%	0.8%
Distribution of Households by Type, 1990[d]		
Total Number of Family and Nonfamily Households	409,602	91,770,958
Married-Couple Families (with and without their own children)	60.6%	56.2%
Female-Headed Families (with and without their own children)	8.1%	11.3%
Male-Headed Families (with and without their own children)	3.0%	3.2%
Nonfamily Households: Single-Person Households	21.8%	24.4%
Nonfamily Households: Other	6.6%	4.9%
Distribution of Women Aged 15 and Older by Marital Status, 1990[e]		
Married	58.6%	55.6%
Single	22.0%	23.1%
Widowed	10.3%	11.9%
Divorced	9.0%	9.4%
Percent of Households with Children Under Age 18 Headed by Women, 1990[f]	**14.1%**	**19.5%**
Proportion of Women Living in Metropolitan Areas, All Ages, 1990[g]	**72.6%**	**83.1%**
Proportion of Women Who Are Foreign-Born, All Ages, 1990[h]	**4.0%**	**7.9%**
Percent of Federal and State Prison Population Who Are Women, 1998[i]	**5.3%**	**6.5%**

* Non-Hispanic.
** Hispanics may be of any race.

Source: [a] U.S. Department of Commerce, Bureau of the Census, 1999b; [b] U.S. Department of Commerce, Bureau of the Census, 1999d; [c] U.S. Department of Commerce, Bureau of the Census, 1997a; [d] Population Reference Bureau, 1993, Table 7; [e] Population Reference Bureau, 1993, Table 10; [f] IWPR, 1995a; [g] Population Reference Bureau, 1993, Table 6; [h] Population Reference Bureau, 1993, Table 3; U.S. Department of Justice, Bureau of Justice Statistics, 1999, Tables 3 and 7.
Compiled by the Institute for Women's Policy Research.

female population and can be used to provide insight on the topics covered in this report. For example, compared with the United States as a whole, New Hampshire has a slightly lower ratio of women to men, a much smaller proportion of African American, Hispanic, Asian American, Native American, and foreign-born women, and a lower proportion of women living in urban areas. Demographic factors also have implications for the location of economic activity, the types of jobs available, market growth, and the types of public services needed.

New Hampshire has the tenth smallest population among all the states in the nation. There were 602,079 women of all ages in New Hampshire in 1998 (see Appendix Table 1). Between 1990 and 1998, the population of New Hampshire grew by 6.8 percent, less than the growth of the nation as a whole (8.7 percent; U.S. Department of Commerce, Bureau of the Census, 1999). However, New Hampshire's population growth rate is the highest among the states in the New England region and far exceeds the average regional growth rate of 1.7 percent. White women are a much larger share of the female population in New Hampshire than they are in the United States as a whole, with minorities making up only 2.7 percent of women in the state (compared with 27 percent for the nation as a whole).

The proportions of single, divorced, and widowed women in New Hampshire are all slightly lower than those of the country as a whole, while the proportion of married women is slightly higher (58.6 percent compared with 55.6 percent in the United States; see Appendix Table 1). New Hampshire's distribution of family types diverges slightly from that in the nation as a whole (see Appendix Table 1). Consistent with the data on marital status, the proportion of single-person households and female-headed families in New Hampshire is smaller than in the nation as a whole, while the proportion of married-couple families in New Hampshire is larger than nationally. Female-headed families with children under age 18 constitute 14.1 percent of all families with children in New Hampshire, a smaller proportion than the 19.5 percent nationally.

New Hampshire's proportion of women living in metropolitan areas is substantially lower than in the nation as a whole (72.6 percent compared with 83.1 percent of women in the United States). The percent of New Hampshire's prison population that is female is also lower than the national average (see Appendix Table 1). Finally, there is a large difference between New Hampshire and the nation as a whole in terms of the proportion of the population that is foreign-born. New Hampshire has a much smaller foreign-born female population than does the United States as a whole (4 percent compared with 7.9 percent).

Appendix II
Methodology, Terms and Sources for Chart I (the Composite Indices)

Composite Political Participation Index

This composite index reflects four areas of political participation: voter registration; voter turnout; women in elective office, including state legislatures, statewide elective office and positions in the U.S. Congress; and institutional resources available for women (such as a commission for women or a legislative caucus).

To construct this composite index, each of the component indicators was standardized to remove the effects of different units of measurement for each state's score on the resulting composite index. Each component was standardized by subtracting the mean value (for all 50 states) from the observed value and dividing by the standard deviation. The standardized scores were then given different weights. Voter registration and voter turnout were each given a weight of 1.0. The component indicator for women in elected office is itself a composite reflecting different levels of office-holding and was given a weight of 4.0. The last component indicator, women's institutional resources, is also a composite of scores indicating the presence or absence of each of two resources: a commission for women and a women's legislative caucus. It received a weight of 1.0. The resulting weighted, standardized values for each of the four component indicators were summed for each state to create a composite score. The states were then ranked from the highest to the lowest score.

To grade the states on this composite index, values for each of the components were set at desired levels to produce an "ideal score." Women's voter registration and voter turnout were each set at the value of the highest state for these components; each component of the composite index for women in elected office was set as if 50 percent of elected officials were women; and scores for institutional resources for women assumed the ideal state had both a commission for women and a women's legislative caucus in each house of the state legislature. Because states can have a negative score on this composite index, values for each of the components were set at low levels as well: voter registration and turnout were each set at the value of the lowest state; each component of the composite index of women in elected office was set at 0.0, and women's institutional resources were each set at 0.0. Each state's score was then compared with the difference between the ideal score and the lowest possible score, to get a percentage value representing the state's performance relative to the ideal performance. The resulting percentage determined the state's grade.

Women's Voter Registration: This component indicator is the average percent (for the presidential and congressional elections of 1992 and 1996) of all women aged 18 and older (in the civilian noninstitutionalized population) who reported registering. Source: U.S. Department of Commerce, Bureau of the Census (1993, 1998b) based on the Current Population Survey.

Women's Voter Turnout: This component indicator is the average percent (for the presidential elections of 1992 and 1996) of all women aged 18 and older (in the civilian noninstitutionalized population) who reported voting. Source: U.S. Department of Commerce, Bureau of the Census (1993, 1998b) based on the Current Population Survey.

Women in Elected Office: This composite indicator is based on a methodology developed by the Center for Policy Alternatives (1995). It has four components and reflects office-holding at the state and national levels as of January 2000. For each state, the proportion of office-holders who are women was computed for four levels: state representatives; state senators; statewide elected executive officials and U.S. Representatives; and U.S. Senators and governors. The percents were then converted to scores that ranged from 0 to 1 by dividing the observed value for each state by the highest value for all states. The scores were then weighted according to the degree of political influence of the

position: state representatives were given a weight of 1.0, state senators were given a weight of 1.25, statewide executive elected officials (except governors) and U.S. Representatives were each given a weight of 1.5, and U.S. Senators and state governors were each given a weight of 1.75. The resulting weighted scores for the four components were added to yield the total score on this composite for each state. The highest score of any state for this composite office-holding indicator is 7.62. These scores were then used to rank the states on the indicator for women in elected office. Source: Data were compiled by IWPR from several sources including the Center for American Women and Politics (1999a, 1999c, 1999d, and 1999e); Council of State Governments, 1998.

Women's Institutional Resources: This indicator measures the number of institutional resources for women available in the state from a maximum of two, including a commission for women (established by legislation or executive order) and a legislative caucus for women (organized by women legislators in either or both houses of the state legislature). States receive 1.0 point for each institutional resource present in their state, although they can receive partial credit if a bipartisan legislative caucus does not exist in both houses. States receive a score of 0.25 if informal or partisan meetings are held by women legislators in either house, 0.5 if a formal legislative caucus exists in one house but not the other, and 1.0 if a formal legislative caucus is present in both houses or the legislature is unicameral. Source: National Association of Commissions on Women, 1997, updated in 1999 by IWPR, and Center for American Women and Politics, 1998.

Composite Employment and Earnings Index

This composite index consists of four component indicators: median annual earnings for women, the ratio of the earnings of women to the earnings of men, women's labor force participation, and the percent of employed women in managerial and professional specialty occupations.

To construct this composite index, each of the four component indicators was standardized; that is, for each of the four indicators, the observed value for the state was divided by the comparable value for the entire United States. The resulting values were summed for each state to create a composite score. Each of the four component indicators has equal weight in the composite. The states were ranked from the highest to the lowest score.

To grade the states on this composite index, values for each of the components were set at desired levels to produce an "ideal score." Women's earnings were set at the median annual earnings for men in the United States as a whole; the wage gap was set at 100 percent, as if women earn as much as men; women's labor force participation was set at the national number for men; and women in managerial and professional positions was set at the highest score for all states. Each state's score was then compared with the ideal score, to get a percentage value representing the state's performance relative to the ideal performance. The resulting percentage determined the state's grade.

Women's Median Annual Earnings: Median yearly earnings (in 1998 dollars) of noninstitutionalized women aged 16 and older who worked full-time, year-round (more than 49 weeks during the year and more than 34 hours per week) in 1996, 1997 and 1998. Earnings were converted to constant dollars using the Consumer Price Index and the median was selected from the merged data file for all three years. Three years of data were used in order to ensure a sufficiently large sample for each state. The sample size for women ranges from 511 in Vermont to 4,805 in California; for men, the sample size ranges from 641 in the District of Columbia to 7,594 in California. For New Hampshire, the sample size is 529 for women and 800 for men. These earnings data have not been adjusted for cost-of-living differences between the states because the federal government does not produce an index of such differences. Source: Economic Policy Institute calculations of the 1997-99 Annual Demographic Files (March) from the Current Population Survey, for the 1996-98 calendar years; Economic Policy Institute, 2000.

Ratio of Women's to Men's Earnings: Median yearly earnings (in 1998 dollars) of noninstitutionalized women aged 16 and older who worked full-time, year-round (more than 49 weeks during the

year and more than 34 hours per week) in 1996-98 divided by the median yearly earnings (in 1998 dollars) of noninstitutionalized men aged 16 and older who worked full-time, year-round (more than 49 weeks during the year and more than 34 hours per week) in 1996-98. See the description of women's median annual earnings, above, for a more detailed description of the methodology and for sample sizes. Source: Economic Policy Institute calculations of the 1997-99 Annual Demographic Files (March) from the Current Population Survey; Economic Policy Institute, 2000.

Women's Labor Force Participation (proportion of the adult female population in the labor force): Percent of civilian noninstitutionalized women aged 16 and older who were employed or looking for work (in 1998). This includes those employed full-time, part-time voluntarily or part-time involuntarily, and those who are unemployed. Source: U.S. Department of Labor, Bureau of Labor Statistics, 1999c (based on the Current Population Survey).

Women in Managerial and Professional Occupations: Percent of civilian noninstitutionalized women aged 16 and older who were employed in executive, administrative, managerial or professional specialty occupations (in 1998). Source: U.S. Department of Labor, Bureau of Labor Statistics, 1999b (based on the Current Population Survey).

Composite Economic Autonomy Index

This composite index reflects four aspects of women's economic well-being: access to health insurance, educational attainment, business ownership, and the percent of women above the poverty level.

To construct this composite index, each of the four component indicators was standardized; that is, for each indicator, the observed value for the state was divided by the comparable value for the United States as a whole. The resulting values were summed for each state to create a composite score. Each of the four components has equal weight in the composite. The states were ranked from the highest to the lowest score.

To grade the states on this composite index, values for each of the components were set at desired levels to produce an "ideal score." Women with health insurance was set at the highest value for all states; women with higher education was set at the national value for men; women-owned business was set as if 50 percent of businesses were owned by women; and women in poverty was set at the national value for men. Each state's score was then compared with the ideal score, to get a percentage value representing the state's performance relative to the ideal performance. The resulting percentage determined the state's grade.

Percent with Health Insurance: Percent of civilian noninstitutionalized women between ages 18 and 65 who are insured. The state-by-state percents are based on the averages of three years of pooled data from the 1997-99 Current Population Survey from the Bureau of the Census, for data years 1996-98. Source: Employee Benefit Research Institute, 1999.

Educational Attainment: In 1989, the percent of women aged 25 and older with four or more years of college. Source: Population Reference Bureau, 1993, based on the Public Use Microdata Sample of the 1990 Census of Population.

Women's Business Ownership: In 1992, the percent of all firms (legal entities engaged in economic activity during any part of 1992 that filed an IRS Form 1040, Schedule C; 1065; or 1120S) owned by women. This indicator excludes Type C corporations. The Census Bureau estimates that there were approximately 517,000 Type C corporations in 1992. The Bureau of the Census was required to provide data on women's ownership of Type C corporations by the Women's Business Ownership Act of 1988. The Bureau's methodology for doing so differs from the methods used for other forms of business ownership, which include individual proprietorships and self-employment, partnerships and Subchapter S corporations (those with fewer than 35 shareholders who can elect to be taxed as individuals). Type C corporations are non-Subchapter S corporations. The Bureau of the Census determines the sex of business owners by matching the social security numbers of individuals who file business tax returns (Form 1040, Schedule C; 1065; or 1120S) with Social Security Administration records

providing the sex codes indicated by individuals on their original applications for social security numbers. For partnerships and corporations, a business is classified as women-owned based on the sex of the majority of the owners. Data for Type C corporations do not come from tax returns and because of the limitations of the sample are considered less reliable. Source: U.S. Department of Commerce, 1996a, based on the 1992 Economic Census. (Please note that results of the 1997 Economic Census were not available at the time of production of this report.)

Percent of Women Above Poverty: In 1996-98, the percent of women living above the official poverty threshold, which varies by family size and composition. The average percent of women above the poverty level for the three years is used; three years of data ensure a sufficiently large sample for each state. In 1997, the poverty level for a family of four was $16,700. Source: Economic Policy Institute calculations of the 1997-99 Annual Demographic Files (March) from the Current Population Survey for the calendar years 1996-98; Economic Policy Institute, 2000.

Composite Reproductive Rights Index

This composite index reflects a variety of indicators of women's reproductive rights. These include access to abortion services without mandatory parental consent laws for minors; access to abortion services without a waiting period; public funding for abortions under any circumstances if a woman is eligible; percent of women living in counties with at least one abortion provider; whether the governor or state legislature is pro-choice; existence of state laws requiring health insurers to provide coverage of contraceptives; policy that mandates that insurers cover infertility treatments; whether second-parent adoption is legal for gay/lesbian couples; and mandatory sex education.

To construct this composite index, each component indicator was rated on a scale of 0 to 1 and assigned a weight. The notification and waiting-period indicators were each given a weight of 0.5. The indicators of public funding for abortions, pro-choice government, women living in counties with an abortion provider, and contraceptive coverage were each given a weight of 1.0. The infertility coverage law and gay/lesbian adoption law were each given a weight of 0.5. Finally, states were given 1.0 point if they mandate sex education for students. The weighted scores for each component indicator were summed to arrive at the value of the composite index score for each state. The states were ranked from the highest to the lowest score.

To grade the states on this composite index, values for each of the components were set at desired levels to produce an "ideal score." An "ideal state" was assumed to have no notification or waiting period policies; public funding for abortion; pro-choice government; 100 percent of women living in counties with an abortion provider; insurance mandates for contraceptive coverage and infertility coverage; maximum legal guarantees of second-parent adoption; and mandatory sex education for students. Each state's score was then compared with the resulting ideal score, to get a percentage value representing the state's performance relative to the ideal performance. The resulting percentage determined the state's grade.

Mandatory Consent: States received a score of 1.0 if they allow minors access to abortion without parental consent or notification. Mandatory consent laws require that minors gain the consent of one or both parents before a physician can perform the procedure, while notification laws require they notify one or both parents of the decision to have an abortion. Source: NARAL and NARAL Foundation, 2000.

Waiting Period: States received a score of 1.0 if they allow a woman to have an abortion without a waiting period. Such legislation mandates that a physician cannot perform an abortion until a certain number of hours after notifying the woman of her options in dealing with a pregnancy. Source: NARAL and NARAL Foundation, 2000.

Restrictions on Public Funding: If a state provides public funding for abortions under most circumstances for women who meet income eligibility standards, it received a score of 1.0. Source: NARAL and NARAL Foundation, 2000.

Percent of Women Living in Counties with at Least One Abortion Provider: For the indicator of the percent of women in counties with abortion providers, states were given a scaled score ranging from 0 to 1, with states with 100 percent of women living in counties with abortion providers receiving a 1. Source: Henshaw, 1998.

Pro-Choice Governor or Legislature: This indicator is based on NARAL's asssessment of whether governors and legislatures would support a ban or restrictions on abortion. Governors and legislatures who would support restrictions on abortion rights are considered anti-choice, and those who would oppose them are considered pro-choice. Each state received 0.33 points per pro-choice governmental body--governor, upper house and lower house--up to a maximum of 1.0 point. Those governors and legislatures with mixed assessments received half credit. Source: NARAL and NARAL Foundation, 1999.

Contraceptive Coverage Laws: Whether a state has a law or policy requiring that health insurers who provide coverage for prescription drugs extend coverage for FDA-approved contraceptives (e.g., drugs and devices) and related medical services, including exams and insertion/removal treatments. States received a score of 1.0 if they mandate full contraceptive coverage. They received a score of 0.5 if they mandate partial coverage, which may include mandating that insurance companies offer at least one insurance package covering some or all birth control prescription methods or requiring insurers with coverage for prescription drugs to cover oral contraceptives. Source: NARAL and NARAL Foundation, 2000.

Coverage of Infertility Treatments: States mandating that insurance companies provide coverage of infertility treatments received a score of 1.0, while states mandating that insurance companies offer policyholders at least one package with coverage of infertility treatments received a score of 0.5. Source: Stauffer and Plaza, 1999.

Same-Sex Couples and Adoption: Whether a state allows gays and lesbians the option of second-parent adoption, which occurs when a nonbiological parent in a couple adopts the child of his or her partner. At the state level, courts and/or legislatures have upheld or limited the right to second-parent adoption among gay and lesbian couples. States were given 1.0 point if the state supreme court has prohibited discrimination against these couples in adoption, 0.75 if an appellate or high court has, 0.5 if a lower court has approved a petition for second parent adoption, 0.25 if a state has no official position on the subject, and no points if the state has banned second parent adoption. Source: Hawes, 1999.

Mandatory Sex Education: States received a score of 1.0 if they require middle, junior or high schools to provide sex education classes. Source: NARAL and NARAL Foundation, 2000.

Composite Health and Well-Being Index

This composite index includes nine measures of women's physical and mental health: mortality from heart disease, mortality from breast cancer, mortality from lung cancer, incidence of diabetes, incidence of chlamydia, incidence of AIDS, prevalence of poor mental health, mortality from suicide, and mean days of activity limitations. To construct the composite index, each of the component indicators was converted to scores ranging from 0 to 1 by dividing the observed value for each state by the highest value for all states. Each score was then subtracted from 1 so that high scores represent lower levels of mortality, poor health, or disease. Scores were then given different weights. Mortality from heart disease was given a weight of 1.0. Breast and lung cancer were each given a weight of 0.5. Incidence of diabetes, chlamydia, and AIDS were each given a weight of 0.5. Mean days of poor mental health and women's mortality from suicide were given a weight of 0.5. Activity limitations were given a weight of 1.0. The resulting values for each of the component indicators were summed for each state to create a composite score. The states were then ranked from the highest to the lowest score.

To grade the states on this composite index, values for each of the components were set at desired levels to produce an "ideal score." Mortality from heart disease, breast cancer and lung cancer were set according to national goals for the year 2010, as determined by the U.S. Department of Health and

Human Services under the Healthy People 2010 program (U.S. Department of Health and Human Services, Public Health Service, 2000). For heart disease and breast cancer, this entailed a 20 percent decrease from the national number. For lung cancer, it entailed a 22 percent decrease from the national number. For incidence of diabetes, chlamydia and AIDS and mortality from suicide, Healthy People 2010 goals are to achieve levels that are "better than the best," and thus the ideal score was set at the lowest rate for each indicator among all states. In the absence of national objectives, mean days of poor mental health and mean days of activity limitations were also set at the lowest level among all states. Each state's score was then compared with the ideal score, to get a percentage value representing the state's performance relative to the ideal performance. The resulting percentage determined the state's grade.

Mortality from Heart Disease: Average annual mortality from heart disease among all women per 100,000 population (in 1995). Data are age-adjusted to the 1970 total U.S. population. Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 1998.

Mortality from Breast Cancer: Average mortality among women from breast cancer per 100,000 population (in 1991-95). Data are age-adjusted to the 1970 U.S. standard population. Source: American Cancer Society, 1999.

Mortality from Lung Cancer: Average mortality among women from lung cancer per 100,000 population (in 1991-95). Data are age-adjusted to the 1970 U.S. standard population. Source: American Cancer Society, 1999.

Percent of Women Who Have Ever Been Told They Have Diabetes: As self-reported by female respondents in the Behavioral Risk Factor Surveillance System (BRFSS) survey in 1996. The Centers for Disease Control and Prevention conduct BRFSS in conjunction with the states among men and women at least 18 years of age, and all data are age-adjusted to the 1970 U.S. standard population. Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 1999a.

Incidence of Chlamydia: Average rate of chlamydia among women per 100,000 population (1993-97). Source: Centers for Disease Control, Division of STD Prevention, 1998.

Incidence of AIDS: Average incidence of AIDS-indicating diseases among women aged 13 years and older per 100,000 population (July 1998-June 1999). Source: U.S. Department of Health and Human Services, Public Health Service, 1999.

Poor Mental Health: Mean number of days in the past 30 days on which mental health was not good, as self-reported by female respondents in the BRFSS survey in 1996. The Centers for Disease Control and Prevention conduct BRFSS in conjunction with the states among men and women at least 18 years of age, and all data are age-adjusted to the 1970 U.S. standard population. Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 1999a.

Mortality from Suicide: Average annual mortality from suicide among all women per 100,000 population (in 1995-97). Data are age-adjusted to the 1970 total U.S. population. Source: Centers for Disease Control, National Center for Injury Prevention and Control, 2000b.

Mean Days of Activity Limitations: Mean number of days in the past 30 days on which activities were limited due to health status, as self-reported by female respondents in the BRFSS survey in 1996. The Centers for Disease Control and Prevention conduct BRFSS in conjunction with the states among men and women at least 18 years of age, and all data are age-adjusted to the 1970 U.S. standard population. Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 1999a.

Appendix III
Sources for Chart II
(Women's Resources and Rights Checklist)

Violence Against Women

Separate Offense: States are given a "yes" if they classify domestic violence as a separate offense from normal assault and battery. A separate offense allows enhanced penalties for repeat offenders and helps ensure equal treatment for victims of domestic violence. Source: Miller, 1999a.

Domestic Violence Training: Whether the state has adopted a legislative statute requiring new police recruits to undergo training about domestic violence. Source: Miller, 1999a.

State Funding for Domestic Violence and Stalking Programs: Amount of federal and state money allocated to a state's domestic violence and stalking programs per person in the state. Funding estimates come from a poll by the Centers for Disease Control and Prevention (CDC) of state and federal agencies administering and distributing the funds. The CDC notes that these numbers may not include all funding because of difficulties with the survey process; specifically, because violence against women and stalking funds are distributed to and by many different state agencies, the survey may not cover them all, and as such it may leave out some funding. Moreover, because data on incidence of domestic violence and stalking are unreliable, it is difficult to gauge how much funding states need to address the problem. The information is provided to indicate which states are above or below the national average. Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 1997.

Stalking Offense Status: Whether a state classifies a first offense for stalking as a felony. Source: Miller, 1999b.

Sexual Assault Training: Whether a state has adopted a legislative requirement mandating sexual assault training for police and prosecutors. Source: Miller, 1999b.

Child Support

Single-Mother Households Receiving Child Support or Alimony: A single-mother household is defined as a family headed by a nonmarried woman with one or more of her own children (by birth, marriage or adoption). Such a family is counted as receiving child support or alimony if it received full or partial payment of child support or alimony during the past year (Annie E. Casey Foundation, 1999). Figures are based on an average of data from the Current Population Survey for 1994-98. Source: Annie E. Casey Foundation, 1999.

Cases with Collection: A case is counted as having a collection if as little as one cent is collected during the year. These figures include data on child support for all family types. Source: U.S. Department of Health and Human Services, Administration for Children and Families, 1998.

Welfare

Child Exclusion/Family Caps: Whether a state extends TANF benefits to children born or conceived while a mother receives welfare. Many states have adopted a prohibition on these benefits, sometimes called a "family cap." Source: U.S. Department of Health and Human Services, Administration for Children and Families, 1999c.

Time Limits: States may not use federal funds to assist families with an adult who has received federally funded assistance for 60 months or more. They can set lower time limits, however. States that allow welfare recipients to receive benefits for the maximum allowable time or more are indicated by "yes." Source: U.S. Department of Health and Human Services, Administration for Children and Families, 1999c.

Work Requirements: What constitutes work activities is a contentious issue at both the state and federal level. State policies around these issues continue to evolve and are subject to caseworker discretion.

This report uses each state's self-reported policy to identify which states require immediate work activities and which allow recipients time before they lose benefits. Those states that allow at least 24 months are indicated as "yes." To receive the full amount of their block grants, states must demonstrate that a specific portion of their TANF caseload is participating in activities that meet the federal definition of work. In fiscal year 2000, states must show that 40 percent of their TANF caseload is working. The required proportion grows each year until 2002, when states must demonstrate that 50 percent of their TANF caseload is engaged in work. PRWORA also restricts the amount of a caseload that may be engaged in basic education or vocational training to be counted in the state's work participation figures and allows job training to count as work only for a limited period of time for any individual. Source: U.S. Department of Health and Human Services, Administration for Children and Families, 1999c.

Transitional Child Care: Whether a state extends child care to families moving off welfare beyond a minimum of twelve months. Source: U.S. Department of Health and Human Services, Administration for Children and Families, 1999c.

Family Violence Provisions in TANF Plans: States can provide exemptions to time limits and other policies to victims of domestic violence under the Family Violence Option. This measure indicates whether a state has opted for the optional certification or adopted other language providing for victims of domestic violence. Source: U.S. Department of Health and Human Services, Administration for Children and Families, 1999c.

Earnings Disregards: States are given leeway in determining how much of a low-income worker's earnings to disregard in determining eligibility for welfare recipiency. Six states have not changed their earnings disregards policy from the test that existed under the former welfare program, AFDC, which disregarded $90 for work expenses and $30 plus one-third of remaining earnings for four months; $120 for the next 8 months; and $90 after a full year. Forty-four states and the District of Columbia have changed their policies. Those that disregard at least 50 percent of earnings are indicated by a "yes." Source: U.S. Department of Health and Human Services, Administration for Children and Families, 1999c.

Size of TANF Benefit: Average monthly amount received by TANF recipient families in the state. This number is not adjusted for family size differences among the states. The average number of individuals in a TANF family in the United States as a whole was 2.8, with two of the family members children. While two in five families had only one child, one in ten had more than three children. Source: U.S. Department of Health and Human Services, Administration for Children and Families, 1999b.

Employment/Unemployment Benefits

Minimum Wage: States receive a "yes" if their state minimum wage rate as of March 2000 exceeded the federal rate. According to the Fair Labor Standards Act, the state minimum wage is controlling if it is higher than the federal minimum wage. A federal minimum wage increase was signed into law on August 20, 1996 and raised the federal standard to $5.15 per hour on September 1, 1997. Source: U.S Department of Labor, 1999.

Temporary Disability Insurance (TDI): In the five states with mandated Temporary Disability Insurance programs (California, Hawaii, New Jersey, New York and Rhode Island), employees and/or their employers pay a small percentage of the employee's salary into an insurance fund and, in return, employees are provided with partial wage replacement if they become ill or disabled. Source: Hartmann, Yoon, Spalter-Roth and Shaw, 1995.

Access to Unemployment Insurance (UI) for Low-Wage Workers: In order to receive UI, potential recipients must meet several eligibility requirements. Two of these are high quarter earnings and base period earnings requirements. The "base period" is a 12-month period preceding the start of a spell of unemployment. This, however, excludes the current calendar quarter and often the previous full calendar quarter (this has serious consequences for low-wage and contingent workers who need to count more recent earnings to qualify). The base period criterion states that the individual must have earned a minimum amount during the base period. The high quarter earnings criterion requires that

individuals earn a total reaching a specified threshold amount in one of the quarters within the base period. IWPR research has shown that women are less likely to meet the two earnings requirements than men are and thus are more likely to be disqualified from receipt of UI benefits. IWPR found that nearly 14 percent of unemployed women workers were disqualified from receiving UI by the two earnings criteria. This rate is more than twice that for unemployed men (Yoon, Spalter-Roth and Baldwin, 1995). States typically set eligibility standards for UI and can enact policies that are more or less inclusive and more or less generous to claimants. For example, some states have implemented a "movable" base period, allowing flexibility to the advantage of the claimant. Source: U.S. Department of Labor, Employment and Training Administration, Unemployment Insurance Service, 1999.

Since states have the power to decide who receives unemployment insurance benefits, some states set high requirements, thereby excluding many low earners. A state was scored "yes" if it was relatively generous to low earners, such that base period wages required were less than or equal to $1,300 and high quarter wages required were less than or equal to $800. If the base period wages required were more than $2,000 or if high quarter wages required were more than $1,000, the state was scored "no"; "sometimes" was defined as base period and high quarter wages which fell between the "yes" and "no" ranges.

Access to UI for Part-Time Workers: Only eight states and the District of Columbia allow unemployed workers seeking a part-time position to qualify for UI. Source: American Federation of State, County and Municipal Employees, 1999.

Access to UI for "Good Cause Quits": Eleven states offer UI coverage for voluntary quits caused by a variety of circumstances, such as moving with a spouse, harassment on the job, or other situations. The specifics of which circumstances are considered "good cause" differ by state. Source: American Federation of State, County and Municipal Employees, 1999.

Use of UI for Paid Family Leave: Recent initiatives in several states have advanced the idea of using UI to provide benefits during periods of family leave. At the federal level, the Department of Labor now allows states to provide partial wage replacement under the unemployment compensation program on a voluntary, experimental basis to parents who take leave or otherwise leave employment following the birth or adoption of a child. The new regulations were issued in June of 2000 and took effect on August 14, 2000. To implement them, state legislatures must approve of plans to use UI in this fashion. Source: National Partnership for Women and Families, 2000.

Pay Equity: Pay equity, or comparable worth, remedies are designed to raise the wages of jobs that are undervalued at least partly because of the gender or race of the workers who hold those jobs. States that have these policies within their civil service system are marked as "yes." Source: National Committee on Pay Equity, 1997.

Sexual Orientation and Gender Identity

Civil Rights Legislation: Whether a state has passed a statute extending anti-discrimination laws to apply to discrimination on the basis of sexual orientation or gender identity. Source: Hawes, 1999.

Same-Sex Marriage: Whether a state has avoided adopting a policy—statute, executive order, or other regulation—prohibiting same-sex marriage. Source: Hawes, 1999.

Hate Crimes Legislation: Whether a state has established enhanced penalties for crimes perpetrated against victims due to their sexual orientation or gender identity. Source: Hawes, 1999.

Reproductive Rights

For information on sources concerning these indicators, please see the section describing the Composite Reproductive Rights Index in Appendix II.

Institutional Resources

For information on sources concerning institutional resources, please see the section on institutional resources within the description of the Composite Political Participation Index in Appendix II.

Appendix IV, Part A: State-by-State Rankings on the Composite Indices and Their Components—Political Participation

	Composite Index			Women in Elected Office Composite Index		Percent of Women Registered to Vote, 1992 and 1996		Percent of Women Who Voted, 1992 and 1996		Number of Institutional Resources Available to Women in the State	
State	**Score**	**Rank**	**Grade**	**Score**	**Rank**	**Percent**	**Rank**	**Percent**	**Rank**	**Score**	**Rank**
Alabama	-2.51	41	D	0.93	44	76.7%	10	61.5%	29	1.5	20
Alaska	1.93	22	C	1.99	15	76.9%	9	65.6%	16	0	44
Arizona	5.15	7	C+	3.11	4	66.5%	38	58.3%	36	0	44
Arkansas	-1.97	39	D	1.79	20	66.1%	39	55.1%	43	0.5	40
California	8.38	3	B	3.60	2	58.5%	50	52.0%	49	2	1
Colorado	2.83	16	C+	2.15	14	74.7%	16	65.6%	16	0.25	41
Connecticut	6.86	5	B-	2.60	6	74.8%	15	66.2%	13	1.25	21
Delaware	2.74	17	C+	2.24	11	68.2%	34	62.0%	28	1	31
District of Columbia	n/a	n/a	n/a	n/a	n/a	77.0%	n/a	66.4%	n/a	1	n/a
Florida	-1.65	37	D	1.52	33	64.2%	47	54.7%	44	2	1
Georgia	-3.79	43	D-	1.16	40	65.1%	43	52.7%	47	2	1
Hawaii	2.51	21	C	2.58	7	58.7%	49	50.1%	50	2	1
Idaho	1.53	23	C	1.69	25	72.9%	22	66.0%	15	1.25	21
Illinois	0.83	29	C	1.55	32	71.4%	27	61.3%	30	2	1
Indiana	1.32	24	C	1.72	22	69.2%	31	60.8%	32	2	1
Iowa	1.09	26	C	1.48	35	76.6%	11	66.5%	10	1.25	21
Kansas	2.94	14	C+	2.20	12	73.8%	21	67.7%	9	0	44
Kentucky	-6.95	50	F	0.71	49	67.3%	35	55.2%	41	1	31
Louisiana	3.22	13	C+	1.72	22	75.5%	13	66.2%	13	2	1
Maine	12.39	1	B	3.52	3	84.4%	2	70.8%	3	0	44
Maryland	6.26	6	B-	2.56	8	69.9%	29	62.4%	24	2	1
Massachusetts	1.05	27	C	1.58	28	70.9%	28	62.2%	26	2	1
Michigan	0.90	28	C	1.60	27	74.6%	17	63.6%	23	1.25	21
Minnesota	6.95	4	B	2.18	13	83.7%	3	72.1%	2	1.25	21
Mississippi	-5.58	47	D-	0.72	48	76.2%	12	61.0%	31	0.25	41
Missouri	3.74	10	C+	1.74	21	78.0%	7	66.3%	12	2	1
Montana	2.58	20	C+	1.85	19	78.1%	6	72.5%	1	0	44
Nebraska	1.18	25	C	1.57	30	74.3%	19	64.4%	21	1.5	16
Nevada	3.59	11	C+	2.92	5	64.7%	44	56.9%	39	0	44
New Hampshire	4.80	8	C+	2.50	9	71.9%	25	62.1%	27	1	31
New Jersey	-0.94	34	D+	1.71	23	66.8%	37	58.6%	35	1	31
New Mexico	0.69	30	C-	1.90	18	65.9%	41	58.8%	34	1.5	16
New York	-2.54	42	D	1.37	38	63.1%	48	55.2%	41	2	1
North Carolina	-2.28	40	D	1.16	40	69.2%	31	57.8%	38	2	1
North Dakota	3.50	12	C+	1.45	36	91.2%	1	68.5%	6	1.25	21
Ohio	-1.54	36	D	1.40	37	69.8%	30	62.4%	24	1	31
Oklahoma	-1.67	38	D	1.10	42	74.5%	18	64.6%	19	1.25	21
Oregon	2.61	18	C+	1.67	26	77.1%	8	68.8%	5	1.25	21
Pennsylvania	-6.14	48	F	0.75	47	64.6%	45	56.8%	40	1.5	16
Rhode Island	-0.27	33	D+	1.22	39	72.6%	23	64.5%	20	2	1
South Carolina	-5.26	45	D-	0.62	50	68.8%	33	57.9%	37	2	1
South Dakota	0.55	31	C-	1.58	28	79.4%	5	68.3%	7	0	44
Tennessee	-5.53	46	D-	0.99	43	65.8%	42	53.8%	46	1.25	21
Texas	-1.15	35	D+	1.95	17	64.5%	46	52.1%	48	1	31
Utah	0.36	32	C-	1.57	30	73.9%	20	64.2%	22	1	31
Vermont	4.00	9	C+	1.99	15	75.2%	14	66.5%	10	1.5	16
Virginia	-3.83	44	D-	0.88	45	67.0%	36	59.6%	33	2	1
Washington	10.77	2	B	3.67	1	72.6%	23	65.5%	18	0.25	41
West Virginia	-6.88	49	F	0.78	46	66.1%	39	54.5%	45	1	31
Wisconsin	2.86	15	C+	1.52	33	82.0%	4	70.7%	4	1.25	21
Wyoming	2.60	19	C+	2.30	10	71.9%	25	68.1%	8	1	31
United States				**0.00**		**68.3%**		**58.9%**		**1.25(median)**	

Appendix IV, Part A: State-by-State Rankings on the Composite Indices and Their Components—Employment and Earnings

	Composite Score			Median Annual Earnings Full-Time, Year-Round for Employed Women		Earnings Ratio between Full-Time, Year-Round Employed Women and Men		Percent of Women in the Labor Force		Percent of Employed Women, Managerial or Professional Occupations	
State	**Score**	**Rank**	**Grade**	**Dollars**	**Rank**	**Percent**	**Rank**	**Percent**	**Rank**	**Percent**	**Rank**
Alabama	3.64	46	D-	$22,084	38	68.8%	41	56.9%	42	27.8%	41
Alaska	4.42	3	B	$30,119	3	74.1%	17	67.8%	5	34.3%	10
Arizona	3.88	26	C	$23,277	30	79.0%	5	56.5%	45	29.7%	26
Arkansas	3.53	50	F	$19,100	51	72.5%	23	56.9%	42	26.4%	48
California	4.22	9	B	$28,001	9	78.7%	6	58.1%	39	33.7%	12
Colorado	4.38	4	B	$26,422	10	74.5%	15	68.1%	3	37.4%	3
Connecticut	4.37	5	B	$30,447	2	75.2%	12	61.5%	25	35.2%	6
Delaware	3.97	19	C+	$25,206	19	71.3%	30	62.3%	23	30.4%	20
District of Columbia	4.87	1	B+	$30,495	1	85.7%	1	61.2%	29	46.3%	1
Florida	3.83	33	C-	$23,355	26	76.7%	8	55.1%	49	29.8%	24
Georgia	3.89	25	C	$23,410	24	72.2%	25	63.1%	19	29.3%	33
Hawaii	4.03	16	C+	$25,246	18	83.8%	2	63.2%	17	26.2%	49
Idaho	3.77	37	D	$22,049	40	74.8%	14	63.3%	15	25.9%	51
Illinois	3.99	17	C+	$25,874	12	68.7%	42	61.5%	25	31.5%	17
Indiana	3.66	44	D-	$22,082	39	66.7%	48	61.5%	25	26.9%	44
Iowa	3.95	21	C+	$23,226	31	76.4%	9	65.7%	10	28.2%	39
Kansas	3.92	22	C	$23,403	25	70.2%	34	65.5%	11	29.7%	26
Kentucky	3.76	38	D	$22,407	33	72.7%	21	56.3%	47	29.6%	28
Louisiana	3.57	49	F	$21,109	44	64.8%	50	56.6%	44	28.6%	38
Maine	3.88	26	C	$22,177	37	72.7%	21	61.5%	25	31.0%	19
Maryland	4.63	2	B+	$30,077	4	79.8%	3	64.0%	12	40.4%	2
Massachusetts	4.35	6	B	$28,367	6	77.6%	7	63.4%	14	35.1%	7
Michigan	3.84	30	C-	$25,372	16	67.4%	47	59.8%	35	28.9%	36
Minnesota	4.32	7	B	$26,241	11	72.4%	24	70.1%	1	35.3%	5
Mississippi	3.61	47	F	$20,356	46	71.5%	27	54.6%	50	29.1%	35
Missouri	4.14	11	B-	$24,421	21	75.4%	11	62.7%	20	34.7%	8
Montana	3.74	42	D	$20,327	48	68.9%	40	63.9%	13	29.4%	32
Nebraska	3.81	35	C-	$21,651	41	71.4%	29	66.6%	7	27.5%	43
Nevada	3.85	29	C-	$24,124	23	74.1%	17	62.4%	22	26.5%	47
New Hampshire	4.08	14	C+	$25,258	17	70.2%	34	66.1%	8	32.1%	15
New Jersey	4.11	12	B-	$28,495	5	70.0%	37	59.1%	38	32.8%	13
New Mexico	3.84	30	C-	$21,376	43	70.2%	34	57.6%	40	33.8%	11
New York	4.16	10	B-	$28,126	7	79.3%	4	55.8%	48	32.7%	14
North Carolina	3.84	30	C-	$22,761	32	75.2%	12	59.9%	34	28.8%	37
North Dakota	3.68	43	D-	$19,540	50	69.6%	39	67.6%	6	26.1%	50
Ohio	3.91	23	C	$25,094	20	70.7%	32	59.8%	35	30.1%	23
Oklahoma	3.79	36	D+	$22,393	34	74.1%	17	57.3%	41	29.5%	30
Oregon	3.82	34	C-	$23,322	28	67.7%	46	61.7%	24	29.8%	24
Pennsylvania	3.88	26	C	$25,424	14	71.5%	27	56.4%	46	30.2%	22
Rhode Island	3.91	23	C	$25,492	13	68.6%	44	60.2%	30	30.4%	20
South Carolina	3.76	38	D	$22,212	36	68.7%	42	60.1%	32	29.6%	28
South Dakota	3.76	38	D	$20,171	49	70.9%	31	68.1%	3	26.9%	44
Tennessee	3.66	44	D-	$20,927	45	70.7%	32	59.2%	37	27.7%	42
Texas	3.96	20	C+	$23,324	27	76.4%	9	60.2%	30	31.2%	18
Utah	3.75	41	D	$22,317	35	64.9%	49	63.3%	15	29.3%	33
Vermont	4.05	15	C+	$23,294	29	73.8%	20	66.1%	8	32.1%	15
Virginia	4.09	13	B-	$25,398	15	69.9%	38	60.1%	32	35.7%	4
Washington	4.26	8	B	$28,087	8	74.4%	16	62.6%	21	34.4%	9
West Virginia	3.48	51	F	$21,626	42	72.1%	26	47.8%	51	26.6%	46
Wisconsin	3.99	17	C+	$24,387	22	68.6%	44	69.0%	2	29.5%	30
Wyoming	3.60	48	F	$20,352	47	62.8%	51	63.2%	17	27.9%	40
United States	**4.00**			**$25,370**		**73.5%**		**59.8%**		**31.4%**	

Appendix IV, Part A: State-by-State Rankings on the Composite Indices and Their Components—Economic Autonomy

	Composite Index			Percent of Women with Health Insurance		Percent of Women with Four or More Years of College		Percent of Businesses that are Women-Owned		Percent of Women Living above Poverty	
State	**Score**	**Rank**	**Grade**	**Percent**	**Rank**	**Percent**	**Rank**	**Percent**	**Rank**	**Percent**	**Rank**
Alabama	3.67	46	D-	81.9%	33	13.5%	45	31.5%	47	85.1%	39
Alaska	4.29	9	B-	83.3%	32	22.2%	7	32.9%	35	91.2%	4
Arizona	3.97	25	C	75.3%	49	17.2%	25	37.6%	3	84.2%	43
Arkansas	3.49	50	F	75.9%	48	11.9%	50	31.6%	45	83.1%	46
California	4.10	20	B-	76.8%	47	20.1%	13	35.5%	12	85.3%	37
Colorado	4.50	2	B	83.8%	30	23.5%	4	37.6%	3	90.4%	10
Connecticut	4.44	5	B	86.7%	12	23.8%	3	33.6%	28	90.8%	6
Delaware	4.19	13	B-	85.7%	21	18.7%	16	35.3%	14	90.7%	8
District of Columbia	4.89	1	B+	84.3%	28	30.6%	1	41.3%	1	79.2%	50
Florida	3.84	39	C-	78.5%	43	15.1%	36	35.2%	16	85.9%	32
Georgia	3.92	31	C	80.8%	38	16.8%	27	33.6%	28	85.9%	32
Hawaii	4.42	7	B	91.9%	1	20.9%	11	37.6%	3	87.3%	29
Idaho	3.81	42	D+	79.9%	40	14.6%	41	33.8%	25	87.7%	27
Illinois	4.13	18	B-	85.9%	17	18.4%	17	34.5%	21	88.7%	19
Indiana	3.86	36	C-	85.7%	21	13.4%	46	34.4%	22	90.8%	6
Iowa	3.96	28	C	87.0%	10	15.0%	38	34.3%	23	90.3%	12
Kansas	4.14	16	B-	86.1%	15	18.4%	17	34.7%	19	88.5%	22
Kentucky	3.62	48	D-	83.9%	29	12.2%	49	31.4%	48	84.7%	41
Louisiana	3.65	47	D-	77.0%	46	14.5%	42	32.5%	37	80.8%	48
Maine	3.98	24	C	85.0%	25	17.2%	25	32.2%	40	88.8%	18
Maryland	4.49	3	B	84.9%	26	23.1%	6	37.1%	6	91.6%	1
Massachusetts	4.44	5	B	87.0%	10	24.1%	2	33.3%	31	89.9%	14
Michigan	3.97	25	C	86.5%	13	15.1%	36	35.2%	16	88.7%	19
Minnesota	4.24	12	B-	90.0%	2	19.2%	15	34.6%	20	90.4%	10
Mississippi	3.52	49	F	77.8%	45	13.3%	47	30.2%	51	80.7%	49
Missouri	3.93	30	C	85.9%	17	15.2%	35	33.8%	25	89.2%	17
Montana	3.94	29	C	79.9%	40	18.0%	20	33.2%	32	83.7%	44
Nebraska	4.07	21	C+	87.6%	8	16.7%	28	35.1%	18	88.5%	22
Nevada	3.84	39	C-	81.6%	36	12.8%	48	36.9%	7	89.8%	15
New Hampshire	4.27	10	B-	88.2%	5	21.1%	9	32.2%	40	91.1%	5
New Jersey	4.17	14	B-	81.8%	34	21.0%	10	31.9%	42	90.7%	8
New Mexico	3.92	31	C	72.5%	51	17.8%	22	37.8%	2	79.1%	51
New York	4.12	19	B-	80.8%	38	20.7%	12	34.1%	24	83.4%	45
North Carolina	3.86	36	C-	83.4%	31	15.7%	32	32.4%	38	86.9%	31
North Dakota	3.91	33	C	85.8%	20	16.7%	28	31.7%	44	85.8%	34
Ohio	3.90	34	C-	87.4%	9	14.4%	43	33.7%	27	88.6%	21
Oklahoma	3.80	43	D+	79.8%	42	15.0%	38	33.6%	28	85.8%	34
Oregon	4.17	14	B-	86.1%	15	18.1%	19	36.8%	8	87.5%	28
Pennsylvania	3.88	35	C-	88.1%	6	15.3%	34	31.2%	49	88.3%	24
Rhode Island	4.05	22	C+	88.6%	4	18.0%	20	31.6%	45	88.2%	26
South Carolina	3.77	44	D	80.9%	37	14.7%	40	32.8%	36	85.1%	39
South Dakota	3.86	36	C-	85.9%	17	15.5%	33	31.9%	42	85.7%	36
Tennessee	3.73	45	D	84.8%	27	14.0%	44	31.1%	50	85.3%	37
Texas	3.84	39	C-	74.3%	50	17.4%	24	33.0%	34	84.7%	41
Utah	4.14	16	B-	86.2%	14	17.5%	23	35.3%	14	91.4%	3
Vermont	4.48	4	B	88.1%	6	23.2%	5	35.7%	11	90.1%	13
Virginia	4.31	8	B-	85.2%	24	21.3%	8	35.4%	13	88.3%	24
Washington	4.27	10	B-	85.7%	21	19.7%	14	36.6%	9	89.4%	16
West Virginia	3.47	51	F	77.9%	44	10.9%	51	32.3%	39	82.3%	47
Wisconsin	4.02	23	C+	89.3%	3	16.0%	31	33.1%	33	91.6%	1
Wyoming	3.97	25	C	81.8%	34	16.1%	30	35.9%	10	87.0%	30
United States	**4.00**			**81.5%**		**17.6%**		**34.1%**		**86.9%**	

Appendix IV, Part A: State-by-State Rankings on the Composite Indices and Their Components—Reproductive Rights

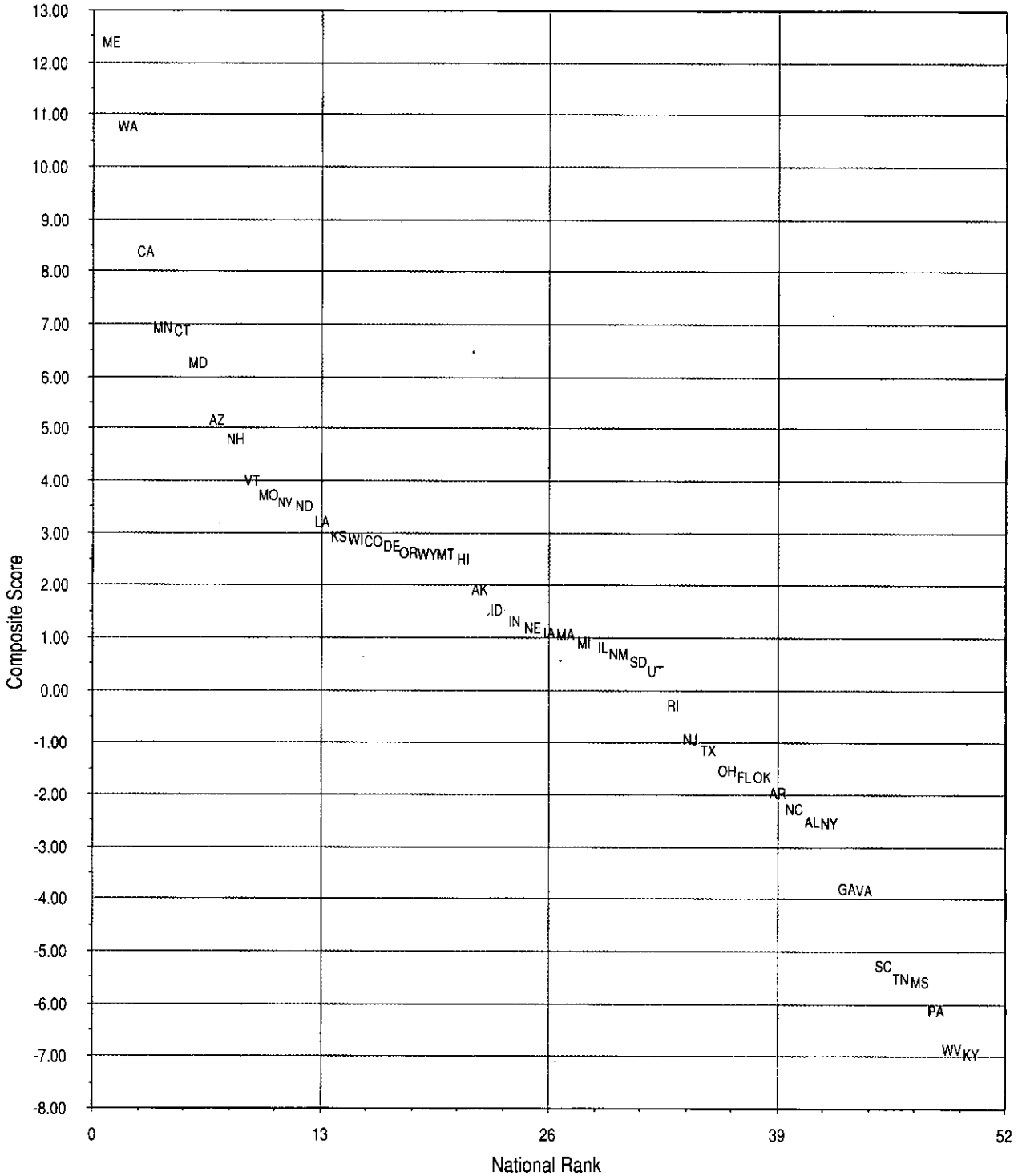
	Composite Index			Parental Consent	Waiting Period	Public Funding	Percent of Women Living in Counties with Providers	Contraceptive Coverage	Pro-Choice Government	Infertility	Second-Parent Adoption	Mandatory Sex Education
State	**Score**	**Rank**	**Grade**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**
Alabama	1.50	36	D	0	1	0	0.42	0.0	0.33	0.0	0.50	0
Alaska	2.85	23	C	0*	1	1	0.77	0.0	0.33	0.0	0.50	0
Arizona	1.94	31	D+	0*	1	0	0.81	0.0	0.50	0.0	0.25	0
Arkansas	1.68	32	D	0	1	0	0.22	0.0	0.33	1.0	0.25	0
California	4.97	6	B+	0*	1	1	0.97	1.0	1.00	0.5	0.50	0
Colorado	2.33	25	C-	0*	1	0	0.66	0.5	0.67	0.0	0.00	0
Connecticut	4.98	5	B+	1	1	1	0.90	1.0	0.83	0.5	0.00	0
Delaware	4.14	10	B	0	1	0	0.85	1.0	0.67	0.0	0.25	1
District of Columbia	4.38	7	B	1	1	0	1.00	0.0	1.00	0.0	0.75	1
Florida	1.28	38	D-	0*	1	0	0.78	0.0	0.00	0.0	0.00	0
Georgia	3.64	15	B-	0	1	0	0.51	1.0	0.50	0.0	0.25	1
Hawaii	5.46	3	A-	1	1	1	1.00	1.0	0.83	1.0	0.25	0
Idaho	0.96	45	F	0	0	0	0.33	0.5	0.00	0.0	0.25	0
Illinois	3.08	20	C	0*	1	0	0.70	0.0	0.00	1.0	0.75	1
Indiana	0.97	43	F	0	0	0	0.39	0.0	0.33	0.0	0.50	0
Iowa	2.73	24	C	0	1	0	0.31	0.5	0.17	0.0	0.50	1
Kansas	1.98	30	D+	0	0	0	0.52	0.0	0.33	0.0	0.25	1
Kentucky	2.04	29	D+	0	0*	0	0.25	0.5	0.17	0.0	0.25	1
Louisiana	0.53	48	F	0	0	0	0.40	0.0	0.00	0.0	0.25	0
Maine	3.07	21	C	0	1	0	0.61	1.0	0.83	0.0	0.25	0
Maryland	5.77	2	A-	0	1	1	0.85	1.0	0.67	1.0	0.50	1
Massachusetts	3.67	14	B-	0	0*	1	1.00	0.0	0.67	1.0	1.00	0
Michigan	0.97	43	F	0	0	0	0.72	0.0	0.00	0.0	0.50	0
Minnesota	3.01	22	C	0	1	1	0.43	0.5	0.33	0.0	0.50	0
Mississippi	0.31	51	F	0	0	0	0.18	0.0	0.00	0.0	0.25	0
Missouri	1.43	37	D	0	1	0	0.47	0.0	0.33	0.0	0.25	0
Montana	2.22	26	C-	0*	0*	1	0.59	0.0	0.00	1.0	0.25	0
Nebraska	0.66	47	F	0	0	0	0.53	0.0	0.00	0.0	0.25	0
Nevada	4.30	8	B	0	1	0	0.88	1.0	0.67	0.0	0.50	1
New Hampshire	3.87	13	B-	1	1	0	0.74	1.0	1.00	0.0	0.25	0
New Jersey	5.01	4	B+	0*	1	1	0.97	0.5	0.67	0.0	0.75	1
New Mexico	3.61	16	B-	0*	1	1	0.53	0.0	0.33	0.0	0.50	1
New York	4.30	8	B	1	1	1	0.92	0.0	0.50	1.0	0.75	0
North Carolina	3.90	12	B-	0	1	0	0.61	1.0	0.67	0.0	0.25	1
North Dakota	0.49	49	F	0	0	0	0.20	0.0	0.17	0.0	0.25	0
Ohio	1.00	42	F	0	0	0	0.50	0.0	0.00	1.0	0.00	0
Oklahoma	1.59	34	D	1	1	0	0.46	0.0	0.00	0.0	0.25	0
Oregon	3.20	19	C+	1	1	1	0.62	0.0	0.33	0.0	0.50	0
Pennsylvania	1.05	41	F	0	0	0	0.63	0.0	0.17	0.0	0.50	0
Rhode Island	3.21	18	C+	0	1	0	0.63	0.0	0.33	1.0	0.50	1
South Carolina	2.05	28	D+	0	0	0	0.42	0.0	0.50	0.0	0.25	1
South Dakota	0.34	50	F	0	0	0	0.21	0.0	0.00	0.0	0.25	0
Tennessee	1.59	34	D	0	0*	0	0.46	0.0	0.00	0.0	0.25	1
Texas	2.18	27	C-	0	1	0	0.68	0.5	0.00	0.5	0.50	0
Utah	1.64	33	D	0	0	0	0.51	0.0	0.00	0.0	0.25	1
Vermont	6.15	1	A-	1	1	1	0.77	1.0	1.00	0.0	0.75	1
Virginia	1.15	40	D-	0	1	0	0.52	0.0	0.00	0.0	0.25	0
Washington	4.10	11	B	1	1	1	0.85	0.0	1.00	0.0	0.50	0
West Virginia	3.29	17	C+	0	1	1	0.16	0.0	0.00	1.0	0.25	1
Wisconsin	0.71	46	F	0	0	0	0.38	0.0	0.33	0.0	0.00	0
Wyoming	1.21	39	D-	0	1	0	0.25	0.0	0.33	0.0	0.25	0

* Indicates the legislation is not enforced but remains part of the statutory code.

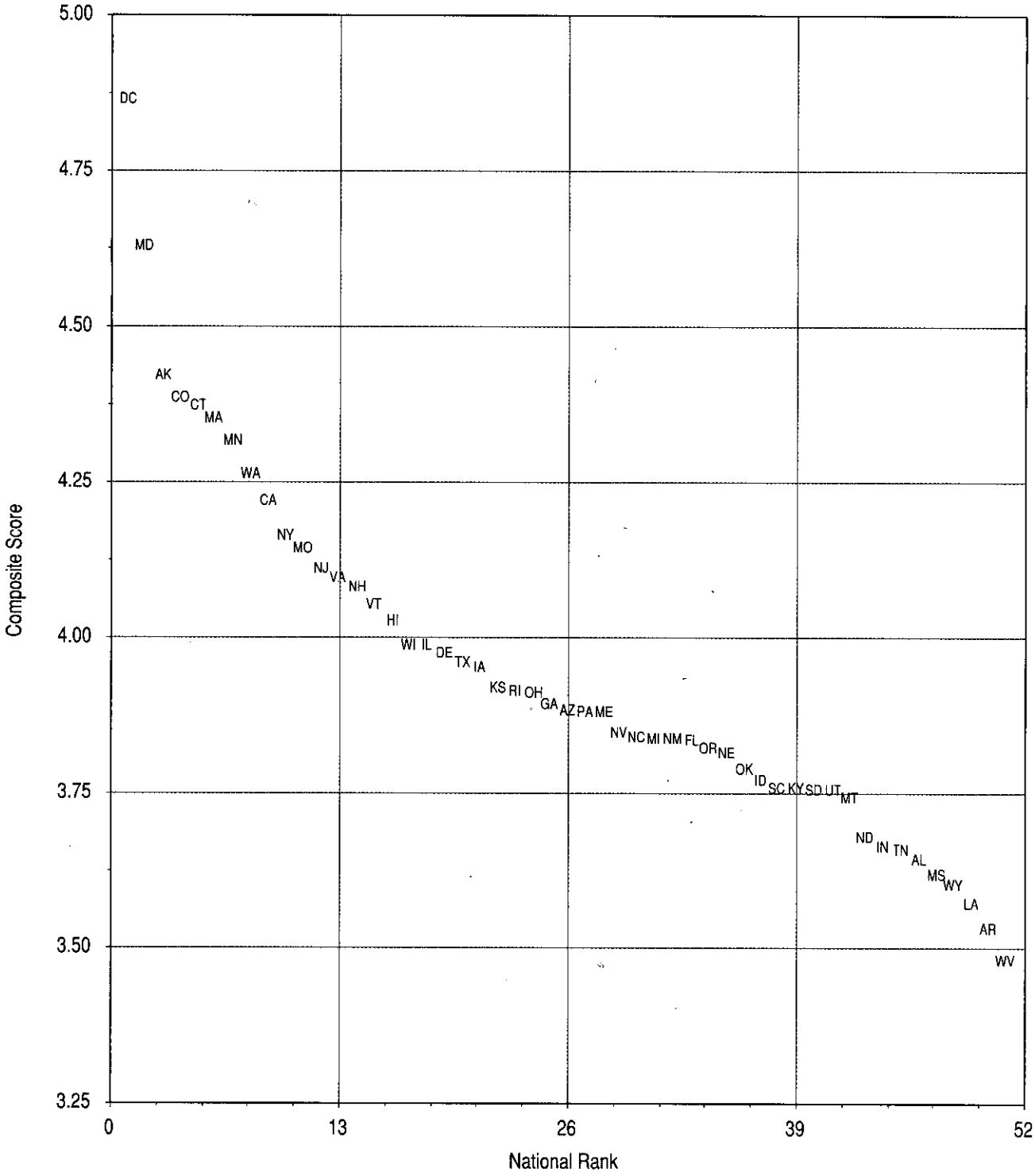
Appendix IV, Part A: State-by-State Rankings on the Composite Indices and Their Components—Health and Well-Being

	Composite Index			Heart Disease Mortality		Lung Cancer Mortality		Breast Cancer Mortality		Incidence of Diabetes		Incidence of Chlamydia		Incidence of AIDS		Poor Mental Health		Suicide Mortality		Limited Activities	
State	**Score**	**Rank**	**Grade**	**Rate**	**Rank**	**Rate**	**Rank**	**Rate**	**Rank**	**Percent**	**Rank**	**Rate**	**Rank**	**Rate**	**Rank**	**Days**	**Rank**	**Rate**	**Rank**	**Days**	**Rank**
Alabama	1.81	38	C-	82.6	15	30.0	14	23.7	9	7.9	50	358.4	36	5.7	32	4.3	47	3.9	23	5.1	45
Alaska	2.22	22	C+	69.7	7	40.0	46	22.5	3	2.6	1	448.4	46	1.3	7	3.0	8	6.6	50	2.6	1
Arizona	2.29	18	B-	86.9	22	32.1	20	23.3	6	2.9	2	384.6	40	3.9	29	1.2	1	5.9	47	3.7	27
Arkansas	1.73	43	D+	102.9	37	35.4	34	23.3	6	6.4	41	181.1	5	3.0	26	3.8	36	4.5	37	5.7	47
California	2.01	31	C	96.3	33	33.9	28	24.8	22	5.5	29	327.7	31	5.1	30	3.4	18	4.4	34	4.0	37
Colorado	2.39	16	B	64.1	4	25.5	5	23.0	5	4.6	16	284.4	25	2.3	23	3.7	30	5.7	46	3.1	13
Connecticut	2.47	10	B	84.9	18	32.6	23	26.0	37	3.8	9	298.9	29	13.6	45	3.2	13	3.0	8	3.2	15
Delaware	1.54	48	D-	89.0	25	41.2	48	28.4	45	4.5	15	557.1	49	13.5	44	3.7	30	3.6	17	6.0	49
District of Columbia	1.51	49	D-	75.7	12	34.7	32	33.2	51	7.2	46	335.8	32	86.7	51	2.4	2	2.3	1	5.9	48
Florida	1.63	45	D	98.0	34	35.7	36	24.9	23	5.9	35	296.4	28	24.1	49	3.7	30	5.0	42	4.8	44
Georgia	2.13	27	C+	93.4	31	31.2	18	24.4	16	5.1	24	369.4	37	11.6	42	4.0	42	3.8	22	3.4	19
Hawaii	2.71	1	A-	60.6	1	22.9	2	17.5	1	5.7	31	261.3	18	2.7	24	2.6	4	4.8	40	3.0	12
Idaho	2.55	7	B+	75.0	11	27.5	8	23.3	6	3.9	11	224.7	12	1.4	10	3.4	18	4.9	41	2.8	4
Illinois	2.26	20	B-	108.0	41	33.7	26	28.4	45	5.9	35	285.4	27	5.5	31	3.5	23	2.9	6	2.7	2
Indiana	2.20	24	C+	106.6	40	36.0	41	25.7	32	5.8	34	261.1	17	1.8	16	3.5	23	3.6	17	2.9	7
Iowa	2.45	12	B	92.3	27	29.8	12	25.1	24	5.3	26	266.7	20	1.1	6	3.6	26	3.3	12	2.8	4
Kansas	2.56	5	B+	85.4	19	29.8	12	23.9	12	3.6	5	255.4	15	2.0	20	3.0	8	3.7	19	3.3	17
Kentucky	1.43	50	F	108.4	42	41.8	50	25.1	24	5.7	31	256.8	16	2.7	24	5.5	51	3.3	12	6.7	51
Louisiana	1.82	36	C-	100.1	36	35.9	38	26.5	38	6.8	45	417.8	44	11.5	41	3.3	15	4.6	38	3.4	19
Maine	2.25	21	B-	92.7	28	39.1	45	25.7	32	4.9	21	141.3	4	1.3	7	3.4	18	3.5	15	4.2	40
Maryland	1.91	34	C	86.7	21	37.7	43	27.8	42	5.7	31	460.0	47	21.6	48	4.1	43	3.1	9	3.8	33
Massachusetts	2.47	10	B	85.8	20	35.7	36	29.1	49	3.1	3	206.9	6	13.0	43	3.2	13	2.8	5	3.6	24
Michigan	1.79	41	C-	112.4	47	34.9	33	27.0	40	7.6	48	371.9	39	3.7	28	4.6	50	3.2	10	3.6	24
Minnesota	2.45	12	B	71.2	9	28.2	10	25.3	26	5.1	24	209.9	7	2.1	21	3.7	30	3.3	11	4.2	40
Mississippi	1.80	39	C-	93.1	29	30.0	14	23.7	9	8.2	51	483.3	48	9.5	40	3.8	36	3.9	24	4.0	37
Missouri	1.84	35	C-	113.6	48	35.9	38	25.4	28	5.6	30	391.1	42	3.4	27	3.9	39	4.1	29	3.7	27
Montana	2.36	17	B	63.9	3	32.0	19	24.5	18	4.1	13	213.3	10	0.5	1	3.4	18	6.1	49	3.2	15
Nebraska	2.44	14	B	77.6	13	26.9	6	24.7	21	5.0	23	271.4	21	1.9	18	3.3	15	3.7	21	3.7	27
Nevada	1.82	36	C-	80.5	14	46.0	51	25.3	26	3.6	5	211.6	8	6.5	34	4.1	43	7.9	51	2.9	7
New Hampshire	2.27	19	B-	93.3	30	38.0	44	28.3	43	3.7	8	108.3	1	1.4	10	3.8	36	4.4	35	3.4	19
New Jersey	2.16	26	C+	111.0	44	33.9	28	29.6	50	4.9	21	234.7	13	20.3	47	2.9	6	2.7	3	3.7	27
New Mexico	2.13	27	C+	60.8	2	24.4	4	22.7	4	4.8	19	403.7	43	1.4	10	4.3	47	5.9	48	3.9	36
New York	1.38	51	F	144.0	51	32.2	21	28.6	47	6.7	43	659.1	51	29.7	50	3.6	26	2.5	2	4.1	39
North Carolina	1.76	42	D+	99.5	35	30.2	16	25.4	28	7.5	47	386.6	41	6.2	33	3.7	30	4.3	32	4.4	43
North Dakota	2.55	7	B+	82.8	16	24.3	3	25.5	30	4.2	14	212.3	9	0.8	3	3.0	8	4.0	26	3.5	23
Ohio	1.98	32	C	114.8	49	35.9	38	27.3	41	5.3	26	342.3	34	1.9	18	3.3	15	3.0	7	4.3	42
Oklahoma	1.55	47	D-	110.9	43	34.4	31	24.3	15	7.8	49	371.5	38	1.7	14	2.4	2	5.4	43	5.1	45
Oregon	2.18	25	C+	72.9	10	40.0	46	24.4	16	4.7	18	237.5	14	1.0	5	3.6	26	5.4	44	3.4	19
Pennsylvania	2.08	29	C	104.0	38	32.2	21	28.3	43	6.0	38	276.0	23	8.8	39	3.1	11	3.5	14	3.8	33
Rhode Island	2.03	30	C	111.4	46	34.1	30	28.7	48	5.9	35	338.3	33	7.9	37	3.5	23	2.8	4	3.7	27
South Carolina	1.68	44	D	106.4	39	29.4	11	25.5	30	6.3	40	581.7	50	16.3	46	3.6	26	4.5	36	3.7	27
South Dakota	2.58	4	B+	90.9	26	26.9	6	24.2	14	3.6	5	278.5	24	1.3	7	2.7	5	4.0	25	2.9	7
Tennessee	1.80	39	C-	111.0	44	33.4	25	25.7	32	6.4	41	349.6	35	6.7	35	4.2	46	4.2	31	3.8	33
Texas	1.92	33	C	96.2	32	32.6	23	23.9	12	6.2	39	441.7	45	7.9	37	4.1	43	4.1	28	3.6	24
Utah	2.62	2	B+	64.8	5	14.0	1	22.0	2	3.8	9	135.2	3	1.8	16	4.4	49	5.5	45	3.3	17
Vermont	2.61	3	B+	82.9	17	35.4	34	25.8	35	4.6	16	126.9	2	0.8	3	3.1	11	3.7	20	2.7	2
Virginia	2.21	23	C+	87.7	24	33.8	27	26.5	38	4.8	19	300.3	30	7.2	36	3.9	39	4.1	30	3.1	13
Washington	2.41	15	B	68.5	6	36.7	42	24.6	20	5.3	26	265.3	19	2.2	22	3.7	30	4.3	32	2.8	4
West Virginia	1.57	46	D-	117.4	50	41.3	49	23.8	11	6.7	43	274.2	22	0.6	2	2.9	6	4.0	27	6.1	50
Wisconsin	2.53	9	B+	87.5	23	28.0	9	25.8	35	4.0	12	284.6	26	1.7	14	3.4	18	3.6	16	2.9	7
Wyoming	2.56	5	B+	70.5	8	30.7	17	24.5	18	3.1	3	224.2	11	1.5	13	3.9	39	4.6	39	2.9	7
United States				**90.9**		**33.3**		**26.0**		**5.3**		**335.8**		**9.4**		**3.5**		**3.9**		**3.6**	

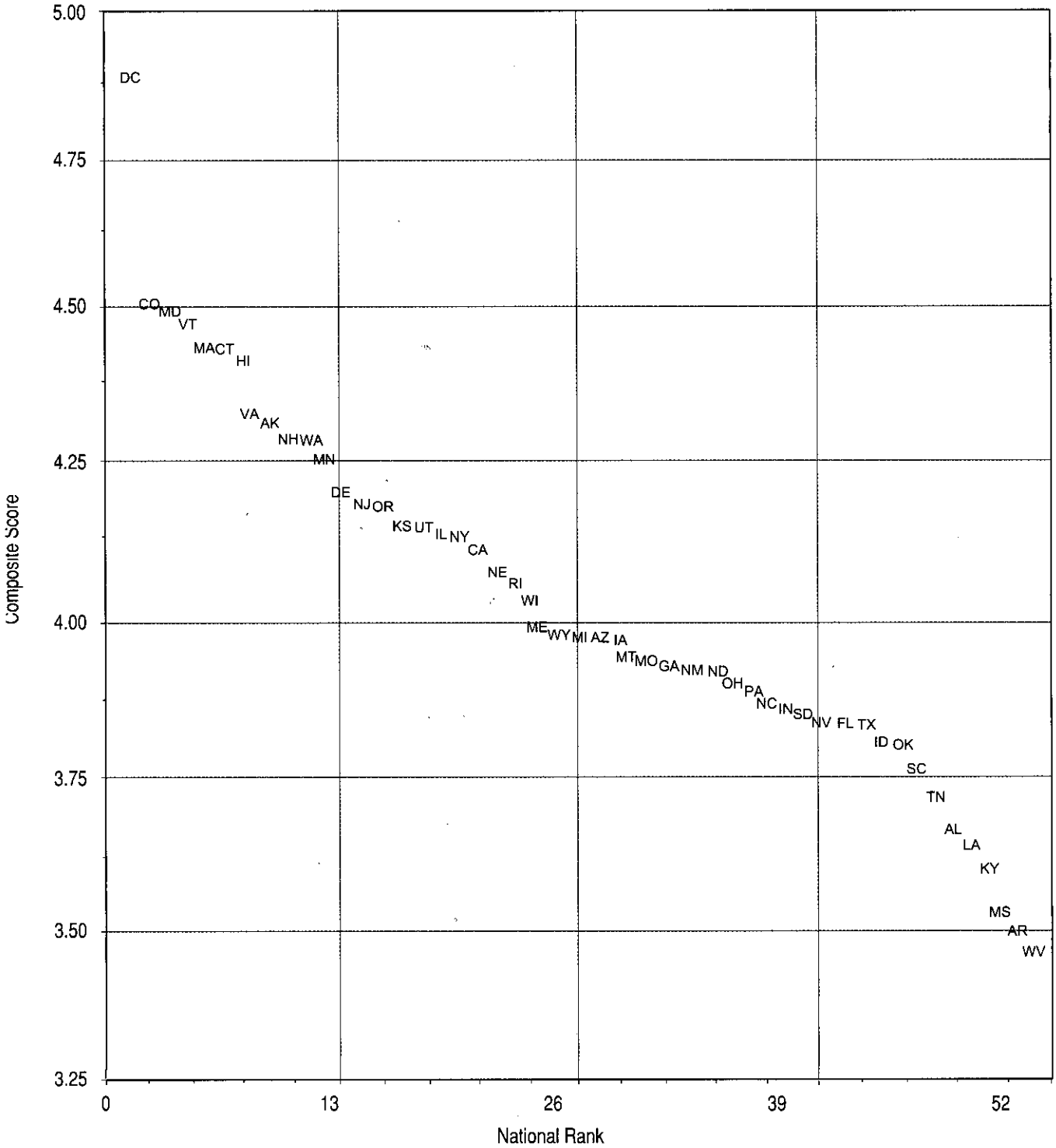
Appendix IV, Part B: Graphs of State-by-State Rankings on the Composite Indices
Political Participation



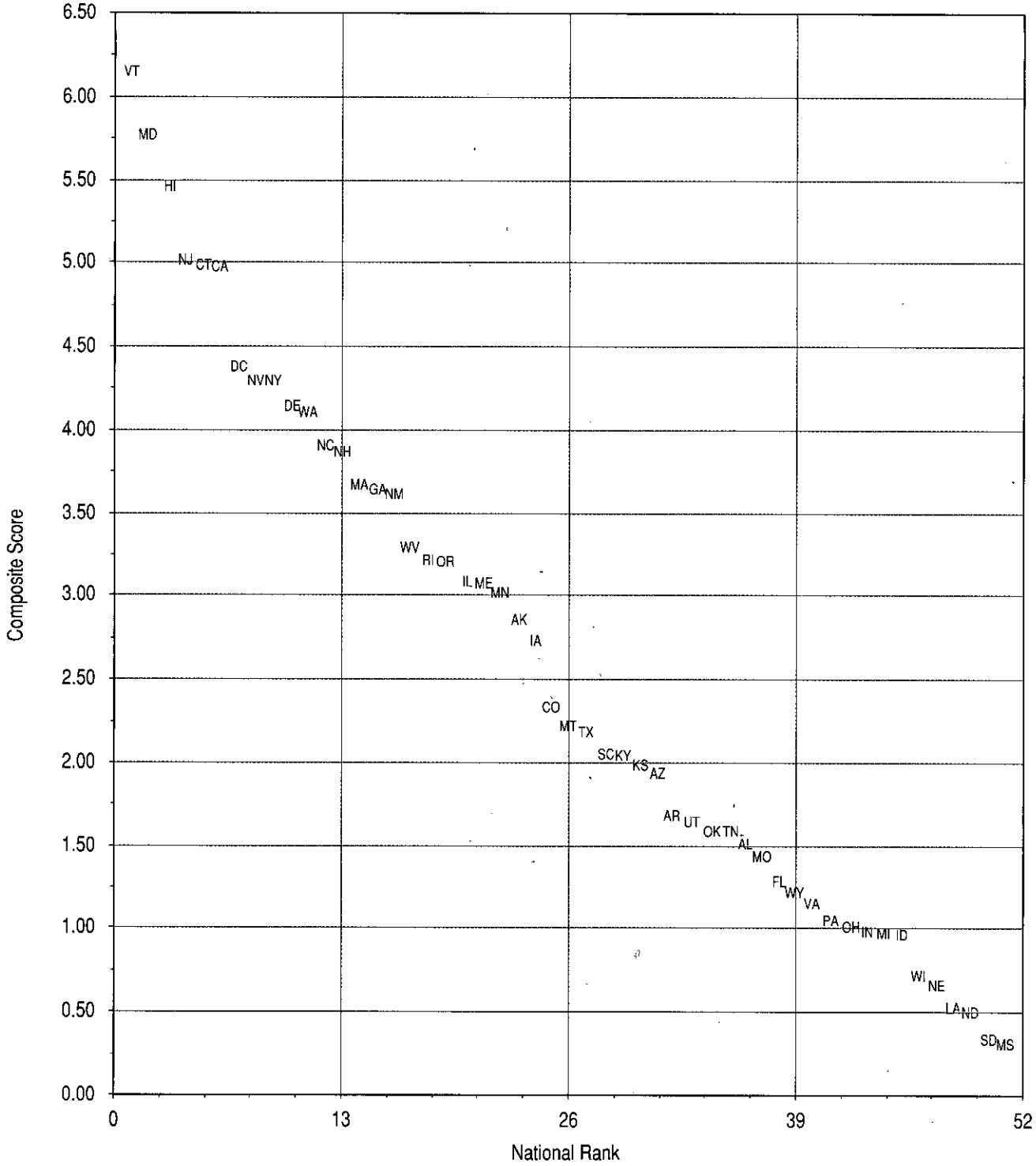
Appendix IV, Part B: Graphs of State-by-State Rankings on the Composite Indices Employment and Earnings



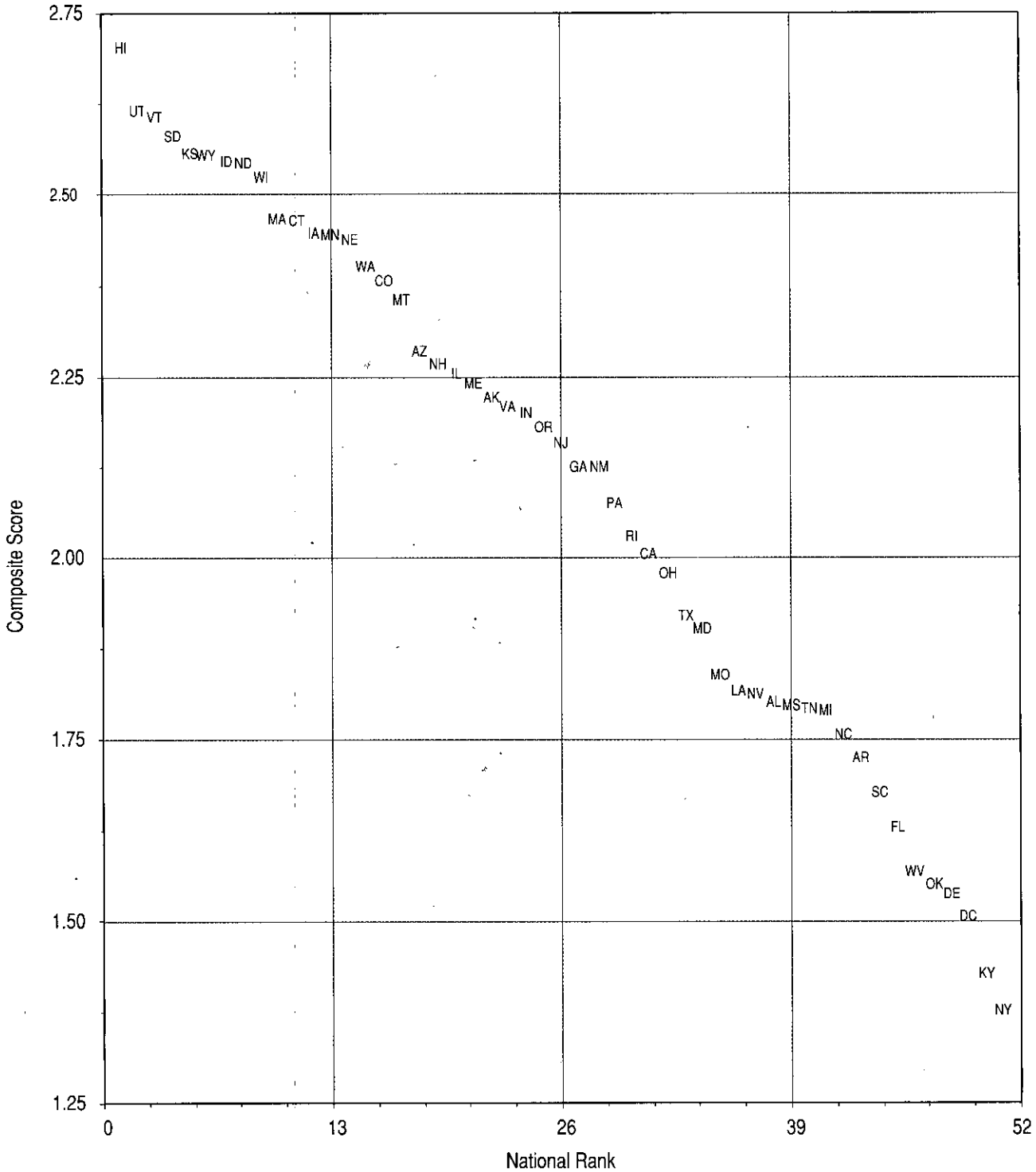
Appendix IV, Part B: Graphs of State-by-State Rankings on the Composite Indices
Economic Autonomy



Appendix IV, Part B: Graphs of State-by-State Rankings on the Composite Indices
Reproductive Rights



Appendix IV, Part B: Graphs of State-by-State Rankings on the Composite Indices
Health and Well-Being



Appendix V
State and National Resources

Selected New Hampshire Resources

Alliance for Progress of Hispanic Americans (ALPHA)
83 Hanover Street
Manchester, NH 03101
Tel: (603) 627-5127
Fax: (603) 627-1650

American Association of University Women (AAUW) - New Hampshire Division
637 Hadley Road
Sugar Hill, NH 03585
Tel: (603) 823-8075
Fax: (603) 823-8075
crbam@alndmarknet.net
www.tiac.net/users/keela/aauwnh.index.html

Breast and Cervical Cancer Program
Department of Health and Human Services, State of New Hampshire
6 Hazen Drive
Concord, NH 03302
Tel: (603) 271-4886
Tel: (800) 852-3345 ext. 4931
Fax: (603) 271-0539
www.dhhs.state.nh.us/index.nsf?Open

Child and Family Services
99 Hanover Street
Manchester, NH 03105
Tel: (603) 668-1920
Fax: (603) 668-6260
www.cfsnh.org

Children's Alliance of New Hampshire
2 Greenwood Avenue
Concord, NH 03301
Tel: (603) 225-2264
Fax: (603) 225-8264
www.childrennh.org
canh@tiac.net

Division of Child Support Services
State of New Hampshire
129 Pleasant Street
Concord, NH 03301-3857
Tel: (603) 271-4427
Tel: (800) 852-3345 ext. 4427
Fax: (603) 271-4787

Division of Children, Youth, and Families
Central Intake, State of New Hampshire
40 Terrill Park Drive, Suite 8
Concord, NH 03301
Tel: (603) 271-6556
Tel: (800) 894-5533
Fax: (603) 271-6565

Division of Family Assistance
State of New Hampshire
Tel: (800) 852-3345
(for local numbers)
www.state.nh.us/dhhs/ofs/ofs_ind.htm

Employment Security-Employment and Labor Market Information (ELMI)
State of New Hampshire
32 South Main Street
Concord NH 03301
Tel: (603) 224-3311
Tel: (800) 852-3400
www.nhes.state.nh.us

Family Works
500 Amherst Street
Nashua, NH 03063
Tel: (800) 264-7189
Fax: (603) 889-7104

Homeless Support Service
40 Pine Street
Manchester, NH 30103
Tel: (603) 668-8010
Fax: (603) 645-6734

Housing Finance Authority
State of New Hampshire
24 Constitution Drive
Bedford, NH 03110
Tel: (603) 472-8622
Tel: (800) 640-7234
Fax: (603) 472-8501
www.nhhfa.org

Latin American Center
521 Maple Street
Manchester, NH 03104
Tel: (603) 669-5661
Fax: (603) 669-5265

League of Women Voters
4 Park Street
Suite 200
Concord, NH 03301
Tel: (603) 225-5344
people.ne.mediaone.net/bingel/index.htm

Legal Advice and Referral Center (LARC)
P.O. Box 4147
Concord, NH 03302-4147
Tel: (603) 224-3333
Tel: (800) 639-5290
www.larc.org

Manchester Cultural Diversity Task Force
c/o Office of Youth Services
50 Bridge Street
Manchester, NH 03104
Tel: (603) 624-6470
Fax: (603) 628-6285

NARAL New Hampshire
18 Low Avenue
Concord, NH 03301
Tel: (603) 228-1224
Fax: (603) 226-4505
www.naral.org

New Hampshire Business and Professional Women (BPW)
P.O. Box 4171
Concord, NH 03302-4171
Tel: (603) 485-1491
www.newww.com/org/concordbpw/

New Hampshire Breast Cancer Coalition
18 Bell Lane
Lee, NH 03824
Tel: (603) 659-3482
Fax: (603) 659-3482
www.nhbcc.org

New Hampshire Coalition Against Domestic and Sexual Violence
P.O. Box 353
Concord, NH 03301
Tel: (603) 224-8893
Fax: (603) 228-6096
www.nhcadsv.org

New Hampshire Coalition for the Homeless
P.O. Box 1544
Concord, NH 03302-0220
Tel: (603) 594-2846
Tel: (800) 852-3388

New Hampshire Commission for Human Rights
2 Chenell Drive
Concord, NH 03302
Tel: (603) 271-2767
Fax: (603) 271-6339
www.state.nh.us/hrc

New Hampshire Commission on the Status of Women
Room 334
State House Annex
25 Capitol Street
Concord, NH 03301
Tel: (603) 271-2660
Fax: (603) 274-4030
www.state.nh.us/csw

New Hampshire Community Loan Fund
7 Wall Street
Concord, NH 03301
Tel: (603) 224-6669
Fax: (603) 225-7425

New Hampshire Feminist Connection
P.O. Box 311
Concord, NH 03302-0311
Tel: (603) 225-3501
www.nh.ultranet.com/~nhfc/nhfc.html

New Hampshire Helpline
2 Industrial Park Drive
Concord, NH 03301
Tel: (603) 225-4033
Tel: (800) 852-3388
Fax: (603) 225-9000
www.nhhelpline.org

New Hampshire Higher Education Assistance Foundation
4 Barrel Court
P.O. Box 877
Concord, NH 03302
Tel: (800) 525-2577
www.nhheaf.org

New Hampshire Legal Assistance
1361 Elm Street, Suite 307
Manchester, NH 03101
Tel: (603) 668-2900
Tel: (800) 562-3174
Fax: (603) 625-1840
www.lavcnh.org

New Hampshire Minority Health Coalition
P.O. Box 3992
Manchester, NH 03105
Tel: (603) 627-7703
Fax: (603) 627-7703

New Hampshire National Organization for Women (NOW)
7 Colby Court
Unit #4-252
Bedford, NH 03110-6245
Tel: (603) 749-8900
www.nh.ultranet.com/~nh-now

New Hampshire Women's Lobby
P.O. Box 1072
Concord, NH 03301
Tel: (603) 224-9105

New Hampshire AARP
118 North Main Street
Concord, NH 03301
Tel: (603) 224-6095
Fax: (603) 224-5029
www.aarp.org

Planned Parenthood of Northern New England
18 Low Avenue
Concord, NH 03301
Tel: (603) 225-2925
Fax: (603) 225-4195
www.plannedparenthood.org/ppnne/

The Women's Fund of New Hampshire
46 South Main Street
Concord, NH 03301
Tel: (603) 226-3355
Fax: (603) 228-0395
www.wfnh.org

University of New Hampshire President's Commission on the Status of Women
Rosemary Lane Batcheller House
Tel: (603) 862-1058
Fax: (603) 862-0116
www.unh.edu.womens-commission/

University of New Hampshire Women's Studies Program
2nd floor Huddleston Hall
Durham, NH 03824
Tel: (603) 862-2194
Fax: (603) 862-4721
www.unh.edu.womens-studies/

Victim's Assistance Commission
Department of Justice, State of New Hampshire
33 Capitol Street
Concord, NH 03301
Tel: (603) 271-1284
Tel: (800) 300-4500
Fax: (603) 271-2110
www.state.nh.us/nhdoj/victim witness/nhvac.html

Women, Infants and Children (WIC)
Bureau with Nutritional Services
State of New Hampshire
6 Hazen Drive
Concord, NH 03301
Tel: (800) 852-3310
Fax: (603) 271-4779

Women's Business Center
150 Greenleaf Avenue, #8
Portsmouth, NH 03801
Tel: (603) 430-2892
Fax: (603) 430-3706
www.womenbiz.org

Women's Business Forum
Greater Manchester Chamber of Commerce
Manchester, NH 03101
Tel: (800) 242-0054

Women's Entrepreneurs Connection
Bank Boston
157 Main Street
Nashua, NH 03060
Tel: (603) 594-1852
Fax: (603) 647-7607

WREN - Women's Rural Entrepreneurial Network
P.O. Box 331
Bethlehem, NH 03574
Tel: (603) 869-9736
Fax: (603) 869-9738
www.wrencommunity.org

National Resources

Administration on Aging
U.S. Department of Health and Human Services
330 Independence Avenue, SW
Washington, DC 20201
Tel: (202) 619-7501
Fax: (202) 260-1012
www.aoa.dhhs.gov

AFL-CIO Department of Working Women
815 16th Street, NW
Washington, DC 20006
Tel: (202) 637-5064
Fax: (202) 637-6902
www.aflcio.org

African American Women Business Owners Association
3363 Alden Place, NE
Washington, DC 20019
Tel: (202) 399-3645
Fax: (202) 399-3645
twarren@idfa.org
www.blackpgs.com/aawboa.html

African American Women's Institute
Howard University
P.O. Box 590492
Washington, DC 20059
Tel: (202) 806-4556
Fax: (202) 806-9263
www.aawi.org

Agency for Health Care Research and Quality
U.S. Department of Health and Human Services
2101 E. Jefferson Street
Suite 501
Rockville, MD 20852
Tel: (301) 594-6662
Fax: (301) 594-2168
www.ahcpr.gov

Alan Guttmacher Institute
1120 Connecticut Avenue, NW
Suite 460
Washington, DC 20036
Tel: (202) 296-4012
Fax: (202) 223-5756
www.agi-usa.org

Alzheimer's Association
919 North Michigan Avenue
Suite 1100
Chicago, IL 60611-1676
Tel: (312) 335-8700
Tel: (800) 272-3900
Fax: (312) 335-1110
www.alz.org

American Association of Homes and Services for the Aging
901 E Street, NW, Suite 500
Washington, DC 20004-2011
Tel: (202) 783-2242
Fax: (202) 783-2255
www.aahsa.org

American Association of Retired Persons
601 E Street, NW
Washington, DC 20049
Tel: (202) 434-2277
Tel: (800) 424-3410
Fax: (202) 434-6477
www.aarp.org

American Association of University Women
1111 16th Street, NW
Washington, DC 20036
Tel: (202) 785-7700
Tel: (800) 326-AAUW
Fax: (202) 872-1425
www.aauw.org

American Federation of State, County, and Municipal Employees (AFSCME)
1625 L Street, NW
Washington, DC 20036-5687
Tel: (202) 429-1000
Fax: (202) 429-1293
www.afscme.org

American Medical Association
1101 Vermont Avenue, NW
Washington, DC 20005
Tel: (202) 789-7400
Fax: (202) 789-7458
www.ama-assn.org

American Medical Women's Association
801 N. Fairfax Street, Suite 400
Alexandria, VA 22314
Tel: (703) 838-0500
Fax: (703) 549-3864
www.amwa-doc.org

American Nurses Association
600 Maryland Avenue, SW
Suite 100 West
Washington, DC 20024
Tel: (202) 651-7000
Tel: (800) 274-4ANA
Fax: (202) 651-7001
www.ana.org

American Psychological Association
750 First Street, NE
Washington, DC 20002-4242
Tel: (800) 374-2721
Fax: (202) 336-5500
www.apa.org

American Sociological Association
1307 New York Avenue, NW
Suite 700
Washington, DC 20005
Tel: (202) 383-9005
Fax: (202) 638-0882
www.asanet.org

American Women's Economic Development Corporation
216 East 45th Street, 10th Floor
New York, NY 10017
Tel: (212) 692-9100
Fax: (212) 692-9296
orgs.womenconnect.com/awed/

The Anne E. Casey Foundation
701 St. Paul Street
Baltimore, MD 21202
Tel: (410) 547-6600
Fax: (410) 547-6624
webmail@aecf.org
www.aecf.org

Asian Women in Business/ Asian American Professional Women
One West 34th Street, Suite 200
New York, NY 10001
Tel: (212) 868-1368
Fax: (212) 868-1373
www.awib.org

Association of American Colleges and Universities
1818 R Street, NW
Washington, DC 20009
Tel: (202) 387-3760
Fax: (202) 265-9532
www.aacu-edu.org

Association of Black Women Entrepreneurs, Inc.
P.O. Box 49368
Los Angeles, CA 90049
Tel: (213) 624-8639
Fax: (213) 624-8639

Association for Health Services Research
1801 K Street, Suite 701-L
Washington, DC 20006-1301
Tel: (202) 292-6700
Fax: (202) 292-6800
www.ahsr.org

Black Women United for Action
6551 Loisdale Court, Suite 222
Springfield, VA 22150
Tel: (703) 922-5757
Fax: (703) 313-8716
www.bwufa.org

Business and Professional Women USA
2012 Massachusetts Avenue, NW
Washington, DC 20036
Tel: (202) 293-1100
Fax: (202) 861-0298
www.bpwusa.org

Catalyst
120 Wall Street
New York, NY 10005
Tel: (212) 514-7600
Fax: (212) 514-8470
www.catalystwomen.org

Catholics for a Free Choice
1436 U Street, NW, Suite 301
Washington, DC 20009-3997
Tel: (202) 986-6093
Fax: (202) 332-7995
www.igc.org/catholicvote

Center for the Advancement of Public Policy and
Washington Feminist Faxnet
1735 S Street, NW
Washington, DC 20009
Tel: (202) 797-0606
Fax: (202) 265-6245
www.essential.org/capp

Center for American Women and Politics
Rutgers, The State University of New Jersey
191 Ryders Lane
New Brunswick, NJ 08901-8557
Tel: (732) 932-9384
Fax: (732) 932-0014
www.rci.rutgers.edu/~cawp/

Center for the Child Care Workforce
733 15th Street, NW, Suite 1037
Washington, DC 20005-2112
Tel: (202) 737-7700
Tel: (800) U-R-WORTHY
Fax: (202) 737-0370
www.ccw.org

Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, GA 30333
Tel: (404) 639-3311
www.cdc.gov/nchs

Center for Law and Social Policy
1616 P Street, NW, Suite 150
Washington, DC 20036
Tel: (202) 328-5140
Fax: (202) 328-5195
www.clasp.org

Center for Policy Alternatives
1875 Connecticut Avenue, NW
Suite 710
Washington, DC 20009
Tel: (202) 387-6030
Fax: (202) 986-2539
www.cfpa.org

Center for the Prevention of Sexual and Domestic Violence
936 N 34th Street, Suite 200
Seattle, WA 98103
Tel: (206) 634-1903
Fax: (206) 634-0115
www.cpsdv.org

Center for Reproductive Law and Policy
1146 19th Street, NW
Washington, DC 20036
Tel: (202) 530-2975
Fax: (202) 530-2976
www.crlp.org

Center for Research on Women
University of Memphis
Campus Box 526105
Memphis, TN 38152-6105
Tel: (901) 678-2770
Fax: (901) 678-3652
cas.memphis.edu/isc/crow

Center for Women's Policy Studies
1211 Connecticut Avenue, NW
Suite 312
Washington, DC 20036
Tel: (202) 872-1770
Fax: (202) 296-8962
www.centerwomenpolicy.org

Center on Budget and Policy Priorities
820 First Street, NE, Suite 510
Washington, DC 20002
Tel: (202) 408-1080
Fax: (202) 408-1056
www.cbpp.org

Child Care Action Campaign
330 Seventh Avenue, 14th Floor
New York, NY 10001
Tel: (212) 239-0138
Fax: (212) 268-6515
www.childcareaction.org

Child Trends, Inc.
4301 Connecticut Ave, NW
Suite 100
Washington, DC 20008
Tel: (202) 362-5580
Fax: (202) 362-5533
www.childtrends.org

Children's Defense Fund
25 E Street, NW
Washington, DC 20001
Tel: (202) 628-8787
Tel: (800) CDF-1200
Fax: (202) 662-3540
www.childrensdefense.org

Church Women United
475 Riverside Drive, Suite 500
New York, NY 10115
Tel: (212) 870-2347
Fax: (212) 870-2338
www.churchwomen.org

Coalition of Labor Union Women
1126 16th Street, NW
Washington, DC 20036
Tel: (202) 466-4610
Fax: (202) 776-0537
www.cluw.org

Coalition on Human Needs
1700 K Street, NW, Suite 1150
Washington, DC 20006
Tel: (202) 736-5885
Fax: (202) 785-0791
www.chn.org

Communication Workers of America
501 Third Street, NW
Washington, DC 20001
Tel: (202) 434-1100
Fax: (202) 434-1279
www.cwa-union.org

Economic Policy Institute
1660 L Street, NW, Suite 1200
Washington, DC 20036
Tel: (202) 775-8810
Fax: (202) 775-0819
www.epinet.org

EMILY'S List
805 15th Street, NW
Suite 400
Washington, DC 20005
Tel: (202) 326-1400
Fax: (202) 326-1415
www.emilyslist.org

Equal Rights Advocates
1663 Mission Street, Suite 550
San Francisco, CA 94103
Tel: (415) 621-0672
Fax: (415) 621-6744
www.equalrights.org

Family Violence Prevention Fund
383 Rhode Island Street
Suite 304
San Francisco, CA 94103
Tel: (415) 252-8900
Fax: (415) 252-8991
www.fvpf.org

Federally Employed Women
P.O. Box 27687
Washington, DC 20038-7687
Tel: (202) 898-0994
www.few.org/

The Feminist Majority Foundation
1600 Wilson Blvd, Suite 801
Arlington, VA 22209
Tel: (703) 522-2214
Fax: (703) 522-2219
www.feminist.org

General Federation of Women's Clubs
1734 N Street, NW
Washington, DC 20036-2990
Tel: (202) 347-3168
Fax: (202) 835-0246
www.gfwc.org

Girls Incorporated National Resource Center
120 Wall Street, 3rd Floor
New York, NY 10005
Tel: (212) 509-2000
Fax: (212) 509-8708
www.girlsinc.org

Girl Scouts of the USA
420 5th Avenue
New York, NY 10018-2798
Tel: (800) GSUSA-4U
Fax: (212) 852-6509
www.gsusa.org

Hadassah
50 West 58 Street
New York, NY 10019
Tel: (212) 355-7900
Fax: (212) 303-8018
www.hadassah.com

Human Rights Campaign
919 18th Street, NW, Suite 800
Washington, DC 20006
Tel: (202) 628-4160
Fax: (202) 347-5323
www.hrc.org

HumanSERVE
Campaign for Universal Voter Registration
739 8th Street, SE, Suite 202
Washington, DC
Tel: (202) 546-3492
Fax: (202) 546-2483
www.igc.org/humanserve

Institute for Research on Poverty
University of Wisconsin—Madison
1180 Observatory Drive
3412 Social Science Building
Madison, WI 53706-1393
Tel: (608) 262-6358
Fax: (608) 265-3119
www.ssc.wisc.edu/irp

Institute for Women's Policy Research
1707 L Street, NW, Suite 750
Washington, DC 20036
Tel: (202) 785-5100
Fax: (202) 833-4362
iwpr@iwpr.org
www.iwpr.org

International Center for Research on Women
1717 Massachusetts Avenue, NW,
Suite 302
Washington, DC 20036
Tel: (202) 797-0007
Fax: (202) 797-0020
www.icrw.org

International Labour Organization
1828 L Street, NW, Suite 600
Washington, DC 20036
Tel: (202) 653-7652
Fax: (202) 653-7687
www.ilo.org

Jacobs Institute of Women's Health
409 12th Street, SW
Washington, DC 20024-2188
Tel: (202) 863-4990
Fax: (202) 554-0453
www.jiwh.org

Jewish Women International
1828 L Street, NW, Suite 250
Washington, DC 20036
Tel: (202) 857-1300
Fax: (202) 857-1380
www.jewishwomen.org

Joint Center for Political and Economic Studies
1090 Vermont Avenue, NW
Suite 1100
Washington, DC 20005-4928
Tel: (202) 789-3500
Fax: (202) 789-6390
www.jointctr.org

Lambda Legal Defense and Education Fund
120 Wall Street, Suite 1500
New York, NY 10005-3904
Tel: (212) 809-8585
Fax: (212) 809-0055
www.lambdalegal.org

League of Conservation Voters
1920 L Street, NW, Suite 800
Washington, DC 20036
Tel: (202) 785-8683
Fax: (202) 835-0491
www.lcv.org

League of Women Voters
1730 M Street, NW, Suite 1000
Washington, DC 20036
Tel: (202) 429-1965
Fax: (202) 429-0854
www.lwv.org

MANA—A National Latina Organization
1725 K Street, NW, Suite 501
Washington, DC 20006
Tel: (202) 833-0060
Fax: (202) 496-0588
www.hermana.org

Ms. Foundation for Women
120 Wall Street, 33rd Floor
New York, NY 10005
Tel: (212) 742-2300
Fax: (212) 742-1653
www.ms.foundation.org

9 to 5, National Association for Working Women
231 W. Wisconsin Avenue
Milwaukee, WI 53203-2308
Tel: (800) 522-0925
Tel: (414) 274-0925
Fax: (414) 272-2870
www.9to5.org

National Abortion Federation
1755 Massachusetts Avenue, NW, Suite 600
Washington, DC 20036
Tel: (202) 667-5881
Fax: (202) 67-5890
www.prochoice.org

National Abortion and Reproductive Rights Action League
1156 15th Street, NW
Suite 700
Washington, DC 20005
Tel: (202) 973-3000
Fax: (202) 973-3096
www.naral.org

National Asian Women's Health Organization
250 Montgomery Street Suite1500
San Francisco, CA 94104
Tel: (415) 989-9747
Fax: (415) 989-9758
www.nawho.org

National Association of Anorexia Nervosa and Associated Disorders
P.O. Box 7
Highland Park, IL 60035
Tel: (847) 831-3438
Fax: (847) 433-4632
www.anad.org

National Association of Commissions for Women
8630 Fenton Street, Suite 934
Silver Springs, MD 20910-3808
Tel: (301) 585-8101
Tel: (800) 338-9267
Fax: (202) 585-3445
www.nacw.org

National Association of Negro Business and Professional Women's Clubs, Inc
1806 New Hampshire Avenue
Washington, DC 20009-3208
Tel: (202) 483-4206
Fax: (202) 462-7253
www.nanbpwc.org

National Association of Women Business Owners
1411 K Street, NW
Washington, DC 20005
Tel: (202) 347-8686
Tel: (800) 556-2926
Fax: (202) 347-4130
www.nawbo.org

National Association of Women in Education
1325 18th Street, NW
Suite 210
Washington, DC 20036
Tel: (202) 659-9330
Fax: (202) 457-0946
www.nawe.org

National Breast Cancer Coalition
1707 L Street, NW, Suite 1060
Washington, DC 20036
Tel: (202) 296-7477
Tel: (202) 622-2838
Fax: (202) 265-6854
www.natlbcc.org

National Center for American Indian Enterprise Development
934 North 143rd Street
Seattle, WA 98133
Tel: (800) 4-NCAIED
Fax: (480) 545-4208
www.ncaied.org

National Center for Lesbian Rights
870 Market Street, Suite 570
San Francisco, CA 94102
Tel: (415) 392-6257
Fax: (415) 392-8442
www.nclrights.org

National Coalition Against Domestic Violence
P.O. Box 18749
Denver, CO 80218
Tel: (303) 839-1852
Fax: (303) 831-9251
www.ncadv.org

National Committee on Pay Equity
1126 16th Street, NW, Suite 411
Washington, DC 20036
Tel: (202) 331-7343
Fax: (202) 331-7406
www.feminist.com/fairpay.htm

National Conference of Puerto Rican Women
5 Thomas Circle, NW
Washington, DC 20005
Tel: (202) 387-4716
buscapique.com/latinusa/buscafile/wash/nacoprw.htm

National Council for Research on Women
11 Hanover Square
New York, NY 10005
Tel: (212) 785-7335
Fax: (212) 785-7350
www.ncrw.org

National Council of Negro Women
633 Pennsylvania Avenue, NW
Washington, DC 20004
Tel: (202) 737-0120
Fax: (202) 737-0476
www.ncnw.com

National Council of Women's Organizations
c/o NCPE
1126 16th Street, NW, Suite 411
Washington, DC 20036
Tel: (202) 331-7343
Fax: (202) 331-7406
www.womensorganizations.org

National Education Association
1201 16th Street, NW
Washington, DC 20036
Tel: (202) 833-4000
Fax: (202) 822-7397
www.nea.org

National Employment Law Project, Inc.
55 John Street, 7th Floor
New York, NY 10038
Tel: (212) 285-3025
Fax: (212) 285-3044
www.nelp.org

National Federation of Democratic Women
719 Woodacre Road
Jackson, MS 39206
Tel: (601) 982-0750
Fax: (601) 713-3068
www.nfdw.org

National Federation of Republican Women
124 North Alfred Street
Alexandria, VA 22314
Tel: (703) 548-9688
Fax: (703) 548-9836
www.nfrw.org

National Foundation for Women Business Owners
1411 K Street, NW, Suite 1350
Washington, DC 20005
Tel: (202) 638-3060
Fax: (202) 638-3064
www.nfwbo.org

National Gay and Lesbian Task Force
1700 Kalorama Road, NW
Washington, DC 20009-2624
Tel: (202) 332-6483
Fax: (202) 332-0207
www.ngltf.org

National Latina Institute for Reproductive Health
1200 New York Avenue, NW
Suite 206
Washington, DC 20005
Tel: (202) 326-8970
Fax: (202) 371-8112
www.nlirh.org

National Law Center on Homelessness and Poverty
1411 K Street, NW, Suite 1400
Washington, DC 20005
Tel: (202) 638-2535
Fax: (202) 628-2737
www.nlchp.org

National Organization for Women
733 15th Street, NW, 2nd Floor
Washington, DC 20005
Tel: (202) 628-8669
Fax: (202) 785-8576
www.now.org

National Organization for Women Legal Defense and Education Fund
395 Hudson Street, 5th Floor
New York, NY 10014
Tel: (212) -925-6635
Fax: (212) -226-1066
www.nowldef.org

National Partnership for Women and Families
1875 Connecticut Avenue, NW
Suite 710
Washington, DC 20005
Tel: (202) 986-2600
Fax: (202) 986-2539
www.nationalpartnership.org

National Political Congress of Black Women
8401 Colesville Road, Suite 400
Silver Spring, MD 20910
Tel: (301) 562-8000
Fax: (301) 562-8303
www.npcbw.org

National Prevention Information Network (HIV, STD, TB)
Centers for Disease Control
P.O. Box 6003
Rockville, MD 20849-6003
Tel: (800) 458-5231
Fax: (888) 282-7681
www.cdcnpin.org

National Resource Center on Domestic Violence
6400 Flank Drive, Suite 1300
Harrisburg, PA 17112-2778
Tel: (717) 545-6400
Tel: (800) 537-2238
Fax: (717) 545-9456
www.healthfinder.gov/text/orgs/HR2494.htm

National Women's Business Council
409 Third Street, SE, Suite 210
Washington, DC 20024
Tel: (202) 205-3850
Fax: (202) 205-6825
www.nwbc.gov

National Women's Health Network
514 10th Street, NW, Suite 400
Washington, DC 20004
Tel: (202) 347-1140
Fax: (202) 347-1168
www.womenshealthnetwork.org

National Women's Health Resource Center
120 Albany Street, Suite 820
New Brunswick, NJ 08901
Tel: (877) 986-9472
Fax: (732) 249-4671
www.healthywomen.org

National Women's Law Center
11 Dupont Circle, NW
Suite 800
Washington, DC 20036
Tel: (202) 588-5180
Fax: (202) 588-5185
www.nwlc.org

National Women's Political Caucus
1630 Connecticut Avenue, NW
Suite 201
Washington, DC 20009
Tel: (202) 785-1100
Fax: (202) 785-3605
www.nwpc.org

National Women's Studies Association
University of Maryland
7100 Baltimore Boulevard
Suite 500
College Park, MD 20740
Tel: (301) 403-0525
Fax: (301) 403-4137
www.nwsa.org

New Ways to Work
785 Market Street, Suite 950
San Francisco, CA 94103
Tel: (415) 995-9860
Fax: (415) 995-9867
www.nww.org

Older Women's League
666 11th Street, NW, Suite 700
Washington, DC 20001
Tel: (202) 783-6686
Fax: (202) 638-2356
www.aoa.dhhs.gov/aoa/dir/207.html

Organization of Chinese-American Women
4641 Montgomery Avenue
Suite 208
Bethesda, MD 20814
Tel: (301) 907-3898
Fax: (301) 907-3899

Pension Rights Center
918 16th Street NW, Suite 704
Washington, DC 20006
Tel: (202) 296-3776
Fax: (202) 833-2472
www.aoa.dhhs.gov/aoa/dir/210.html

Planned Parenthood Federation of America
810 Seventh Avenue
New York, NY 10019
Tel: (212) 541-7800
Fax: (212) 245-1845
www.plannedparenthood.org

Population Reference Bureau, Inc.
1875 Connecticut Avenue, NW
Suite 520
Washington, DC 20009
Tel: (202) 483-1100
Fax: (202) 328-3937
www.prb.org

Poverty and Race Research Action Council
3000 Connecticut Avenue, NW
Suite 200
Washington, DC 20008
Tel: (202) 387-9887
Fax: (202) 387-0764
www.prrac.org

Religious Coalition for Reproductive Choice
1025 Vermont Avenue, NW
Suite 1130
Washington, DC 20005
Tel: (202) 628-7700
Fax: (202) 628-7716
www.rcrc.org

Substance Abuse and Mental Health Services Administration (SAMHSA)
3600 Fisher's Lane
Room 12-105
Rockville, MD 20857
Tel: (301) 443-4795
Fax: (301) 443-0284
www.samhsa.gov

U.N. Division for the Advancement of Women
Two United Nations Plaza
New York, NY 10017
Tel: (212) 963-3177
Fax: (212) 963-3463

The Urban Institute
2100 M Street, NW
Washington, DC 20037
Tel: (202) 833-7200
Fax: (202) 331-9747
www.urban.org

U.S. Agency for International Development
Office of Women in Development
RRB 3.8-042U
Washington, DC 20523-3801
Tel: (202) 712-0570
www.genderreach.com

U.S. Department of Commerce
Bureau of the Census
Population Division
Washington, DC 20233
Tel: (301) 457-4100
Fax: (301) 457-4714
www.census.gov

U.S. Department of Education
400 Maryland Avenue, SW
Washington, DC 20202-0498
Tel: (202) 401-1576
Tel: (800) USA-LEARN
Fax: (202) 401-0689
www.ed.gov

U.S. Department of Justice, Violence Against Women Office
Office of Justice Programs
810 Seventh Street, NW
Washington, DC 20531
Tel: (202) 616-8894
Fax: (202) 307-3911
www.ojp.usdoj.gov/vawo

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201
Tel: (202) 619-0257
www.os.dhhs.gov

U.S. Department of Labor
Bureau of Labor Statistics
State Labor Force Data
2 Massachusetts Avenue, NE
Washington, DC 20012
Tel: (202) 691-5200
Fax: (202) 691-7890
stat.bls.gov

U.S. Department of Labor
Women's Bureau
200 Constitution Avenue, NW
Room No. S-3002
Washington, DC 20210
Tel: (202) 219-6611 x157
Tel: (800) 827-5335
Fax: (202) 219-5529
www.dol.gov/dol/wb

Victim Services, Inc.
2 Lafayette Street, 3rd Floor
New York, NY 10007
Tel: (212) 577-7700
Fax: (212) 385-0331
www.victimservices.org

White House Office for Women's Initiatives and Outreach
Room 15, O.E.O.B.
Washington, DC 20502
Tel: (202) 456-7300
Fax: (202) 456-7311
www2.whitehouse.gov/women
Wider Opportunities for Women
815 15th Street, NW, Suite 916
Washington, DC 20005
Tel: (202) 638-3143
Fax: (202) 638-4885
www.w-o-w.org

Women Employed
111 N. Wabash
13th Floor
Chicago, IL 60602
Tel: (312) 782-3902
Fax: (312) 782-5249
www.womenemployed.org

Women, Ink.
777 United Nations Plaza
New York, NY 10017
Tel: (212) 687-8633
Fax: (212) 661-2704
www.womenink.org

Women Work!
The National Network for Women's Employment
1625 K Street, NW, Suite 300
Washington, DC 20006
Tel: (202) 467-6346
Fax: (202) 467-5366
www.womenwork.org

Women's Cancer Center
900 Welch Road, Suite 300
Palo Alto, CA 94304
Tel: (650) 326-6500
Fax: (650) 326-6553
www.wccenter.com

Women's Environmental and Development Organization
355 Lexington Avenue
3rd Floor
New York, NY 10017
Tel: (212) 973-0325
Fax: (212) 973-0335
www.wedo.org

Women's Institute for a Secure Retirement
1201 Pennsylvania Avenue, NW
Suite 619
Washington, DC 20004
Tel: (202) 393-5452
Fax: (202) 638-1336
www.network-democracy.org/socialsecurity/bb/whc/wiser.html

Women's International League for Peace and Freedom
1213 Race Street
Philadelphia, PA 19107
Tel: (215) 563-7110
Fax: (215) 563-5527
www.people-link.com/wilpf

Women's International Network
Charlotte Crafton
c/o Women's International Network
45 E. City Line Avenue
Suite 299
Bala Cywnyd, PA 19004
Tel: (215) 871-7655
Tel: (888) 594-3342
www.w-i-n.com

Women's Research and Education Institute
1750 New York Avenue, NW
Suite 350
Washington, DC 20006
Tel: (202) 628-0444
Fax: (202) 628-0458
www.wrei.org

Young Women's Christian Association of the USA (YWCA)
Empire State Building
350 Fifth Avenue, Suite 301
New York, NY 10118
Tel: (212) 273-7800
Fax: (212) 465-2281
www.ywca.org

The Young Women's Project
923 F Street, NW, 3rd Floor
Washington, DC 20004
Tel: (202) 393-0461
Fax: (202) 393-0065
www.tidalwave.net/~ywp

Appendix VI:
List of Census Bureau Regions

East North Central

Illinois
Indiana
Michigan
Ohio
Wisconsin

East South Central

Alabama
Kentucky
Mississippi
Tennessee

Middle Atlantic

New Jersey
New York
Pennsylvania

Mountain West

Arizona
Colorado
Idaho
Montana
New Mexico
Nevada
Utah
Wyoming

New England

Connecticut
Maine
Massachusetts
New Hampshire
Rhode Island
Vermont

Pacific West

Alaska
California
Hawaii
Oregon
Washington

South Atlantic

Delaware
District of Columbia
Florida
Georgia
Maryland
North Carolina
South Carolina
Virginia
West Virginia

West North Central

Iowa
Kansas
Minnesota
Missouri
Nebraska
North Dakota
South Dakota

West South Central

Arkansas
Louisiana
Oklahoma
Texas

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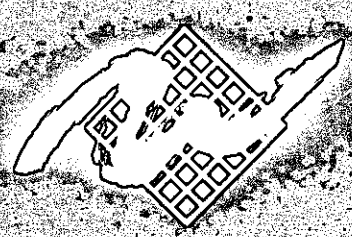
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**TESTIMONY IN SUPPORT OF HB 762,
AN ACT INCREASING THE CIGARETTE TAX
TO ALLOW FOR A HEALTHY FAMILIES TRUST FUND
AND FOR INCREASED FUNDING FOR
THE TOBACCO USE PREVENTION FUND**

March 15, 2001

Good morning, Mr. Chairman and members of the Committee. I'm Gina Balkus, Director of Government Relations for Dartmouth-Hitchcock, which includes Dartmouth-Hitchcock Medical Center in Lebanon, NH, and the Dartmouth-Hitchcock Clinic community practices throughout New Hampshire. Dartmouth-Hitchcock Medical Center is home to the Norris Cotton Cancer Center, the state's only National Cancer Institute-approved comprehensive cancer center and ChaD -- the Children's Hospital at Dartmouth -- which is a nationally-accredited children's hospital offering the state's only pediatric intensive care unit.

We support House Bill 762 from several different perspectives. As a provide of highly-specialized cancer care and research, we see the ravages of lung cancer in the patients we treat. Smoking is a major cause of lung cancer. Reducing smoking, especially among our youth in New Hampshire, should be major state initiative. Increases in the cost of cigarettes are a proven deterrent to youth smoking. HB 762 is a step in the right direction toward deterring youth smoking. Secondly, the additional $7.8 million that will be directed to the tobacco use prevention fund will bring New Hampshire closer to the CDC's recommendation for prevention resources in this state.

As a children's hospital and a major provider of pediatric primary care throughout New Hampshire, we support HB 762's dedicated funding of the Children's Health Insurance Program. This program has increased access to health care for low and middle income children in New Hampshire. We are seeing more and more children who have coverage through CHIP. These children now have a "medical home" – a regular pediatrician that they most likely did not have when they were uninsured. A State revenue stream is essential to assuring the continued success of the CHIP program in New Hampshire.

HB 762 offers the multiple advantage of generating new revenues for important programs such as tobacco prevention, CHIP and other worthwhile family health initiatives, and it also serves as an important public health effort to deter youth smoking. On behalf of Dartmouth-Hitchcock, I urge you to recommend HB 762 as "ought to pass."

Hearing Testimony March 15, 2001
RE: HB 762 Health Now

Kimberly McGlinchey
HC 74 Box 823 Strafford, New Hampshire. 03884
603-664-9513

To the New Hampshire House Ways and Means Committee,

My Name is Kimberly McGlinchey and I am a resident of Strafford, New Hampshire. I am currently a graduate student at the University of New Hampshire, a mother of three and a part time waitress. My husband is a self employed roofer. Our children are enrolled in the healthy kids program and have been since its inception.

Before this program came into existence we struggled to pay for immunizations, check ups and much needed dental appointments. Any type of insurance we priced was well above and beyond what we could afford for even minimum coverage. So we went without.

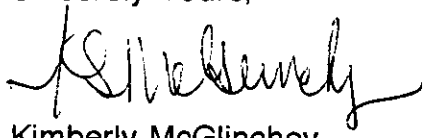
At this point my husband and I have no coverage at all. This is risk we feel we have to take, the cost is just too exorbitant. But, this risk has not panned out for us so well in the last year.

In August my husband feel 18 feet and broke his neck. we were lucky- he has healed is currently back at work. The bills totaled approximately $7,000 and the fact that he lost ten weeks of work brings the total loss to approximately 10,000. Our credit was good, it is now becoming tarnished. This is all because we could not afford the coverage we wanted.This incident is not uncommon and is the number one reason people claim bankruptcy.

Having insurance for us, even minimal coverage, would save our family, as well as, others like us from undue hardship and stress. Whether it be from tarnished credit or the impacts of a health emergency.

Please consider creating the Healthy Families Trust Fund which will insure that our children will continue to be have health insurance, and that many parents will too.

Sincerely Yours,



Kimberly McGlinchey

Children Alliance eleonard@childrennh.org

3.4 Substance Abuse

Definition

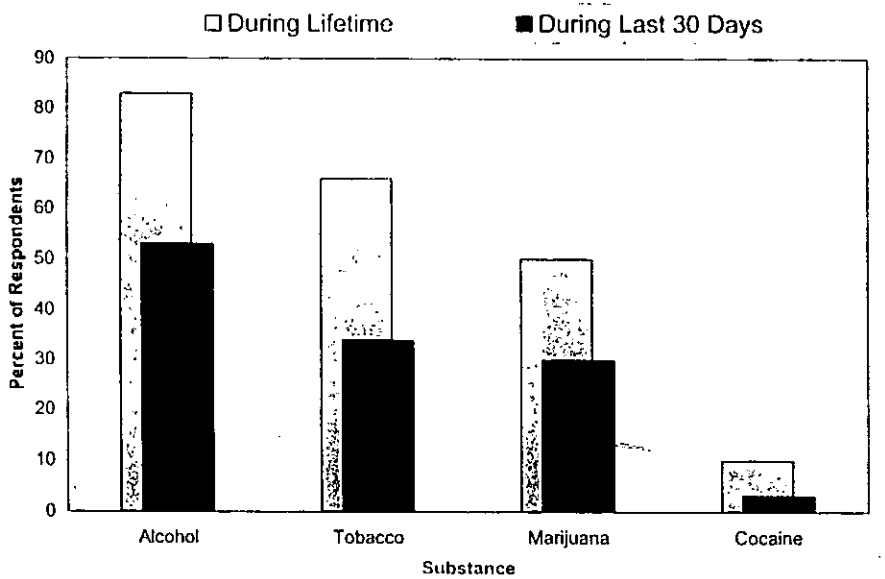
Substance abuse measures the percentage of youth (grades 9-12) who indicate they have used alcohol, tobacco, or illegal drugs during a specified period of time.

Findings

In 1999, the New Hampshire Department of Education conducted a survey among high school students (grades 9-12) regarding risky behavior.[20] Of 2,213 New Hampshire high school students who responded, 53% indicated they had consumed alcohol within the past 30 days, 34% had smoked tobacco, 30% had smoked marijuana, and 3% had used some form of cocaine during the same period. The rates of ever having used these substances during their lifetimes were 83%, 66%, 50%, and 10% respectively. These are shown in Figure 3-4.

Of 33 states surveyed in 1997, New Hampshire ranked sixth highest for high school drinking. That figure contrasts sharply with our ranking as the sixth lowest state nationwide for per capita expenditures on alcohol and other drug services.[21]

Figure 3-4 Substance Abuse by Responding Teens



Significance

Substance abuse poses a risk to children, families, and the broader community:

- Children who abuse drugs and alcohol are more likely to engage in high-risk sexual behavior, become teen parents, drop out of school, and/or become court involved.[22]
- Children ages 12 to 17 who smoke marijuana are twice as likely to cut classes at school, steal, assault others, or destroy property than those who do not smoke marijuana.[23]
- Children who use alcohol are more likely to abuse drugs as adults.[24]
- Children who use tobacco are more likely to become addicted to nicotine, thereby increasing their risk for smoking and nicotine-related diseases.[25]

New Hampshire needs to make a substantial investment in substance abuse prevention efforts and aggressively address the serious challenge of drug and alcohol use by New Hampshire youth.

Prevention programs need to target children before as well as during adolescence and focus on helping our youth develop critical life skills and supportive relationships.[26] Immediate action steps recommended in the *Children's Agenda 2000* include:

- Government agencies need to identify and support best-practice models for in-school and community-based substance abuse prevention programs, peer acceptance, and self-esteem programs.
- Community-based substance abuse support groups should be incorporated into the school setting.
- Local businesses should consider ways to develop mentoring and job-shadowing opportunities in their communities.
- Local schools should encourage parental involvement.
- State government should make grants available to communities for violence prevention training.
- State and local government should support after school programming as a part of an adequate education.
- Comprehensive health education, including information on sexuality, drugs and alcohol should be incorporated as an integral part of school curricula, kindergarten through grade twelve.

March 15, 2001

Written testimony of:
Candice Leonard
Dir. of Research & Policy Analysis
Children's Alliance of New Hampshire 225-2264 CLeonard@ChildrenNH.org

Attachment: *Raising State Tobacco Taxes Always Reduces Tobacco Use (and Always Increases State Revenues),* publication of Campaign for Tobacco-Free Kids, Washington, DC

Testimony in support of HB 762: An act increasing the tobacco tax to allow for a healthy families trust fund and for increased funding for the tobacco use prevention fund.

Speaking on behalf of the children of the state of New Hampshire, the Children's Alliance enthusiastically supports HB 762 because it is an effective way of addressing a number of critical health care issues today, and it also has many positive ripple effects that will enhance the health and well-being of New Hampshire's children and families in the future. It is an intelligent response to today's challenges, that also takes a prevention approach to the challenges of tomorrow.

I would like to comment specifically on the three provisions of this bill that have the most impact on children:

Increasing the cigarette tax will raise revenue to fund prevention efforts, and be an economic deterrent to youth smoking:

- Tobacco is a huge problem in the New Hampshire:
- 1 out of 3 households use tobacco products
- Almost a quarter of adults in New Hampshire smoke cigarettes
- 1.2 million packs of cigarettes are sold (illegally) to children in NH every year.
- Over half of all adult smokers start smoking prior to age 18
- 70,000 children in NH are exposed to second-hand smoke at home

If this increase in the price of cigarettes deters a few thousand NH children from becoming addicted to nicotine, the bill will have accomplished something very important. In addition, the revenue it generates will be used for tobacco education and smoking prevention efforts, allowing our state to fund these efforts at the minimum level suggested by the CDC.

Recent KIDS COUNT data show that the proportion of births to mothers who smoke is higher in NH (17%) than the US average—and this is after a 20% decrease over the past eight years. Maternal smoking is the

single biggest contributor to low birthweight babies. These babies are at risk for serious respiratory and neurological complications, which often require costly hospital care. (New Futures; KIDS COUNT, *Right Start*)

Funding CHIP: (Healthy Family Trust Fund)

The Healthy Kids program has been a huge success, but can no longer be supported by the Healthy New Hampshire Foundation. HB 762 would ensure the continuation and expansion of the Healthy Kids programs. The Healthy Kids program should not be a victim of its own success.

W/o health insurance, kids are 3 ½ times less likely to get the medical care they need, and 4 times less likely to get dental care. These delays in care cause minor health problems to become serious, with greater cost, both in human suffering and in dollars. Lack of access to health care negatively impacts children's education because of frequent absences. Many uninsured children need eyeglasses but go without them because they can't afford it. Just as uninsured kids miss school, their parents miss more days of work, thus impacting workplace productivity and income.

The number of uninsured kids will grow in the future due to rising insurance and health care costs. Fewer employers will offer insurance, and those that do may not offer plans that can include employees children.

HB 762 would also expand insurance coverage to adults whose children are currently enrolled in Healthy Kids.

Health Insurance for Child Care Workers

This bill would explore the possibilities of the state providing health insurance for child care workers. Currently, there is a shortage of qualified child care workers, and turnover in this profession is as high as 60% in some areas of the state. Many child care centers have closed their doors because of staffing problems. HB762 would add stability to the child care workforce through provision of a much needed benefit. This bill would also have a positive ripple effect on the quality of care throughout the state by reducing the turnover that has such a devastating impact on quality of care.

HB 762 is an effective way of directly addressing a number of critical health care issues today, but it also has many ripple effects that will have a positive impact on the health and well-being of New Hampshire's children and families in the future.

We respectfully urge the Ways and Means committee to pass HB 762.

CAMPAIGN for TOBACCO-FREE Kids®

RAISING STATE TOBACCO TAXES ALWAYS REDUCES TOBACCO USE (AND ALWAYS INCREASES STATE REVENUES)

For over 15 years, economic research studies have consistently documented the fact that cigarette price increases reduce smoking, especially among kids. These studies currently conclude that every 10 percent increase in the real price of cigarettes will reduce the total amount of adult smoking by about four percent and reduce teen smoking by roughly seven percent.[1] Over the past decade or so, many states have raised their cigarette tax rates and, as the economic research predicts, the tax increases reduced cigarette consumption in each of these states below what it would otherwise have been. Nevertheless, every single one of these states also enjoyed increased cigarette tax revenues, despite the reductions in smoking and cigarette sales. Put simply, in every state the revenue losses from fewer cigarette sales were more than made up for by the increased state revenues per pack.

Recent State Experiences With Tobacco Tax Increases

State	Date	Tax Increase Amount (per pack)	New Tax (per pack)	Consumption Decline (percent)	Revenue Increase (percent)	New Revenues (millions)
Alaska	1997	71¢	$1.00	-13.5%	+202%	$28.7
Hawaii	1998	20¢	$1.00	-8.1%	+19.9%	$6.4
Illinois	1997	14¢	58¢	-8.9%	+19.0%	$77.4
Maine	1997	37¢	74¢	-15.5%	+66.7%	$30.8
Maryland	1999	30¢	66¢	-16.3%	+53.9%	$69.0
Massachusetts	1996	25¢	76¢	-14.3%	+28.0%	$64.1
Michigan	1994	50¢	75¢	-20.8%	+139.9%	$341.0
New Hampshire	1999	15¢	52¢	-10.3	+26.2%	$19.2
New Jersey	1998	40¢	80¢	-16.8%	+68.5%	$166.6
Oregon	1997	30¢	78¢	-8.3%	+77.0%	$79.8
Rhode Island	1997	10¢	71¢	-1.5%	+16.2%	$8.6
South Dakota	1995	10¢	33¢	-5.6%	+40.4%	$6.1
Utah	1997	25¢	51.5¢	-25.7%	+42.4%	$12.7
Vermont	1995	24¢	44¢	-16.3%	+84.2%	$11.7
Wisconsin	1997	15¢	59¢	-6.5%	+25.8%	$52.9

Sources: Orzechowski & Walker, *Tax Burden on Tobacco* (2000) [a tobacco industry funded compilation of state tobacco tax, price, and revenue data]; Maryland and New Hampshire data from the states' revenue offices. Consumption declines and revenue increases calculated from the first full fiscal year before the tax increase to the first full year after the tax increase.

Final data from California, which increased their cigarette taxes in 1999, is not yet available, but preliminary reports indicate that in the fiscal year after California raised its tax by an additional 50 cents per pack (to 87 cents per pack), state cigarette sales fell by eleven percent while revenues increased by 38 percent (or more than $300 million).[2] In addition, the early evidence from New York state -- which raised its cigarette taxes by 55 cents to $1.11 per pack (the highest rate in the country) in March 2000 -- shows that from April to July 2000 state cigarette sales dropped by more than 22 percent compared to the same months the previous year but the state's cigarette tax revenues had still increased by 47 percent (or more than $100

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million).[3]

Cigarette Company Attacks on State Tobacco Tax Increases

Internal tobacco industry documents that have been made public in the various lawsuits against the cigarette companies show that since at least the early 1980s the companies have fully accepted the fact that cigarette tax increases reduce their sales, especially among kids (their replacement customers).[4] Accordingly, it is not surprising that the companies spend millions of dollars to oppose any proposed state tobacco tax increases. But when the cigarette companies argue that state cigarette tax increases will not reduce smoking or that state tobacco revenues will be eroded by cigarette smuggling and cross-border purchases they are ignoring the firmly established fact that *every single state that has significantly increased its cigarette taxes has both reduced cigarette sales and increased state revenues.*

Despite this fact, 36 states have not increased their cigarette tax rates for at least five years, and 17 of those states not having increased their cigarette taxes for ten years or more. Six states have not increased their cigarette taxes since the 1970s or 1960s. Compared to when they were first passed into law, the cigarette tax rates in most states have been substantially eroded by inflation and now constitute a much smaller percentage of the total price of a pack of cigarettes.

The National Center for Tobacco-Free Kids, September 18, 2000

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[1] See, e.g., Chaloupka, F. J., "Macro-Social Influences: The Effects of Prices and Tobacco Control Policies on the Demand for Tobacco Products," *Nicotine and Tobacco Research* (forthcoming); Chaloupka, F. J. & R. Pacula , *An Examination of Gender and Race Differences in Youth Smoking Responsiveness to Price and Tobacco Control Policies*, National Bureau of Economic Research, Working Paper 6541 (April 1998). See, also, Gruber, J. & J. Zinman, "Youth Smoking in the U.S.: Evidence and Implications," National Bureau of Economic Research Working Paper No. 7780 (July 2000); Purcell, W. D., *Changing Prices, Changing Cigarette Consumption*, Virginia Tech Rural Economic Analysis Program (May 1999); Evans, W.N., and L.X Huang, "Cigarette Taxes and Teen Smoking: New Evidence from Panels of Repeated Cross-Sections," Manuscript, Department of Economics, University of Maryland (1998); Credit Suisse, "Sensitivity Analysis on Cigarette Price Elasticity," First Boston Corporation (December 1998); Evans, W. N. & L. X. Huang, *Cigarette Taxes and Teen Smoking: New Evidence from Panels of Repeated Cross-Sections*, working paper (April 15, 1998);Harris, J. E. & S. W. Chan, "The Continuum-of-Addiction: Cigarette Smoking in Relation to Price Among Americans Aged 15-29," *Health Economics Letters* 2(2) 3-12 (February 1998); U.S. Centers for Disease Control and Prevention (CDC), "Responses to Cigarette Prices By Race/Ethnicity, Income, and Age Groups -- United States 1976-1993," Morbidity and Mortality Weekly Report 47(29): 605-609 July 31, 1998); Institute of Medicine, *Taking Action to Reduce Tobacco Use*, the National Academy of Sciences (1998); Chaloupka, F. J. & M. Grossman, "Cigarette Taxes: The Straw to Break the Camel's Back," *Public Health Reports* 112(4): 291-97 (July/August 1997); Lewitt, E.M., A. Huland, N. Kerrebrock, and K.M. Cummings, "Price, Public Policy and Smoking in Young People," *Tobacco Control*, 6(S2)"17-24 (1997); Chaloupka, F.J., and M. Grossman, "Price, Tobacco Control Policies, and Youth Smoking," National Bureau of Economic Research Working paper Number 5740 (1996); National Cancer Institute, *The Impact of Cigarette Excise Taxes on Smoking Among Children and Adults: Summary Report of a National Cancer Institute Expert Panel* (1993); Lewit, E.M., and D. Coate, "The Potential for Using Excise Taxes to Reduce Smoking, " *Journal of Health Economics*, 1(2):121-54 (1982).

[2] See, e.g., Reuters, "California Cigarette Sales Plunge After New Tax" (September 13, 1999).

[3] From NY State Department of Taxation and Finance, www.tax.state.ny.us.

[4] See, e.g., Philip Morris Executive Jon Zoler, "Handling An Excise Tax Increase," (September 3, 1987), PM Bates Number: 2058122240/2241; R.J. Reynolds Executive D. S. Burrows, "Estimated Change In Industry Trend Following Federal Excise Tax Increase" (September 20, 1982), RJR Bates Number 500045052/5132; Philip Morris Research Executive Myron Johnston, "Teenage Smoking and the Federal Excise Tax on Cigarettes" (September 17, 1981), PM Bates Number: 2001255224/5227.

New Hampshire Association for the Elderly
4 Park Street, Suite 403, Concord, New Hampshire 03301
Phone: 228-1054; fax: 228-3360

The Alliance for a Healthy New Hampshire
4 Park Street, Suite 403
Concord, NH 03301

Re: Health Now! Campaign

Health care access is one of the most important issues for New Hampshire seniors, specifically access for seniors to receive adequate and *essential*, prescription drug coverage. That is why the New Hampshire Association for the Elderly (NHAE) supports the Health Now! Campaign and the legislation in front of you today, HB 762. NHAE is a non-profit organization with a statewide membership of over 3,000 members and prescription drug coverage is a top policy priority. NHAE has been working towards our goal of having prescription drug coverage for as many seniors as possible for the last few years – something that is desperately needed.

HB 762 creates several mechanisms to expand coverage for seniors, an issue that has risen to almost crisis proportions. One of the mechanisms is through expansion of Medicaid for seniors with incomes between 75% and 100% of the federal poverty level (fpl). Currently there are over 17,000 seniors in NH below the fpl, and only 8,500 on Medicaid. This would increase the number of seniors eligible for expansion to at least another 8,500. In addition, this legislation initiates a program that would provide seniors over 65 and people with disabilities who are at or below 200% of the fpl and not eligible for Medicaid a $1,250 benefit for 32,000 people.

That is a lot more coverage for at least 40,500 New Hampshire residents!

There are seniors in this state who struggle every day between taking their medication or buying their groceries because of the high cost of their prescriptions. Creating a source of revenue to increase access for seniors on prescription drugs is critically needed. Passing this legislation is one step forward in working to addresses that need.

Sincerely,

Bob Stauffer
New Hampshire Association for the Elderly

American Heart Association.

Fighting Heart Disease and Stroke

Testimony of Nancy Pederzini
Advocacy and Community Programs Director, American Heart Association, NH
March 15, 2001

Chairman Alukonis and Committee Members, thank you for allowing me to speak today. For the record, my name is Nancy Pederzini, Advocacy and Community Programs Director for the American Heart Association. On behalf of the New Hampshire office of the American Heart Association, I would like to ask for your support for HB 762.

One of the American Heart Association's top advocacy priorities is reducing tobacco use. The largest portion of the more than 400,000 smoking-related deaths each year is cardiovascular related. In fact, one in five deaths from cardiovascular disease is smoking related. And hundreds of thousands of others suffer from cardiovascular diseases such as atherosclerosis, peripheral vascular disease, congestive heart failure, heart attacks and stroke as a result of their smoking.

Also, given that tobacco use is the most preventable cause of cardiovascular disease, the American Heart Association is strongly supportive of HB 762 because it offers the best approach to reducing tobacco use in New Hampshire – increasing the state's tobacco tax while strengthening the state's tobacco prevention program.

The best way to reduce tobacco use is to combine a fully-funded, comprehensive tobacco control program with a large increase in the state's tobacco tax. Economic studies have consistently shown that cigarette price increases by themselves can reduce smoking rates. This effect is even stronger among young people. Increasing tobacco taxes is reliable and effective method to decrease smoking. Research has shown that because children have less disposable income, they are three times more likely than adults to quit smoking as a result of a tax increase. And an increase of 10% in the price of tobacco would also result in one out of every fifteen college-age smokers quitting – a group that is increasingly targeted by tobacco manufacturers.

But, tobacco use is a complex issues that must be addressed on several fronts simultaneously to have a significant impact. Evidence from California, Massachusetts and Oregon has shown that a tobacco tax increase, combined with a comprehensive tobacco control program, can reduce tobacco use rates by substantial amounts among adults and young people, and can achieve impressive health benefits.

Studies conducted in California found decreases in tobacco use, lung cancer and heart disease. In fact, a study in the December 14, 2000 New England Journal of Medicine by the University of California (that examined that state's comprehensive program that was

funded with a 25 cent increase in the tobacco tax) showed that not only did this state have the most significant drop in tobacco use at 50%, but, **33,000 heart-disease deaths were also prevented during the first nine years of the program.** Perhaps even more striking is that researchers in the study also found that cutting back on programs has negative results. The University of California researchers found that 8,300 deaths from heart disease could be attributed to budget cuts and changes made to narrow the focus of the program in 1992.

The California experience has clearly demonstrated that a comprehensive tobacco control program and a significant tax increase will save lives. New Hampshire has the opportunity to provide its residents with the same benefits. Please support HB 762 in order to raise the funding for New Hampshire's program to an adequate and effective level. The Centers for Disease Control (CDC) has developed recommended funding levels for each state based on science and programs that have been found to be effective in other states. The current funding of $3,000,000 is only 27.5% of the CDC's recommended minimum funding level for New Hampshire. Passing HB 762 would bring the annual funding for the program to $10.8 million – the CDC's recommended minimum for New Hampshire.

We also know that tobacco tax increases need to be significant if they are to be effective in reducing tobacco consumption. HB 762 accomplishes this by increasing the existing tax by 50 cents to $1.02. Yet, at the same time, stores in New Hampshire's border communities can still maintain a competitive advantage. Governor Howard Dean of Vermont has requested a 67 cent increase in that state's tax which would bring Vermont's tobacco tax to $1.11.

Because smoking levels are highest among low-income residents, the cigarette companies argue that cigarette tax increases are regressive. In reality, low income residents in this state disproportionately suffer from smoking and therefore the economic and personal costs related to smoking. Increasing the tobacco tax will help prompt smokers to quit and keep kids from ever starting. The state has set aside $150,000 to provide low income residents with vouchers to help them quit smoking, the tobacco program funding included in HB 762 could provide additional cessation assistance. Additionally, revenues raised by the cigarette tax will help offset health care costs for those least able to bear the burden of tobacco related disease. The funding provided to the Health Families Trust Fund under HB 762 would alleviate many health care concerns for low income residents by providing greater access to health care to the elderly, children and parents.

I strongly urge you to support this bill. The combination of a comprehensive tobacco control program with a tobacco tax increase and greater funding for health access will save New Hampshire lives and save all New Hampshire residents millions in health care costs. Thank you for your time.

AMERICAN CANCER SOCIETY®
New England Division, Inc.

TESTIMONY

Dennis A. Hebert
Director of Advocacy
American Cancer Society

Re: HB 762-FN-A, An Act increasing the tobacco tax to allow for a healthy families trust fund and for increased funding for the tobacco use prevention fund.

Good morning Mr. Chairman and members of the Committee. On behalf of the American Cancer Society, I want to thank you for the opportunity to testify in support of HB 762.

There is not a person in this room who has not been directly or indirectly impacted by the ravages of this modern day "plague" we call cancer. Cancer does not recognize whether it is the best of times or the worst of times. Cancer cares not whether you are 80 years old or eight years old. Cancer does not care whether you are a republican, democrat or independent. Cancer does not patiently wait for resolution of a state's governmental problems whether they are political, economic or social.

Tobacco use causes 430,700 deaths a year and creates $138 billion in annual costs. In fact, nearly 1 in 5 deaths in the US result from the use of tobacco products. Every year, more than 5 million years of life could have been saved if every person who died from cigarette smoking had lived to his or her average life expectancy. Exposure to second-hand smoke, for example, is an acknowledged health hazard that each year causes 3,000 lung-cancer deaths among nonsmokers. In addition, more than 6,000 deaths among children each year are linked to parental smoking, primarily from low birth weights caused by smoking during pregnancy.

The American Cancer Society has long recognized that smoking is the most preventable cause of death in this country. Compared to people who have never smoked during their lifetime, lung cancer mortality rates are about 23 times higher for current male smokers and 13 times higher for current female smokers. In addition to being responsible for 87% of lung cancers, smoking is also associated with cancers of the mouth, pharynx, larynx, esophagus, pancreas, uterine cervix, kidney and bladder. Smoking accounts for at least 30% of all cancer deaths, is a major cause of heart disease and is associated with conditions ranging from colds and gastric ulcers to chronic bronchitis, emphysema, and cerebrovascular disease (which relates to blood circulation).

Every day in the state of New Hampshire, five citizens die from the end-result of protracted use of tobacco products. This amounts to over 1800 people a year, young and old, poor and rich. Increasingly, tobacco use has become in a real sense a "pediatric" disease because, most often, its genesis is found in our precious youth who are the most susceptible to the allure of false promises that tobacco companies advertise. These are our sons and daughters, our grandchildren, the future leaders of this great state.

Perhaps more revealing are the results of the "Smoke Free New England Survey" conducted in August of 2000 by the Institute for Policy and Social Science Research at the University of New Hampshire. The purpose of this survey was to assess the attitudes of both New England and New Hampshire voters about programs designed to reduce smoking by youth, attitudes toward limiting smoking in public, attitudes toward cigarette taxes and how to spend tobacco settlement money. 2480 registered voters from the six state region were interviewed and this included 413 registered voters in New Hampshire.

(I have included the Executive Summary and a number of charts from this survey in my written testimony)

There were a number of startling results and I will only mention a few:

- **regarding reducing smoking among youth, 75% favor making all public places, including restaurants, smoke-free**

- **62% say they would be more likely to vote for their state legislator if he or she voted to increase the state tax on cigarettes by 25 cents per pack. 83% of these voters indicated that they would also be more likely to vote for that legislator if the proposal were for 50 cents per pack.**

- **62% strongly favor using cigarette tax revenues for tobacco control programs that discourage young people from smoking**

- **78% favor using cigarette tax revenues to help seniors pay for prescription drugs**

- **4 in 5 current smokers (i.e. 82%) say they have made at least one serious attempt to quit smoking with 40% making 3 or more serious attempts.**

- **The most helpful options to quit smoking, as reported by current smokers, are raising the price of cigarettes by $1 or a loved one's advice to quit.**

At the American Cancer Society, the emphasis on access to care is to ensure that all people have access to the full range of high-quality cancer-related services. HB 762 is not the final resolution of these ills but it would be another step in the process to

ensure that all New Hampshire citizens have the support of their elected officials in the struggle against cancer and the opportunity for complete health care access.

Testimony on HB 762
Submitted by Sam Mekrut
Executive Director, NH Citizens Alliance for Action
March 15, 2001

Good Morning Mr. Chairman, members of the committee. Thank you for the opportunity to speak on HB 762 – the Healthy Families Trust Fund Act. My name is Sam Mekrut and I am the director of NH Citizens Alliance for Action. NH Citizens Alliance for Action is an organization with 5,000 members statewide committed to a mission of social, economic and political justice for all. As a founding member of the growing coalition of organizations supporting HB 762, I wanted to explain the genesis of this legislation and express why so many of us here today feel that this is the right thing to do and the right time to do it.

Last summer, members of the Medical Society, the American Cancer Society and consumer groups focused on health care issues throughout New England came together to discuss the possibility of working together as a region to uniformly raise tobacco taxes to fund tobacco control and health access programs. In joining together, the intention is to eliminate cross-border sales issues that arise when one state moves forward alone. Since last summer, hundreds of groups have signed on to active campaigns in each of the six New England states to devote revenues from a $0.50 increase in tobacco taxes to bring tobacco control funding up to levels recommended by the Center for Disease Control and to address critical health care needs in their states. Each of the New England states have proposed new, innovative programs to address the most urgent needs of its citizens and improve the overall efficiency of their health care systems.

Here in NH, HB 762 was crafted to address issues identified in the study committee established under SB 183 relative to the uninsured. It addresses the problem of access to prescription drugs for low-income senior citizens and for adults with disabilities and the lack of state funding for the current Child Health Insurance Program. It also attempts to address the growing childcare crisis in our state by helping low wage child care workers access health insurance coverage. The health care programs outlined in HB 672 have the

potential to help improve the lives of more than 100,000 people in our state, just a few of whom you will hear from today.

Providing access to health care services is not only good for our state's citizens, but it is also fiscally responsible. Efforts to expand health access issues do come at a cost, but these costs pale in comparison to the burden borne by our economy and our health care system by *not* addressing them. Studies have shown that people lacking health care coverage are more apt to lose work time. They are also more likely to delay care, resulting in costly emergency room visits and hospitalizations. And I'm sure all of us have heard stories from seniors – our own grandparents and parents – who share their prescriptions with their spouses or take half of the required dosage of expensive pills, resulting in costly medical complications.

By providing greater funding for tobacco use prevention and cessation programs, HB 762 also stands to save the state's health care system considerable expense. NH currently spends an estimated $325 million each year on the direct costs of treating smoking-related illnesses. By investing $7.8 million to bring NH's tobacco control in line with CDC- recommended levels, NH could not only save countless families from the suffering incurred from smoking illnesses and death, but also alleviate a substantial financial burden on our health care system.

In creating new programs to address serious health care issues in NH, HB 762 offers a responsible revenue source to offset their costs. Given that one of the goals of HB 762 is to reduce smoking, it makes good sense to use tobacco taxes as the revenue source. Others here today will testify about the effectiveness of raising tobacco taxes to reduce smoking rates, particularly among teens.

The coalition of organizations in NH supporting HB 762 is large and growing. Among its members to date are: NH Medical Society, American Cancer Society, American Lung Association, Children's Alliance of NH, NH Nurses Association, American Heart Association, NH Healthy Kids Corporation, NH Women's Lobby, NH Citizens Alliance

for Action, NH Nurse Practitioners Association, New Future, Kickin' Butts, NH Teen Institute, NH Association for the Elderly, American Red Cross Greater Manchester Chapter, NH Chapter of the National Association of Social Workers, NH Association for the Education of Young Children, and the Congress of Claremont Senior Citizens. Together, these organizations represent tens of thousands of NH citizens – citizens who believe in the goals of reducing tobacco use and expanding access to health care services.

It is not only our organizations' members, but NH voters in general who care deeply about tobacco and health care issues. In speaking to citizens, we have found the level of intensity about the need to address tobacco use – particularly youth smoking – to be extremely high. NH citizens also see the connection between tobacco revenues and health access. A recent survey done by the American Cancer Society also showed that 79% of registered voters in NH favor using tobacco tax revenues for health care for uninsured and underinsured. In the same survey, a large majority of NH voters said they would be more likely to vote for a state legislator who voted to substantially increase the state's current tobacco tax.

All of us here recognize the many fiscal challenges facing our state – and particularly you as policy makers. Two years ago, NH missed an opportunity to use tobacco settlement money to begin to address health-related issues instead allocating the bulk of tobacco settlement dollars and an increase in tobacco taxes to fund its education obligations. While our state continues to struggle with education funding and reconciling the state budget, HB 762 offers a means to move forward on the other issues that NH citizens care deeply about – tobacco and health care. I urge you to support HB 762. Thank you.

SMOKE FREE
New Hampshire

Wednesday, March 14, 2001

A Testimony in Support of HB 762: An act increasing the tobacco tax to allow for healthy families trust fund and for increased funding for the tobacco use prevention fund.

As Chair of the New Hampshire SmokeFree Alliance and President - Elect for the New Hampshire Public Health Association, I urge your support of HB 762, an act that would increase the tobacco tax in New Hampshire. I wholeheartedly believe that by increasing a tax on tobacco the New Hampshire Legislature will send a clear and resounding message to residents of our state which underscores your commitment to the public health.

No one can deny the impact that tobacco has on health status, nor can one deny the accompanying cost of tobacco related illnesses. The cost to NH in 1993 for smoking attributable expenditures totals $340 million dollars. Further the tax burden of NH residents amounts to $180 million.

By increasing the tax on tobacco and allocating the revenue to the Healthy Families Trust Fund and the Tobacco Use Prevention Fund, New Hampshire residents might enjoy a much brighter and healthier future. Higher cigarette prices can result in an overall lowering of tobacco consumption. For example, the Centers for Disease Control and Prevention site a 3-5% reduction in tobacco usage in states that increase taxes by 10%. Further, youth, minorities and low-income smokers are more likely to quit or smoke less when faced with higher tobacco costs; thereby influencing not only individual health and wellbeing, but also those ultimately exposed to environmental tobacco smoke.

This legislation will enhance tobacco prevention efforts throughout New Hampshire by increasing funding to the tobacco use prevention fund. Efforts devoted to protect the public health that include assessing tobacco use, assuring access to care, particularly cessation efforts and developing policy aimed at reducing tobacco use or exposure are sure to be enhanced.

There are an estimated 25,000 children in NH who do not have health insurance. Revenue generated from this tax will help to assure health care access to many residents currently experiencing difficulty in meeting rising health care costs for primary and preventive services.

Again, I urge your support of this bill. I know that one day we all will look back upon this day as one when we made a decision to make a strong and lasting impact on the health of New Hampshire residents.

Respectfully Submitted by,

MaryAnn Cooney, RN,C, MS
New Hampshire Smoke Free Alliance
and New Hampshire Public Health Department, President Elect

3 Pine Knoll Drive
Atkinson, NH 03811
(603)362-9930

March 15, 2001

Dear Chairman Alukonis and Honorable Members of House Ways and Means Committee,

I submit this written testimony as a representative from the Governor's Commission on Disability, a voter, and a New Hampshire parent. The Governor's Commission is in support of HB762. You may or may not be aware that the Commission is responsible for monitoring of programs and policies that have an impact on the lives of individuals who experience a range of disabling conditions. The intent of HB762 brings many benefits to the disabled community. The interest of the Commission, with respect to HB762, goes beyond the benefits for individuals who experience disabilities. The Commission believes that HB762 is good policy. The Commission supports legislation that would fund CHIP, increase funding for tobacco control, increase Medicaid for seniors, establish a pharmacy assistance program, and increase the reimbursement for the Senior Prescription Drug Discount Program.

As a voter and parent, I extend my support to HB762. I applaud the effort to increase funding for tobacco control. I firmly believe that cost is an effective deterrent to teenagers who contemplate smoking. I have seen my elderly parents, now both deceased due to cancer, struggle with the decision of poverty over health. Both of my parents went without the necessities in order to pay for their drugs to help them battle cancer. Both felt they could forego a meal if it meant having the drugs they needed to buy one more day with their grandchildren. Unfortunately, people battling cancer need proper nutrition. My parents could not afford both and they paid with their lives. My children and I pay today because we have lost two beloved family members.

Because I have a teenage daughter who has developmental disabilities due to meningitis in infancy, I am also encouraged by this bill's intent to establish a Pharmacy Assistance Program for seniors and people with disabilities.

On behalf of the Governor's Commission on Disability and as a New Hampshire citizen, I urge you to support HB762.

Sincerely,

Linda J. Steir

The Telegraph

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Jeers to low sum spent on anti-smoking program

JEERS to being in the middle of the pack.

New Hampshire ranks 30th among states in using money from the national tobacco lawsuit settlement to keep kids from smoking, according to a new study by the Campaign for Tobacco-Free Kids, the American Heart Association, the American Cancer Society and the American Lung Association.

Despite taking in about $40 million last year as its share of a nationwide $246 billion settlement with tobacco companies, the state spends only $3 million a year on tobacco prevention programs, less than half the minimum amount recommended by the U.S. Centers for Disease Control and Prevention, the study found.

That may not be as troubling as it sounds, because only six states meet the minimum amount, according to the Associated Press. But it still raises a question: Where does the additional money go? For education funding, of course.

In fact, more than 90 percent of the tobacco settlement money goes toward education funding. Why? Because it needs to.

That's the New Hampshire Way; ignore the obvious need for developing steady, fair and economically realistic funding streams and just hope a pile of money turns up somewhere to balance the books, like the federal "Mediscam" reimbursements in the early 1990s and now the tobacco settlement.

The state expects to receive $1.4 billion from the tobacco companies by 2025 – between $42.7 million and $55.9 million each year. It's not reasonable to think that all the tobacco settlement money should go toward education and prevention. That would probably be overkill and the money could be better used for other public health initiatives.

The Tobacco-Free Kids campaign said 34.1 percent of high school students in New Hampshire smoke, and each year, 5,000 kids become daily smokers.

HB 762

Healthy Families Trust Fund Act

Alliance For A Healthy New Hampshire

NH Medical Society
American Cancer Society
Children's Alliance of NH
NH Nurses' Association
American Heart Association
NH Healthy Kids Corporation
NH Women's Lobby
Congress of Claremont Senior Citizens
NH National Association of Social Workers
NH Commission on the Status of Women
American Red Cross Greater Manchester Chapter
NH Citizens Alliance for Action
American Lung Association of NH
Bi-State Primary Care Association
NH Nurse Practitioners Association
New Futures (drug and alcohol prevention)
NH Association for the Elderly
NH Teen Institute
Kickin' Butts (tobacco prevention)
Institute for Women's Policy Research
NH Association for the Education of Young Children

HB 762-FN-A - AS INTRODUCED
2001 SESSION
01-1009
09/01
HOUSE BILL *762-FN-A*
AN ACT increasing the tobacco tax to allow for a healthy families trust fund and for increased funding for the tobacco use prevention fund.
SPONSORS: Rep. M. Fuller Clark, Rock 36; Rep. Buckley, Hills 44; Sen. Wheeler, Dist 21
COMMITTEE: Ways and Means
ANALYSIS
This bill increases the tobacco tax to allow for increased funding of the tobacco use prevention fund and for a healthy families trust fund. The healthy families trust fund is to be administered by the department of health and human services and provides funding for: medical assistance for persons 65 years of age and older; the Children's Health Insurance Program and expansion of the Children's Health Insurance Program to parents; a pharmacy assistance program; a pilot program providing health insurance coverage for child care workers; and the senior prescription drug discount program.

- -

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.
01-1009
09/01
STATE OF NEW HAMPSHIRE
In the Year of Our Lord Two Thousand One
AN ACT increasing the tobacco tax to allow for a healthy families trust fund and for increased funding for the tobacco use prevention fund.
Be it Enacted by the Senate and House of Representatives in General Court convened:
1 Statement of Purpose. It is the intent and purpose of this act to address the health care needs of the citizens of New Hampshire. The general court recognizes that a healthy citizenry contributes greatly to the overall health of the economy and general well being of the state. The general court declares that it is the policy of the state of New Hampshire to share in the costs of tobacco control programs and health care access in order to assist the more critically needy components of the population in attaining access to quality health care.
2 Cigarette Tax Increased. Amend RSA 78:7 to read as follows:
78:7 Tax Imposed. A tax upon the retail consumer is hereby imposed at the rate of [~~52 cents~~] ***$1.02*** for each package containing 20 cigarettes or at a rate proportional to such rate for packages containing more or less than 20 cigarettes, on all tobacco products sold at retail in this state. The payment of the tax shall be evidenced by affixing stamps to the smallest packages containing the tobacco products in which such products usually are sold at retail. The word "package" as used in this section shall not include individual cigarettes. No tax is imposed on any transactions, the taxation of which by this state is prohibited by the Constitution of the United States.
3 Distribution of Funds. Amend RSA 78:32 to read as follows:
78:32 Distribution of Funds.
I.***(a)*** The commissioner shall determine the additional amount of revenue produced by any additional tax in excess of 37 cents ***and less than 53 cents*** for each package containing 20 cigarettes or at a rate proportional to such rate for packages containing more or less than 20 cigarettes, on all tobacco products sold at retail in this state imposed by RSA 78:7 and shall certify such amount to the state treasurer by October 1 of each year for deposit in the education trust fund established by RSA 198:39.
[~~II.~~]***(b)*** The commissioner shall make quarterly estimates of the amount of additional revenues that will be produced by such increase in tax rate for the next fiscal year and shall certify such amount to the state treasurer for deposit in the education trust fund established by RSA 198:39. Such estimates shall be certified on June 1, September 1, December 1, and March 1 of each year.
II. The commissioner shall determine the additional amount of revenue produced by any additional tax in excess of 52 cents for each package containing 20 cigarettes or at a rate proportional to such rate for packages containing more or less than 20 cigarettes, on all tobacco products sold at retail in this state imposed by RSA 78:7 and shall certify such amount to the state treasurer by June 30 of each year for deposit as follows:
(a) The sum of no less than $7,800,000 shall be deposited in the tobacco use prevention fund established pursuant to RSA 126-K:15.

(b) The remainder of the amount shall be deposited in the healthy families trust fund established pursuant to RSA 126-P:1.

4 Applicability. Section 2 of this act shall apply to all persons licensed under RSA 78:2. Such persons shall inventory all taxable tobacco products in their possession and file a report of such inventory with the department of revenue administration on a form prescribed by the commissioner within 20 days after the effective date of this act. The tax rate effective July 1, 2001 shall apply to such inventory and the difference, if any, in the amount paid previously on such inventory and the current effective rate of tax shall be paid with the inventory form. The inventory form shall be treated as a tax return for the purpose of computing penalties under RSA 21-J.

5 Tobacco Use Prevention Fund. Amend RSA 6:12, I (yyy) to read as follows:

(yyy) Moneys received under RSA 126-K:15 ***and RSA 78:32, II(a),*** which shall be credited to the tobacco use prevention fund.

6 New Subparagraph; Healthy Families Trust Fund. Amend RSA 6:12, I by inserting after subparagraph (dddd) the following new subparagraph:

(eeee) Moneys received under RSA 78:32, II(b), which shall be credited to the healthy families trust fund established in RSA 126-P:1.

7 Tobacco Use Prevention Fund. Amend the introductory paragraph of RSA 126-K:15 to read is follows:

126-K:15 Tobacco Use Prevention Fund. There is hereby established in the office of the state treasurer a fund to be known as the tobacco use prevention fund. Of tobacco settlement funds received by the state of New Hampshire, $3,000,000 annually, commencing with fiscal year 2001, shall be deposited in the tobacco use prevention fund. ***The sum of $7,800,000 from tobacco tax revenues shall be deposited annually in the fund, pursuant to RSA 78:32, II(a).*** Moneys in this fund shall be nonlapsing and continually appropriated, beginning with fiscal year 2001, for tobacco use prevention and cessation programs, which shall include but not be limited to:

8 New Chapter; Healthy Families Trust Fund. Amend RSA by inserting after chapter 126-O the following-new chapter:

CHAPTER 126-P

HEALTHY FAMILIES TRUST FUND

126-P:1 Healthy Families Trust Fund.

I. There is hereby established in the office of the state treasurer a separate fund to be known as the healthy families trust fund. This trust fund shall be administered by the state treasurer. There shall be credited to this fund:

(a) All revenues collected pursuant to RSA 78:32, II(b) as certified by the commissioner of revenue administration.

(b) Any rebates credited to this fund pursuant to RSA 167:98.

(c) Any premiums, grants, gifts or other contributions explicitly made to this fund.

II. Amounts credited to said fund shall be expended by the commissioner of health and human services in the following priority:

(a) The medical assistance program, to provide Medicaid coverage for seniors with incomes at or below 100 percent of the federal poverty level who are eligible for said program according to RSA 167:6, VII;

(b) The pharmacy assistance program, established pursuant to RSA 167:98 in an amount not to exceed $40,000,000;

(c) The Children's Health Insurance Program, administered by the department of health and human services, pursuant to Title XXI of the Social Security Act;

(d) The Children's Health Insurance Program for parents administered by the department of health and human services, pursuant to Title XXI of the Social Security Act;

(e) Any pilot program established within the department of health and human services which provides health insurance coverage for child care workers; and

(f) To increase the prescription reimbursement dispensing fee to pharmacists for the senior prescription drug discount program; provided that funding dedicated to said program from this fund shall only be used for the dispensing fee for pharmacists and not for the operation of said program.

III. Any funds allocated from this fund that are not expended for the prioritized programs shall lapse to this fund at the end of each biennium, beginning with the biennium ending June 30, 2003.

9 Medical Assistance for Seniors. Amend RSA 167:6, VII to read as follows:

VII. For purposes hereof, a person shall be eligible for medical assistance as categorically needy or as medically needy. A person shall be eligible as categorically needy if he receives financial assistance under RSA 167:6, I, IV, V or VI, or is otherwise eligible to receive such assistance but does not. A person shall be eligible as medically needy if he meets the categorical, age, and technical requirements under RSA 167:6, I, IV, V or VI, and if his income and assets meet the standards as prescribed for the medically needy program. A person shall also be eligible as categorically needy or as medically needy who is eligible for medical assistance pursuant to the mandates of federal law or regulation or pursuant to optional state coverage groups which are allowed by federal regulation and defined

by the commissioner of the department of health and human services in accordance with rules adopted under RSA 541-A, but who does not receive assistance or would not be otherwise eligible to receive assistance under paragraph I, IV, V, or VI of this section. ***A person shall be eligible for the medical assistance program, who meets the criteria established in paragraph I of this section and has an income at or below 100 percent of the federal poverty level.***
10 New Subdivision; Pharmacy Assistance Program. Amend RSA 167 by inserting after section 97 the following new subdivision:
Pharmacy Assistance Program
167:98 Program Established. There is hereby established the pharmacy assistance program, to be funded by the healthy families trust fund established pursuant to RSA 126-P:1. The department is hereby authorized to administer this program.
167:99 Definitions.
I. "Department" means the department of health and human services.
II. "Eligible person" means a resident of New Hampshire who:
(a) Is 65 years of age or older; or
(b) Is 18 years of age or older and has been determined to be "disabled" by the Social Security Administration; and
(c) Has a gross annual household income of not more than 200 percent of the federal poverty level. For the purposes of determining eligibility under this section, annual income shall not include the cost of Medicare Part B premiums unless the cost of the premium is paid by the department; and
(d) Is not eligible for the medical assistance program under this chapter.
III. "Program" means the pharmacy assistance program established under this subdivision.
IV. "Drugs" means all prescription drugs that have been approved as safe and effective by the federal Food and Drug Administration or are otherwise legally marketed in the United States, including insulin, insulin syringes, and insulin needles.
V. "Enrollee" means an eligible individual who receives benefits under the pharmacy assistance program established by this subdivision.
167:100 Administration of the Program.
I. The department of health and human services shall administer the pharmacy assistance program in order to provide prescription drug coverage to eligible persons who lack sufficient access to necessary prescription drugs. Enrollment in the program shall be voluntary and shall be funded by the healthy families trust fund, established under RSA 126-P:1, in an amount not to exceed $40,000,000 in each fiscal year.
II. Enrollees shall be provided a benefit of not more than $1,250 for the cost of prescription drugs that are purchased as part of this program.
III. The department shall verify the income of applicants for the program according to the most recent income tax returns for the applicant. If an applicant is not required to pay income tax, the department shall verify the applicant's income through submission of monthly checks received by said applicant.
IV. The department shall conduct outreach marketing efforts to ensure that eligible senior citizens and people with disabilities are aware of the availability of the program, to provide eligible individuals with the guidelines of said program, and to maximize enrollment in said program.
V. The department shall have the authority to close enrollment to the program or create a waiting list, if the commissioner reasonably believes that the costs of said program will exceed the available appropriation for said program.
VI. The department shall establish a procedure for enrollees to appeal a decision by the department to deny payment for a certain drug.
167:101 Copayments. The department shall develop copayment requirements for all purchases of drugs by an enrollee in the program. Said copayment amounts shall not be more than $5 for generic drugs or $12 for brand drugs. The department shall provide information in writing to individuals who enroll in the program as to which drugs are covered by the program, the copayment amounts, and any restrictions on drugs.
167:102 Rebates. The department may negotiate a rebate arrangement with pharmaceutical companies. Revenues received from such rebate shall be credited to the healthy families trust fund, established pursuant to RSA 126-P:1, and may be used to supplement the funding, eligibility, and drug coverage of the program.
167:103 Reports. The department shall report to the general court on the pharmacy assistance program on or before January 1 of each year, commencing one year following implementation of the program. This report shall be submitted by the department to the house and senate finance committees, the senate public institutions, health and human services committee and the house health, human services and elderly affairs committee. The report shall address the enrollment status of the program, outreach efforts by the department to educate senior citizens and

persons with disabilities about the program, the expenditures and projected expenditures of the program, utilization of the program, and demographics of enrollees.
167:104 Rulemaking. The department shall adopt rules, pursuant to RSA 541-A, in order to implement the program established by the subdivision.
11 Reference Change; Education Trust Fund. Amend RSA 198:39, I (d) to read as follows:
(d) Funds collected and paid over to the state treasurer by the department of revenue administration pursuant to RSA 78:32, *I,* relative to tobacco taxes.
12 Expansion of Medicaid Coverage to Parents of Children Eligible for Medicaid.
I. The commissioner of the department of health and human services shall establish a program providing benefits under the medicaid program to parents of children, who are eligible for medicaid pursuant to Title XIX of the Social Security Act, who have incomes at or below 133 percent of the federal poverty level. The commissioner shall administer this program under Title XXI of the Social Security Act. The commissioner shall apply to the federal Health Care Financing Administration for a waiver pursuant to Title XXI of the Social Security Act in order to extend the S-CHIP program to include parents with incomes at or below 133 percent of the federal poverty level. The program shall receive funding from the healthy families trust fund established pursuant to RSA 126-P:1.
II. The commissioner shall adopt rules, pursuant to RSA 541-A, in order to implement the program. The department shall conduct significant outreach efforts in order to provide information to eligible parents on the availability of said program. The commissioner shall report to the general court on the implementation of the program 12 months following the effective date of this section and on or before January 20 of each subsequent year. The report shall detail the number of enrollees in the program, the outreach efforts undertaken by the department for the program, and the estimated annual cost of the program.
13 Pilot Program Established. Health Insurance Coverage for Child Care Workers.
I.(a) The general court hereby finds that it is the intent of this pilot program to provide health insurance coverage for child care workers who care for the children of New Hampshire's lowest income working families. Child care is a vital component of New Hampshire's welfare to work initiatives and this pilot program will provide an incentive for licensed child care agencies to accept state subsidized children.
(b) The general court further finds that this pilot program will increase benefits in a field which currently has low wages and few employer-sponsored benefits. It is the intent of the general court that increasing the availability of health insurance coverage will result in stabilizing the child care workforce.
II. There is hereby established a 3-year pilot program within the department of health and human services for providing employees of certain child day care agencies with access to health care insurance. The pilot program shall receive funding from the healthy families trust fund, established pursuant to RSA 126-P:1. For the purposes of this program, "department" shall mean the department of health and human services. The pilot program shall terminate on July 1, 2004, unless the legislature acts to extend the program.
III.(a) The state shall pay 50 percent of the premium for medical and surgical benefits, including group hospitalization, hospital medical care, and surgical care, for each full-time employee of a family day care home or family group day care home, as such homes are defined in RSA 170-E:2, IV (a) and (b), provided such homes meet the following eligibility requirements:
(1) The family day care home or family group day care home is licensed pursuant to RSA 170-E;
(2) The family day care home or family group day care home has provided care for 2 or more children for which the home received payment under any of the department's child care programs for 9 or more of the preceding 12 months prior to applying to the department for health care coverage under this program; and
(3) The family day care home or family group day care home continues to provide child care services for 2 or more children, for which either home is receiving payment under any of the department's child care programs as of the time the application to the department for health care coverage is submitted.
(b) To be eligible for the benefit established in this paragraph, a full-time employee of a family day care home or family group day care home shall not be eligible to receive health insurance benefits under a spouse's employer-sponsored health insurance programs.
IV. The state shall pay a percentage of the premium for medical and surgical benefits, including group hospitalization, hospital medical care, and surgical benefits, for each full-time employee of a child day care agency, as defined in RSA 170-E:2, IV (c)-(e) and (g), which provides child day care services paid for in whole or in part by the department and which is licensed pursuant to RSA 170-E.
(1) The state shall pay 35 percent of the premium for a full-time employee of a child day care agency where, during the 6-month period immediately preceding application to the department for health care insurance, the number of children served by that agency who are enrolled in any of the department's child care subsidy or assistance programs is not less than 35 percent or more than 50 percent of the child day care agency's total licensed capacity.

(2) The state shall pay 50 percent of the premium for a full-time employee of a child day care agency where, during the 6-month period immediately preceding application to the department for health care insurance, the number of children served by that agency who are enrolled in any of the department's child care subsidy or assistance programs is greater than 50 percent of the child day care agency's total licensed capacity.
(b) To be eligible for the benefit established in this paragraph, a full-time employee of a child day care agency as defined in this section shall not be eligible to receive health insurance benefits under a spouse's employer-sponsored health insurance program.
(c) No benefit provided under this paragraph shall exceed benefits provided by the medicaid program.
V. The department of health and human services shall prepare a report detailing the number of participating providers, the number of workers covered by the provisions of the pilot program, the changes in the number of licensed providers, and an estimate of the effect on staff retention. The report shall be submitted to the speaker of the house of representatives, the senate president, and the governor no later than November 1 of each year of the pilot program.
VI. The commissioner of the department of health and human services shall adopt rules, pursuant to RSA 541-A, relative to application procedures, eligibility criteria, limitations and restrictions, insurance coverage benefits limited to the level of benefits provided through the medicaid program, and any other matter consistent with the provisions of the pilot program.
14 Repeal. Section 13 of this act, relative to a pilot program providing health care insurance for child care workers, is repealed.
15 Effective Date.
I. Section 14 of this act shall take effect July 1, 2004.
II. The remainder of this act shall take effect July 1, 2001.
LBAO
01-1009
2/21/01

HB 762-FN-A - FISCAL NOTE

AN ACT increasing the tobacco tax to allow for a healthy families trust fund and for increased funding for the tobacco use prevention fund.

FISCAL IMPACT:

The Office of Legislative Budget Assistant is unable to complete a fiscal note for this bill as it is awaiting information

Summary of the "Healthy Families Trust Fund Act"
HB 762

It is the purpose of this bill is to address a variety of critical health care needs of the citizens of New Hampshire. In accordance with a region-wide effort to uniformly raise tobacco taxes in all New England states, HB 762 raises New Hampshire's tobacco tax by $.50. Revenue from this tax will go into a new Healthy Families Trust Fund, from which funds will be allotted for programs that provide much needed prescription drug coverage and health insurance coverage for seniors, children, adults with disabilities and low income parents.

TOBACCO TAX

Increase the current tax on tobacco products by $.50 as a new section 33 under the tobacco tax revenue statute, RSA 78. This tax will be in addition to any previously established tobacco tax for all tobacco products including RSA 78:7 and 78:32. Currently tobacco tax in excess of $.37 and less than $.53 is deposited each year into the education trust fund established by RSA 198:39. Revenue in excess of $.52 (i.e. funding from this $.50 tax) will be distributed as follows:

- $7.8 million shall be deposited in the Tobacco Use Prevention Fund (see **A** below) established pursuant to RSA 126-K:15.
- The remaining funds shall be credited to the Healthy New Hampshire Trust Fund (see **B** below) established in Section 1 of this bill as RSA 126-P:1

A. TOBACCO USE PREVENTION FUND

Amend the Tobacco Use Prevention Fund (established in the office of the state treasurer under RSA 126-K:15) to include the additional funding of $7.8 million that will be received by the Tobacco Use Prevention Fund from the $.50 tobacco tax established in section 2 of this bill as RSA 78:33.

B. HEALTHY FAMILIES TRUST FUND

This fund is established under RSA 126-P: 1 and administered by the State Treasurer. Funds that go into the Healthy Families Trust Fund in RSA 126-P: 1 are:

- The $.50 tobacco tax
- Rebates from pharmaceutical companies that are collected as part of the Pharmacy Assistance Program

Funds that are not spent from this fund will be returned and deposited back into the fund

Funds from the Healthy Families Trust Fund will be expended by DHHS and distributed to the listed programs in the following priority:

a) The medical assistance program, to provide Medicaid coverage for seniors with incomes at or below 100% of the federal poverty level who are eligible according to RSA 167:6, VII
b) The pharmacy assistance program – established in section 7 of this bill as RSA 167:98 in an amount not to exceed $40M.

c) Children's Health Insurance Plan (CHIP) administered by the department of health and human services, pursuant to Title XXI of the Social Security Act.
d) The Children's Health Insurance Program for parents administered by the department of health and human services, pursuant to Title XXI of the Social Security Act.
e) A 3 year pilot program to provide health care insurance for child care workers established in section 8 of this bill
f) To increase the prescription reimbursement dispensing fee to pharmacists for the senior prescription drug discount program.

HEALTH ACCESS PROGRAMS FUNDED THROUGH THE HEALTHY FAMILIES TRUST FUND:

a) EXPANDING MEDICAID FOR SENIORS

Expanding full Medicaid benefits to seniors with incomes from the current eligibility level of 75% up to 100% of the federal poverty level.

b) PHARMACY ASSISTANCE PROGRAM

The program is a voluntary program with expenditures capped at $40,000 and administered by the Department of Health and Human Services.
It establishes the Pharmacy Assistance Program for seniors and adults with disabilities. This program will be a benefit program for:

1. Seniors 65 or older with incomes between 100%-200% of the federal poverty level (fpl).
2. Adults with disabilities who are determined disabled by the Social Security Administration with incomes between 75% and 200% fpl.

- The benefit amount will be no more than $1,250 a year for each enrollee.
- Copayment amounts will be established in statute as:
  Generic drugs: no more than $5
  Brand name drugs: no more than $12
- Rebates from participating pharmaceutical companies will be negotiated by the department and will be deposited in the Healthy New Hampshire Trust Fund established in PURSUANT TO RSA 126-P: 1 (section 1 of this bill under RSA 11:8)
- The department will provide a report to the federal court on the program and shall adopt rules to implement this program.

c) *CHILDREN'S HEALTH PLAN (CHIP)*

This section allocates funding to the CHIP program in NH, which is administered by the Department of Health and Human Services and is authorized by Title XXI of the Social Security Act. This allocation will pay the full state cost of the CHIP program.

d) EXPANDING MEDICAID TO PARENTS (CHIP)

The commissioner of DHHS shall establish a program providing benefits under the medicaid program to parents of children, who are eligible for medicaid pursuant to Title XIX of the Social Security Act, who have incomes at or below 133% of the federal poverty level. (parents of CHIP recipients) This will require the commissioner to apply

for a waiver. In addition, the commissioner shall adopt rules and provide a report to the General Court.

e) HEALTH CARE FOR CHILD CARE WORKERS

The intent of this pilot program is to provide health insurance coverage for child care workers who care for children of New Hampshire's lowest income working families (and those working at the lowest wages).

Re: **Full-time workers in family day care settings**: under the program, the Department of Health and Human Services will pay 50% of the premium for health insurance for a full-time child care worker

Re: **Full-time workers in child day care agencies**:

- The department will pay 35% of the cost of the premium for a worker at an agency that has between 35%-50% of its children receiving state subsidies.
- The department will pay 50% of the cost of the premium for a worker at an agency that has over 50% of its children receiving state subsidies.

The department shall provide a report on this program relative to health care coverage and child care worker retention and will also adopt rules pursuant to RSA 541-A.

f) INCREASE PRESCRIPTION REIMBURSEMENT FEE TO PHARMACISTS FOR THE SENIOR PRESCRIPTION DRUG DISCOUNT PROGRAM

The funding dedicated to this program from this fund shall only be used for the dispensing fee for pharmacists and not for the operation of the program.

EFFECTIVE DATES

The act shall take effect July 1, 2001 with the exception of Section 14 (repeal of Section 13, relative to the pilot program for child care workers) which shall take effect July 1, 2004.

Alliance for a Healthy New England Research Report

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New Hampshire Revenue Estimate – Calculations and Methods

The average annual revenue from a 50-cent per pack cigarette tax increase in New Hampshire is estimated to be **$78.8 million** over the 5-year period from 2002 through 2006. This amount would be available to finance new health programs.

The $78.8 million revenue estimate is based on a number of assumptions and adjustments. This paper explains the methodology and calculations that are the basis of this estimate.

The estimate starts with an estimate of fiscal year 2001 cigarette packs sales. The estimate was derived by reducing the actual 2000 sales as reported by New Hampshire (180.5 million packs) by 1.5%, to reflect the continued decline in consumption in the state.

The estimate assumes a $.50/pack tax increase goes into effect on July 1, 2001, the start of FY2002. Estimated sales in future years are then lowered starting in 2002 by two factors.

First, the estimated revenue is reduced by assuming a continued natural decline in cigarette consumption of 1.5% annually through the period. The level of natural decline assumes a continued impact of the state and national tobacco control programs in the coming years.

Second, the impact of a drop in sales caused by the new tax itself must be included. This effect, called "negative price elasticity" by economists, has been the subject of a great deal of research. The strong consensus of the research is that the price elasticity for cigarettes is between -.30 and -.50. This means that a 10% increase in the price of cigarettes results in about a 4% reduction in cigarette sales. About half of the demand change if due to a reduction in the number of smokers; the other half comes from reduced purchases by remaining smokers. According to most researchers, the effect of the price increase continues, with further reductions in consumption that lag the initial decline. This effect is estimated at 1.75 times the initial decline after four years. The model uses an initial .4% elasticity sales decline factor for the first year, 2002. Over the subsequent four years, the delayed-effect drop in sales is evenly phased in, culminating in a -.70 elasticity decline factor in 2006.

The calculations also assume an average cost of a pack of cigarettes in New Hampshire to be around $3.70. This price was used to account for some inflation, as the major tobacco companies recently announce new price hikes for premium brands. Thus a $.50/pack tax increase translates into a 13.5% price increase in percentage terms. The elasticity factor is multiplied by the price increase (in percentage terms) to get at the total impact on sales of the price increase.

The math is as follows. Each factor is applied to the initial sales level for 2001:

Year	Natural sales decline factors	elasticity factor calculation	packs sold (rounded to nearest 100,000)
2002	(.985)	-0.40 * .135	165,700,000
2003	(.985) * (.985)	-0.475 * .135	161,500,000
2004	(.985) * (.985) * (.985)	-0.550 * .135	157,400,000
2005	(.985) * (.985) * (.985) * (.985)	-0.625 * .135	153,300,000
2006	(.985) * (.985) * (.985) * (.985) * (.985)	-0.700 * .135	149,300,000

These sales amounts translate into the following revenue estimates for each year:

year	Available revenue
2002	$82,900,000
2003	$80,800,000
2004	$78,700,000
2005	$76,700,000
2006	$74,700,000

The average amount available over the 5-year period is **$78.8 million.**

Because this figure derives from conservative assumptions, planning a health expansion program based on this amount provides a substantial cushion for unforeseen cost increases.

(2/5/01)

Tobacco Tax Revenue and Expenditure by Year

	Year One	Year Two	Year Three	Year Four	Year Five
Revenue					
Tobacco Tax	$ 82,900,000	$ 80,800,000	$ 78,700,000	$ 76,700,000	$ 74,700,000
Expenditures					
Medicaid Expansion for Seniors (6 mos)	$ 8,698,900	$ 19,659,514	$ 22,215,251	$ 25,103,233	$ 28,366,654
Medicaid Expansion for Parents	$ 1,231,256	$ 3,604,762	$ 5,346,604	$ 5,947,563	$ 6,616,069
CHIP	$ 1,680,000	$ 1,890,000	$2,097,900	$ 2,328,669	$ 2,584,823
Pharmacy Program (6 mos)	$ 20,000,000	$ 40,000,000	$ 40,000,000	$ 40,000,000	$ 40,000,000
Tobacco Control	$ 7,800,000	$ 7,800,000	$ 7,800,000	$ 7,800,000	$ 7,800,000
Health Care for Child Care Workers (6 mos)	$ 500,000	$ 3,000,000	$ 3,000,000	$ -	$ -
Pharmacist Reimbursements	$ 500,000	$ 500,000	$ 500,000	$ 500,000	$ 500,000
Total	$ 40,410,156	$ 76,454,276	$ 80,959,755	$ 81,679,465	$ 85,867,546
Fund balance	$ 42,489,844	$ 46,835,568	$ 44,575,813	$ 39,596,348	$ 28,428,802

The numbers in this document are compiled from a myriad of sources, including national agencies, NH state agencies and Governor Shaheen's office.

Tobacco Control:

New Hampshire Statistics:

- Number of people who die each year in New Hampshire from smoking 1,700
- Annual health care expenditures in New Hampshire directly related to tobacco use $340 million
- New Hampshire residents' state and federal tax burden caused by tobacco-related health costs $180 million
- New Hampshire government Medicaid payments directly related to tobacco use $90 million
- Additional annual expenditures in New Hampshire for babies' health problems caused by mothers smoking or being exposed to second hand smoke during pregnancy $6 to $ 18 million
- Kids in New Hampshire exposed to secondhand smoke at home 70,000
- Number of packs of cigarettes illegally sold to kids in New Hampshire each year 1.2 million
- Adults in New Hampshire who smoke 24%

(Tobacco Free Kids, October 5, 2000)

One of the priorities for the use of the tobacco tax revenue is to help the state meet the Center for Disease Control (CDC) recommended expenditure levels for effective tobacco control programs. In order to meet the minimum level recommended by the CDC, New Hampshire must allocate $7.8M to make the total expenditures $10.8M.

Currently, New Hampshire has dedicated $3M to tobacco control which is funded by the tobacco settlement monies allocated to New Hampshire. The $3M has been placed in a trust fund called the "Tobacco Use Prevention Fund" which allocates the funding through grants to tobacco control programs. The $7.8M that will be dedicated to tobacco control from this tobacco tax will be placed in the previously established Trust Fund to be distributed by that fund.

Funding from the Tobacco Use Prevention Fund will be distributed to cessation programs, school based programs, local enforcement measures and other tobacco control programs.

Year	Amount
Year 1	$7,800,000
Year 2	$7,800,000
Year 3	$7,800,000
Year 4	$7,800,000
Year 5	$7,800,000

Expanding Medicaid to Seniors up to 100% fpl :

Program Structure: Extend Medicaid income eligibility for seniors up to 100% of the federal poverty level.

Enrollees: Current income eligibility for seniors for NH Medicaid is $526/month for an individual and $770/month for a couple.[1] This is below the federal poverty level which is $695.83/month for an individual.

Costs for seniors: There is no cost to seniors except copay amounts.

Federal Requirements: NH has the option to expand eligibility for Medicaid for seniors under 1902 federal requirements without applying for a Medicaid waiver. If NH wishes to do less than the full Medicaid package and just include prescription drugs then a Medicaid 1115 waiver is required.

The state will be reimbursed 50% of the cost by the Federal government for this program.

Benefits: The benefit is full prescription drug coverage as well as medical coverage from Medicaid.

Cost:

- Number of seniors below 100% fpl[2] = 17,000(1995)
- Number of seniors on Medicaid[3] = 8,500
- Number of seniors eligible for expansion = 17,000 – 8,500 = 8,500
- Cost for a senior on Medicaid in NH

Cost of a senior on Medicaid in NH (1998)[4]:	$20,468
Nursing Facility cost:	80% of the Medicaid cost
Cost per senior for expanding Medicaid:	20% of cost
Total:	**$4093.6**

- Cost for expansion: 8,500 X $4093.6 = $34,795,600
- 50% Federal Reimbursement: $17,397,800
- First Year cost (6 months): **$8,698,900**

Year	Cost[5]
Year 1 (6 months):	$8,698,900
Year 2:	$19,659,514
Year 3:	$22,215,251
Year 4:	$25,103,233
Year 5:	$28,366,654

[1] Department of Health and Human Services, New Hampshire.
[2] Kaiser Family Foundation.
[3] Governor Shaheen's office.
[4] Urban Institute.
[5] Years 2-5 represent a 13% cost inflation per year.

Pharmacy Assistance Program, Seniors and Disabled:

Program Structure: This program is designed to dedicate $40M which will provide a $1250 benefit for 32,000 seniors and people with disabilities. Because implementation will take 6 months, the first year cost will be $20M.

Enrollees:

- *Seniors:* individuals over the age of 65
- *Disabled:* people with disabilities who have been determined to be "disabled" by the Social Security Administration.

Income eligibility: seniors and people with disabilities who are at or below 200% of the federal poverty level. It will include those who are not eligible for Medicaid since Medicaid recipients receive full prescription drug coverage.

- *Seniors:* In this legislation, Medicaid is extended to seniors with incomes up to 100% fpl. Therefore, this program will cover seniors between 100-200% fpl.
- *Disabled:* People with disabilities will be eligible if they have an income that is above the Medicaid limit for the disabled which is 75% fpl up to 200%fpl.

Benefit: Enrollees will be provided with $1250 in prescription drug coverage per year.

Cost Sharing: The program requires enrollees to pay copays of $5 for generic drugs and $12 for brand drugs.

Seniors:

CATEGORIES	SENIORS	DISABLED
Seniors below 200% and all disabled	53,280[6]	31,308[7]
Already on Medicaid	8,500[8]	12,124[9]
Subtotal	44,780	19,184
To be added to Medicaid in this legislation	8,500[10]	0
Subtotal	36,280	
60% of eligible seniors will participate	21,768	
55% of disabled will participate		10,551
Amount of benefit	$1,250	$1,250
TOTAL	$27,210,000	$13,189,000

Seniors and People with Disabilities = $40,399,000

First Year Cost (6 months): $20,000,000

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[6] Governor Shaheen's office. This number represents seniors with incomes below $17,499.50. 200% fpl is $16,700.

[7] Social Security Administration, 1998.

[8] Governor Shaheen's office.

[9] Health Care Financing Administration, fiscal year 1998.

[10] This legislation increases the income eligibility for seniors for Medicaid up to 100% fpl. This number represents those seniors who would be eligible for Medicaid with this legislation and ineligible for this program.

CHIP:

The state cost of the Children's Health Insurance Program is currently funded by a private foundation called the Healthy Kids Foundation. In order to provide a stable, permanent revenue source for the CHIP program to ensure that the program will continue to provide valuable health coverage to eligible children, a portion of the tobacco tax will be dedicated to fully fund the state cost of the CHIP program. This proposal does not increase eligibility for the CHIP program but rather pays for those children who are already eligible.

The CHIP program is authorized under Title XXI of the Social Security Act which means the federal government provides reimbursement to the state for each child that is covered under the program. The state cost of the program reflects the 65% federal reimbursement that the state receives for the CHIP program. This is higher than the 50% reimbursement the state receives for the Medicaid program.

Year 1	Cost to State	$1,680,000[11]
Year 2	Cost to State	$1,890,000[12]

Cost increase per year: 11%

Year 3	projected cost	$2,097,900
Year 4	projected cost	$2,328,669
Year 5	projected cost	$2,584,823

[11] Governor Shaheen's office.
[12] Governor Shaheen's office.

Medicaid Expansion for CHIP parents:

Program Structure: This section will expand the current Medicaid program to include parents of children, who are eligible for Medicaid.

Income Eligibility: Parents up to 133% of the federal poverty level, which is $11,105. Currently, New Hampshire covers adults up to 64% of the federal poverty level.

Federal Participation: The parents will be included under the Medicaid program through the Children's Health Insurance Program. The Federal government will reimburse 65% of the cost of the program under CHIP. The CHIP program is authorized under Title XXI of the Social Security Act. In order to receive the 65% reimbursement it is necessary for the Department of Human Services to apply for a waiver to New Hampshire's Medicaid application in order to cover a new group of people in the program.

Cost: The numbers used in determining the cost of this program were based on a report that was prepared by a commission established by legislation, SB183. The calculations in that report were based on increasing Medicaid to 185% of the federal poverty level to parents and single adults. However, this legislation expands Medicaid for parents up to 133% fpl.

Uninsured up to 185% fpl[13]: 10,480
Uninsured up to 133% fpl(72% of 10,480): 7,545

CATEGORIES	Year 1	Year 2	Year 3	Year 4	Year 5
Uninsured 133% fpl[14]	7,545	7,545	7,771	8,004	8,244
Expected Participation[15]	1,252.47 (16.6%)	3,395 (45%)	4,663 (60%)	4,802 (60%)	4,946 (60%)
Crowd Out (1/2 of enrollees)[16]	626	1,697	2,331	2,401	2,473
Total Enrollees	1,878	5,092	6,994	7,204	7,420
Cost per enrollee[17]	$2,675	$2,889	$3,120	$3,369.60	$3,639.17
Total Cost	$5,025,536	$14,713,315	$21,822,877	$24,275,768	$27,004,365
Reduce 30% for pregnant women	$3,517,875	$10,299,321	$15,276,014	$16,993,038	$18,903,055
Reduce by 35% = the state cost	$1,231,256	$3,604,762	$5,346,604	$5,947,563	$6,616,069

[13] This number represents those uninsured up to 185% fpl. The proposal in the legislation is to increase Medicaid to parents up to 133% fpl.

[14] Years 1, 2 and 3 represent data in SB183 and Years 4 and 5 represent a 3% increase in enrollment based on what is recommended by SB183.

[15] SB 183 estimated the first year of the program would only include 16.6% of eligible uninsured. SB183 estimated that 45% of eligible individuals would participate in the program in the second and future years. 45% has been included for the second year but is increased to 60% participation in future years.

[16] Crowd out represents those individuals within the income eligibility who already have insurance from another source who may enroll in this Medicaid expansion. SB183 estimated that this represents half of the number of uninsured.

[17] Years 1, 2 and 3 represent costs projected in SB183. Years 4 and 5 represent an 8% cost inflation that is recommended in SB183.

Health Care for Child Care Workers:

Program Structure: 3 year pilot program to provide health care for child care workers.

- Under the program, the Department of Health and Human Services will pay 50% of the premium for health insurance for a child care worker in a family day care setting.
- The department will pay 35% of the cost of the premium for a full time employee of a child day care agency that has between 35%-50% of its children receiving state subsidies.
- The department will pay 50% of the cost of the premium for a full time employee of a child day care agency that has over 50% of its children receiving state subsidies.

Year	Cost[18]
Year 1 (6 months)	$500,000
Year 2	$3,000,000
Year 3	$3,000,000
Year 4	0
Year 5	0

[18] Governor Shaheen's Office

Alliance for a Healthy New England Research Report

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The Fiscal Cost of Treating Smoking in New England

Cigarette smoking is the leading preventable cause of illness and death. Treating illness caused due to smoking places a significant burden on the strained New England health care system, and tight state budgets. This burden can be reduced by cutting the consumption of tobacco products in New England. Raising the excise on cigarettes is the most effective way of reducing consumption.

For 2001, the New England states will collectively spend over **$5.8 billion** in direct health care expenditures due to cigarette smoking.

The state-by-state estimated figures are as follows:

State	Health Care expenditures attributable to smoking ($ millions)
Connecticut	2,240.8
Maine	625.7
Massachusetts	2,183.8
New Hampshire	323.8
Rhode Island	310.2
Vermont	139.6
Total	5,824.0

These estimates only include the direct costs of treating smoking-related disease. They exclude other medical costs associated with smoking, such as burn care resulting from smoking-related fires, extra care provided to newborns with low birth weights due to maternal smoking, and costs due to disease caused by exposure to environmental cigarette smoke. They also exclude the indirect costs, such as lost work days and productivity, due to cigarettes.

These costs directly impact on each state's budget. Each state's Medicaid program must shoulder a portion of these costs. The estimated direct state share of Medicaid costs for treating smoking-related disease in each New England state is as follows

State	State net Medicaid expenditures attributable to smoking ($ millions)
Connecticut	170.3
Maine	60.4
Massachusetts	180.2
New Hampshire	44.0
Rhode Island	40.4
Vermont	10.6
Total	505.8

Again, these estimates substantially understate the true fiscal cost smoking imposes on state budgets, as they do not include many indirect costs as well as costs of caring for infants and children.

(3/7/01)

Sources and methods: Total state costs attributable to smoking calculated by updating HCFA-reported medical expenditures by state for 1998 for five categories of expenditure (physicians, prescription drugs, hospital, home health and nursing-home care) to 2001, using HCFA's national inflation indices for each service. The proportion of each service attributable to smoking was then applied, using estimates found in Bartlett, et al., *Medical Care Expenditures Attributable to Cigarette Smoking—United States 1993*, U.S. CDC, Morbidity and Mortality Weekly Report (July 8, 1994). The proportion of such expenditures born by Medicaid is based on estimates in Miller et al, *State Estimates of Total Medical Expenditures Attributable to Smoking, 1993* US Public Health Reports (Sept./Oct. 1998).

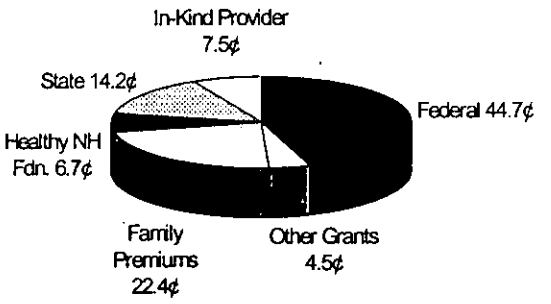
New Hampshire HEALTHY KIDS

The Children's Health Insurance Program is a Great Investment

You Can't Spend a Better Dollar

- **Every 20 cents of State money buys $1 of health coverage for uninsured children.** Premiums paid by families, federal funding, provider discounts, and private grants support 80% of the program's cost.

CHIP Financial Partnerships Make the Difference



Projected Funding Mix for CHIP
January - December 2001
Assumes Inclusion of CHIP Funding in State Budget Beginning July 2001

- New Hampshire's **CHIP program promotes family responsibility** by offering a way for families to pay a greater share of their health care cost as their income increases rather than lose benefits.
- Health insurance provides kids with **access to a medical home and a personal physician** who coordinates needed care and helps parents nurture their child's growth and development.
- Health coverage means families can **take advantage of the preventive and primary care services** kids need most to stay healthy and avoid unnecessary emergency room visits.
- **Healthy kids learn better,** miss fewer school days and are better able to reach their potential as tomorrow's workforce.
- Health coverage for kids **means greater work productivity for parents** who miss fewer workdays due to a child's poor health and who have the peace of mind that coverage provides.

Children Need Health Insurance

Health coverage is key to staying healthy. Without health insurance, children are far less likely to get medical care when they are sick or injured. **Compared with insured children, uninsured kids are:**

- 2½ times less likely to see a doctor in a year
- 6 times less likely to have a usual source of care and twice as likely to seek care in an emergency room
- 3½ times less likely to receive needed medical care and 4 times less likely to receive needed dental care
- 3 times less likely to fill a prescription or buy eyeglasses because of cost

Families Need Assistance in Obtaining Health Coverage for their Children

The SB 183 Adult Coverage Study Committee recently reported to the NH Legislature that families must earn incomes at or about 200% of the federal poverty level before they have $1 to dedicate to the purchase of health coverage (see chart below). The group's conclusion is based on data published by the Josiah Bartlett Center regarding the level of income needed to meet basic living expenses such as housing, food, utilities and transportation.

Income Needed to Pay for Basic Living Needs

Family Unit	Annual Livable Wage *	Percent of FPL
Two parents & two children (both parents working)	$40,655	238%
Two parents & two children (one parent working)	$28,555	167%
Two parents & one child (both parents working)	$34,655	245%
Two parents & one child (one parent working)	$26,532	188%
Single parent & two children	$34,505	244%
Single parent & one child	$28,713	255%

** The livable wage in this chart excludes a contribution to health insurance and 5% savings that was included in the original report.*

25 HALL STREET, SUITE 303, CONCORD, NH 03301-3477 (603) 228-2925

Health Insurance Coverage in New Hampshire

Issue Brief 1999

In 1999, the Department of Health and Human Services sponsored the New Hampshire Health Insurance Coverage and Access Survey, a telephone survey of New Hampshire residents under the age of 65 designed to understand health insurance coverage, access to health care, and general medical needs. This issue brief presents key initial findings.

❖ Almost 84 Percent of New Hampshire Residents are Covered Through the Private Sector.

Private insurance - including both employer-based and non-group privately purchased - covers almost 84 percent of all New Hampshire residents (Figure 1). This is significantly higher than the national average. An important question to be addressed is how the state of New Hampshire can build on this success, particularly in a period where trends suggest that employers are finding it more difficult to offer insurance.

❖ An Estimated 96,000 Residents are Uninsured.

Despite broad coverage through the private sector, approximately 9 percent of New Hampshire residents remain uninsured. With a non-elderly population of slightly more than 1 million individuals, approximately 96,000 New Hampshire residents under age 65 are estimated to be currently uninsured. Seven percent of New Hampshire residents are covered through public programs.

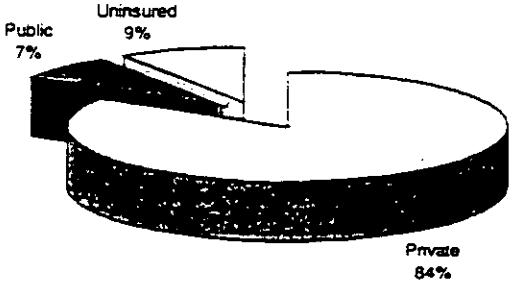


Figure 1: Distribution of Insurance Coverage

❖ Three Quarters of the Uninsured are Adults.

Approximately 74 percent of the uninsured are adults - an estimated 71,000 individuals. Those ages 30-44 account for the largest share of the uninsured (Figure 2). Adults ages 18-29 account for 25 percent of the uninsured individuals in the state.

❖ An Estimated 25,000 Children are Uninsured.

Approximately 26 percent of the estimated 96,000 uninsured are children (Figure 2). Many of these 25,000 children may be eligible for existing public programs.

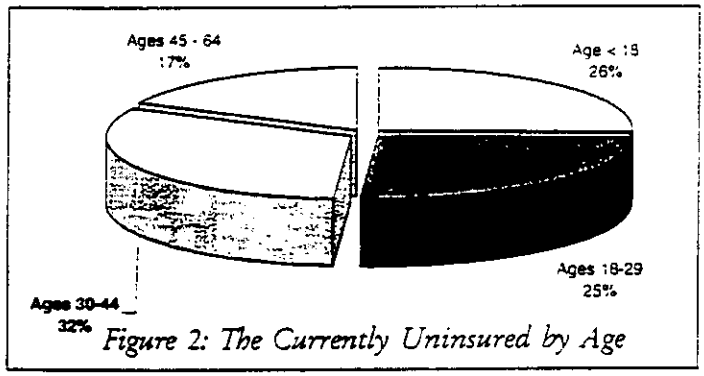


Figure 2: The Currently Uninsured by Age

❖ The Uninsured are Working.

To a large extent the uninsured are working. Almost 73 percent of all uninsured individuals have at least one family member who is working full-time (Figure 3). In addition, approximately 12 percent of uninsured individuals live in families with at least one individual working part-time.

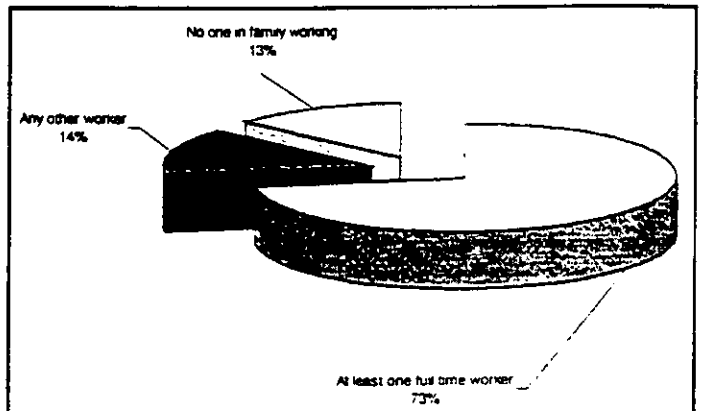


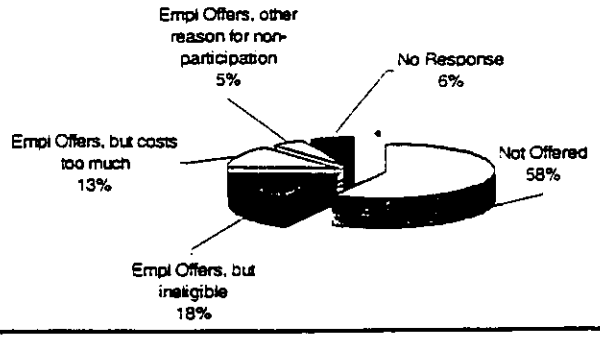
Figure 3: The Uninsured and Family Work Status

❖ **Working Uninsured Report Little Access to Employer-Sponsored Insurance.**

Approximately 58 percent of working uninsured adults indicated that they were working in firms that did not offer insurance coverage (Figure 4). An additional 18 percent reported that their employer offered coverage but they were ineligible for that coverage as a result of the length of employment, the part-time nature of the work, or as a result of medical issues which restricted their access to employer-based insurance.

Figure 4:

Working Uninsured and Offer of Employer-Based Insurance.



◆ **Regional Variation in Uninsurance Exists**

The Northern part of the State has significantly higher rates of uninsurance than the Southern regions. Approximately 14 percent of residents are uninsured in the North Country, the area north of 'The Notch.' Approximately 13 percent of residents are uninsured in Central Eastern New Hampshire, including the Mt. Washington Valley and the Lakes Region.

While the uninsurance rate is higher in the North Country and Central Eastern New Hampshire, the more urban areas of New Hampshire - including those centered around Manchester, Nashua, Concord and Portsmouth - account for approximately 70 percent of the total number of currently uninsured individuals.

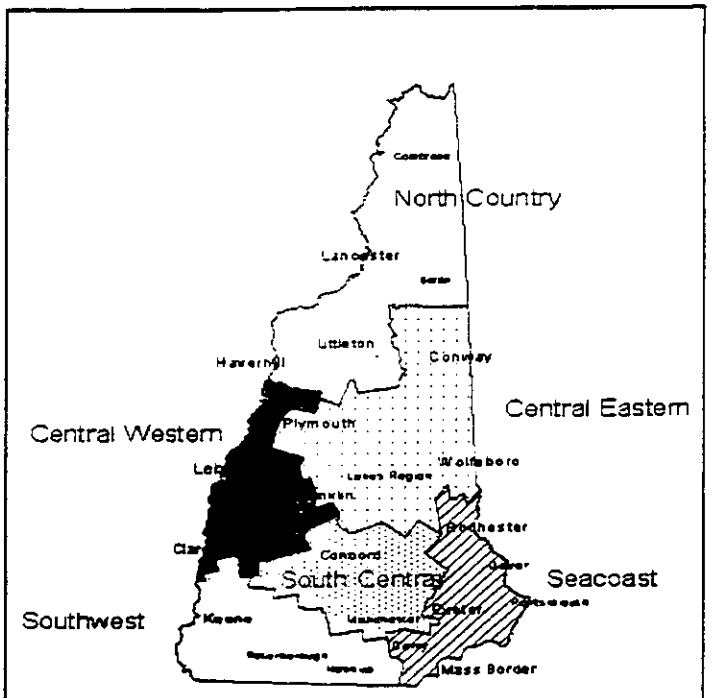


Figure 5: Regions of New Hampshire

Future Challenges

In spite of general economic prosperity, an estimated 96,000 New Hampshire residents are uninsured. Given that most job growth is in the retail and service industries - those least likely to offer insurance coverage - the uninsured may increase. The number of uninsured will also increase in the event that there is a downturn in the economic and/or insurance cycles.

Two current initiatives could have a significant effect on the lives of uninsured New Hampshire residents. A portion of the uninsured are children potentially eligible for existing programs. These children will benefit from private and state outreach efforts currently underway. The greatest share of the uninsured - adults - will be the focus of a subcommittee involving a partnership between the Department of Health and Human Services, the Legislature, representatives of health care providers and businesses in New Hampshire and the Healthy Kids Corporation.

These two initiatives have the potential of significantly reducing the rate of uninsurance in New Hampshire.

ARE WE CARING FOR THOSE WHO CARE?

	Target's **SHIPPING & RECEIVING NIGHT WORKER**	NH Department of Health and Human Services' **DATA ENTRY OPERATOR I** *	New Hampshire's **CHILD CARE PROVIDERS**
Average Hourly Wage	**$8.50** *starting*	**$7.60** *starting*	**$7.15** *statewide average* **
Health Insurance Coverage?	Full family coverage for health insurance paid by employer	Full family coverage for health insurance paid by employer	♦ 37% offer no health insurance at all ♦ in 50% of those with a health plan, employees pay for the coverage ♦ < 14% offer paid employee coverage ♦ < 2% offer paid family coverage
Minimum Qualifications **1. High School Diploma?** **2. College Course Work?** **3. Other Requirements?**	**1.** not req. but G.E.D. preferred **2.** NO **3.** ***NO experience needed***	**1.** NO - 2 yrs High School only **2.** NO **3.** ***NO experience needed***	**1.** YES - H.S. diploma needed **2.** YES - 6 related College Credits **3.** YES - First Aid and CPR training
What's at Stake?	**?**	**?**	The health, safety, and emotional well-being of young children while their parents are at work.
Job's Value to New Hampshire	**?**	**?**	"Improving child care is essential to the future of New Hampshire's economy and to the future of our children..." ***

Boxes of merchandise and a computer keyboard don't seem to notice when someone leaves the job – but, "employee turnover" in child care affects a young child in a profound way – it is experienced as nothing less than the loss of someone they love. This shouldn't have to happen often in a young child's life... Let's help the people who care for our State's poorest families stay with the children.

* This is reported to be one of the lowest-paid hourly positions at the NH Department of Health and Human Services: Labor Grade 2

** Information in this column is taken from *1997 New Hampshire Wages*, the NH Child Care Licensing Rules, and the Child Care Resource & Referral Network of NH survey of Nov 99

*** Opening sentence of *New Hampshire's Child Care Challenge*, the final report of the Governor's Business Commission on Child Care and Early Childhood Education

Prepared by Invest in Kids, the New Hampshire Child Care Association, and the United Ways of NH's Success by Six, January 2000

HEALTH INSURANCE & CHILD CARE PROVIDERS

WHAT ARE THE FACTS?*

- 130 of New Hampshire's child care centers have no health insurance plan.
- 150 child care centers have health insurance plans for full-time staff only
- In 50% of centers with plans the cost of health insurance is paid by employees
- Only 7 centers could contribute to the cost of family coverage
- Centers with insurance report dramatic cost increases –health insurance costs keep wages low and affect program quality.
- New Hampshire child care employees cannot afford plan premiums on the mean average pay of $7.15 an hour.

WHAT ARE THE RESULTS?

- Hundreds of New Hampshire child care workers have no health insurance due to cost. Child care workers are forced to leave the profession to get benefits. The turnover rate in center staff is a crisis. This is bad for children and the workforce.
- Child care centers cannot compete with other industries in hiring and health benefits .
- Losing insurance benefits from their job prevents people from entering the Family Child Care profession.
- New Hampshire workers have a hard time finding child care for their kids and worry about the quality of care with so much turnover.

***Based on a telephone survey of 353 child care centers by the Child Care Resource & Referral Network of New Hampshire, 11/99.**

For further information contact:

Jack Lightfoot
Child and Family Services
1-800-640-6486 ext 145
LightfootJ@cfsnh.org

Susan Lloyd
The Child Care Project
1-800-323-5446
susan.lloyd@dartmouth.edu

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Fax: (603) 645-6220

E-mail: info@nhlung.org
Web Site: www.nhlung.org

When You Can't Breathe, Nothing Else Matters®

Founded in 1904, the American Lung Association includes affiliated associations throughout the U.S., and a medical section, the American Thoracic Society.

AMERICAN LUNG ASSOCIATION®
of New Hampshire

March 15, 2001

Dear Legislator,

The American Lung Association of New Hampshire supports House Bill 762, which would increase the tobacco tax by fifty cents and allow for a healthy families trust fund.

We see this legislation as being beneficial to the residents of New Hampshire – fewer youths smoking today, means less spending on future medical care that they may require through state assistance programs.

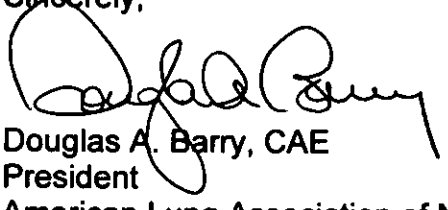
This tobacco tax seeks to expand the capabilities of existing state programs, such as the Children's Health Insurance Program, and also creates new programs like health insurance coverage for child care workers. An additional benefit would be increasing the funding in the Tobacco Use Prevention Fund bringing New Hampshire up to the recommended level set forth by the Centers for Disease Control.

This legislation will affect may peoples lives positively. Everyone from our youngest citizens right up to the oldest would directly or indirectly benefit from what this legislation seeks to achieve.

The State of New Hampshire has made numerous budget cuts over the past several years and this legislation seeks to raise revenue for specific areas that have been affected by these cuts.

It is for the reasons stated above and the health of all New Hampshire citizens that the American Lung Association of New Hampshire supports HB 762.

Sincerely,



Douglas A. Barry, CAE
President
American Lung Association of New Hampshire

AMERICAN CANCER SOCIETY®

New England Division, Inc.

March 14, 2001

David J. Alukonis
Chairman, House Ways & Means Committee
Legislative Office Building
Concord, NH 03301

Dear Chairman Alukonis,

The American Cancer Society enthusiastically supports and encourages the passage of HB762 as introduced by Representative Martha Fuller Clark. The American Cancer Society has long recognized that smoking is the most preventable cause of death in this country. In fact, nearly 1 in 5 deaths in the US result from the use of tobacco products. The 1982 US Surgeon General's Report stated that " Cigarette smoking is the major single cause of cancer mortality in the United States."

The toll of tobacco use in New Hampshire can't be denied.

- 24% of New Hampshire adults and 39% of the state's high school students smoke.
- 5,000 youth under the age of 18 become new daily smokers annually.

The monetary cost associated with tobacco use also creates a burden on the state.

- $340 million is spent annually in New Hampshire on tobacco-related health care costs.
- $180 million of residents' state/federal tax burden is due to tobacco-related health costs.
- $6 to $18 million is spent annually for babies' health problems caused by mothers smoking or being exposed to secondhand smoke during pregnancy.

Dedicating $7.8 million of the revenue generated from a tobacco tax increase to increase the funding for New Hampshire's tobacco prevention use fund would significantly improve the health of smokers and non-smokers alike.

The creation of the Healthy Families Trust Fund would enable many of New Hampshire's children, senior citizens and disabled to take advantage of the full range of high-quality health care services that are readily available, accessible and affordable. Access to these services will contribute to a reduction in cancer mortality and morbidity rates.

Passage of HB762 would be another step in the process to ensure that all New Hampshire citizens have the support of their state in the struggle against cancer and the opportunity for complete health care access.

Sincerely,

Jim David
Regional Vice President

Gail Singer Memorial Building • 360 State Route 101 • Suite 501 • Bedford, NH 03110-5032
Phone 603-472-8899 • 1-800-640-7101 in NH • Fax 603-472-7093
For cancer information call **1-800-ACS-2345**

CONCORD HOSPITAL
Center For Health Promotion
8 Loudon Road • Concord NH 03301 • 603-228-7240
Your resource to better health

March 13, 2001

Dear Elected Official;

As the coordinator for the Capital Area Smoke Free Coalition, I am pleased to support your efforts along with the American Cancer Society, to increase the tobacco tax by $.50 per package.
I work with individuals trying to quit every day and their trails are heartbreaking. For some, despite major medical problems cannot break the addiction. Given the powerful, addictive nature of this drug, we need to take immediate steps to prevent future generations from smoking. A higher price at the checkout stand is one way.

Moreover, the money raised from the increase allows us to expand our efforts to educate the people of New Hampshire about the continuing dangers of tobacco. The money generated from the increased tax would allow us to fund a comprehensive tobacco plan recommended by the Centers for Disease Control and Prevention. As you well know, New Hampshire has one of the highest smoking rates in the nation. These funds would enable New Hampshire to expand its existing statewide coalitions and coordinate their efforts to change public policy related to tobacco use. It is certainly an opportunity that our state should not pass up.

This is a community wide problem that is going to take the dedication of all facets of our society with a strong financial commitment from private and public sources. There is much to accomplish in the area of tobacco prevention and this tax can provide the opportunity to reach a new level of prevention efforts while at the same time fund other necessary health care initiatives. Let's direct this tax to support related health care issues.

Sincerely,

Martha Bradley

Martha Bradley
Health Educator Coordinator

Susan Kirwan

90 Primrose Lane
Penacook, NH 03303

March 14, 2001

Dear Legislators,

RE: HB 762

My name is Susan Kirwan of Penacook, New Hampshire. I am a mother of three small children. My husband is self-employed which means we have the unsurmountable task of searching for affordable health insurance on our own.

The escalating cost of health insurance is shocking. Our health insurance is up for renewal during this month of March and it frustrates me to think that if these high costs continue, I may be another statistical number joining the ranks of the underinsured. Single health coverage alone this year went up 50%! The family rate, depending on the insurance company, costs anywhere between $626.00 - $668.00 and those rates were for the fiscal year 2000! They are up 17% for this year!

Programs such as New Hampshire Healthy Kids, (CHIP), which relies on private, charitable funds, has been a monumental value to our family. We need to make sure that those funds continue. Relying on private funds doesn't mean that they will and the State of New Hampshire needs to find a funding source to continue this program. HB 762 does just that. New Hampshire Healthy Kids, (CHIP), has enabled our family to get affordable health, as well as dental coverage, for my children. The program is based on monthly payments according to your family's yearly income. With the children covered, my husband and I could sign up for health insurance, through an agent, at the "couple rate" instead of the otherwise unaffordable "family plan". New Hampshire Healthy Kids is a wonderful, vital program however, it solely covers just the children. I believe children are our highest priority, but what good are we to them as parents if we are incapacitated and unable to care for them due to sickness? We need access to affordable health insurance as a family unit! Hb 762 has the mechanism to provide for health insurance to eligible parents already enrolled in the CHIP program.

Please consider these two questions:

1. What can we do to provide the much needed revenue for affordable health care programs?

2. How can we commit to ensuring access to quality, affordable health care to all our state's residents?

The health of New Hampshire is at stake. Help us to continue the circle of life. We need your support to take steps to develop new programs that allow us to continue quality and affordable health insurance coverage for our New Hampshire families. Please support HB 762 to access these programs for our New Hampshire families. With these programs, we will be assured to significantly change our economic development for our state!

Thank you in advance for your support!

Sincerely,

Susan Kirwan

New Hampshire Association for the Elderly
4 Park Street, Suite 403, Concord, New Hampshire 03301
Phone: 228-1054; fax: 228-3360

Dear Legislators,

Health care access is one of the most important issues for New Hampshire seniors, specifically access for seniors to receive adequate and *essential*, prescription drug coverage. That is why the New Hampshire Association for the Elderly (NHAE) supports the Health Now! Campaign and the legislation in front of you today, HB 762. NHAE is a non-profit organization with a statewide membership of over 3,000 members and prescription drug coverage is a top policy priority. NHAE has been working towards our goal of having prescription drug coverage for as many seniors as possible for the last few years – something that is desperately needed.

HB 762 creates several mechanisms to expand coverage for seniors, an issue that has risen to almost crisis proportions. One of the mechanisms is through expansion of Medicaid for seniors with incomes between 75% and 100% of the federal poverty level (fpl). Currently there are over 17,000 seniors in NH below the fpl, and only 8,500 on Medicaid. This would increase the number of seniors eligible for expansion to at least another 8,500. In addition, this legislation initiates a program that would provide seniors over 65 and adults with disabilities who are at or below 200% of the fpl and not eligible for Medicaid, a $1,250 prescription drug benefit for 32,000 people.

That is a lot more coverage for at least 40,500 New Hampshire residents!

There are seniors in this state who struggle every day between taking their medication or buying their groceries because of the high cost of their prescriptions. Creating a source of revenue to increase access for seniors on prescription drugs is critically needed. Passing this legislation is one step forward in working to addresses that need.

Sincerely,

Bob Stauffer
Program Director
New Hampshire Association for the Elderly

New Hampshire HEALTHY KIDS

March 4, 2001

The Alliance for a Healthy New Hampshire
4 Park Street, Suite 403
Concord, NH 03301

Re: Health Now! Campaign

To Whom It May Concern:

Access to adequate health care represents one of the most important public policy issues facing New Hampshire and the nation. That's why New Hampshire Healthy Kids Corporation supports the Health Now! Campaign. This initiative represents an opportunity to generate new revenue that is needed to increase access and improve the health and quality of life of our State's residents.

A specific goal of the campaign is to ensure the continuing success of the Children's Health Insurance Program (CHIP), which provides free and low-cost health coverage to uninsured children. New Hampshire's CHIP program was implemented in 1999 as a partnership between the Department of Health and Human Services and the New Hampshire Healthy Kids Corporation. Since that time, more than 12,000 children have gained access to health coverage through Healthy Kids. But our work is not done. It is estimated that another 9,000 – 10,000 children are eligible but not enrolled.

Before we move forward in covering every eligible child, we must secure the State funds needed to draw down federal dollars specifically designated for children's health coverage. To date, the State's financial share has been funded through a private grant from the Healthy New Hampshire Foundation. However, the program's success has outgrown the Foundation's ability to fully fund the state match in future years.

As the attached fact sheet suggests there are numerous reasons to substantiate why children's health coverage is important. Insured children are much more likely to receive the preventive and timely medical care they need to stay healthy. Healthy kids learn better and are more likely to reach their potential as tomorrow's workforce. The Children's Health Insurance Program is a great investment. Every 20¢ of State funds buys $1 worth of health coverage by leveraging other funds.

A source of revenue to fund the Children's Health Insurance Program and tackle other health care access issues in New Hampshire is critically needed. The Health Now! Campaign addresses this need.

Sincerely,

Tricia Brooks

Tricia Brooks
Executive Director

25 HALL STREET, SUITE 303, CONCORD, NH 03301-3477 (603) 228-2925

American Heart Association.

Fighting Heart Disease and Stroke

Dear Legislator,

The American Heart Association would like to give its strong support to HB 762 and ask for your support for this important piece of legislation. The American Heart Association has set an ambitious goal of reducing heart disease and stroke and the risk factors that cause them by 25% by the year 2010. The AHA is proud to be a coalition partner in the Alliance for a Healthy New England and Health Now! New Hampshire because reducing the number of adults and children who smoke, while providing greater access to health care, are effective strategies for reducing the large number of people who suffer from cardiovascular disease.

One of the American Heart Association's top advocacy priorities is reducing tobacco use. The largest portion of the more than 400,000 smoking-related deaths each year is cardiovascular related. Tobacco use is also the most preventable cause of cardiovascular disease.

This proposal to significantly increase the tobacco tax, fund comprehensive tobacco programs and offer greater access to health care is sound public policy. Cigarette smoking is a very serious problem that has not changed much in the past two decades. Twenty-four percent of New Hampshire adults are regular smokers, and thirty-nine percent of New Hampshire's young people smoke. Each year, about 1,700 of our family members, friends and neighbors die from tobacco-related disease, while thousands more live with the debilitating effects of heart disease, lung disease and cancer caused by smoking. The health care costs, which all of us share, are conservatively estimated to be $340 million each year in New Hampshire.

Economic studies have consistently shown that cigarette price increases by themselves can reduce smoking rates. But, tobacco use is a complex issues that must be addressed on several fronts simultaneously to have a significant impact. Evidence from California, Massachusetts and Oregon has shown that a tobacco tax increase, combined with a comprehensive tobacco control program, can reduce tobacco use rates by substantial amounts among adults and young people, and can achieve impressive health benefits.

In fact, a study in the December 14, 2000 New England Journal of Medicine by the University of California showed that not only did this state have the most significant drop in tobacco use at 50%, but, 33,000 heart-disease deaths were also prevented during the first nine years of the program. This is very encourgaing news to the American Heart Association. We urge you to support HB 762 so that we might shorten the time until we experience in New Hampshire the reductions in heart disease demonstrated in California.

This legislation would also raise the funding for New Hampshire's tobacco control program to an adequate and effective level of $10.8 million. The current funding of

$3,000,000 is only 27.5% of the CDC's recommended minimum funding level for New Hampshire.

We know that reduced numbers of smokers will further reduce health care costs. The cost of cardiovascular disease alone in this country will hit $327 billion this year. Reductions in tobacco use will help to lower these costs as well as health care costs associated with cancer and lung disease.

Finally, the American Heart Association strongly supports public policy initiatives to provide greater access to quality medical care. Funds generated by the cigarette excise taxes under HB 762 would provide increased access to healthcare for people with limited incomes. These healthcare services would include access to prevention and cessation programs, which would further reduce the number of lives lost to tobacco and heart disease. Additionally, funding provided to the Health Families Trust Fund under HB 762 would alleviate health care concerns for many groups, from children and parents to the elderly. Offering expanded health insurance coverage and prescription drug assistance for low income residents is a prudent use of these funds. It is sound legislation that will save lives and dollars. The American Heart Association would appreciate your support for this important legislation.

Thank you for your time.

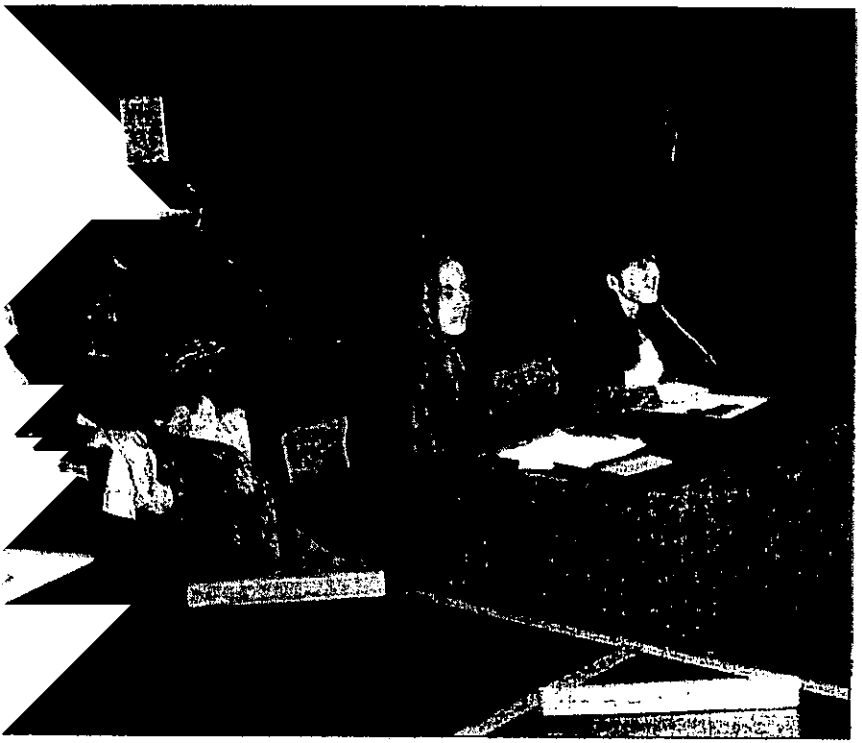
Sincerely,

Tina Zuk

Tina Zuk
Vice President, Advocacy
American Heart Association New England Affiliate
20 Merrimack Street, Suite 1
Manchester, NH 03101-2244

SECOND FRONT PAGE

Dover youth testify



Courtesy photo

BETH HERLIHY, RIGHT, AND KARI FITCH, left, testify at the Statehouse in support of a bill to ban the sale of rolling papers to minors. The high school juniors are members of Dover Youth-to-Youth, which sponsored a similar ban at the city level.

Students seek ban on sale of rolling papers to minors

By BRAD MORIN
Democrat Staff Writer

DOVER — A group of Dover youth who pushed adoption of a city ordinance that banned the sale of rolling papers to minors traveled to Concord last week to testify on behalf of a bill to extend the ban statewide.

The papers are used to smoke tobacco or marijuana. Dover Youth-to-Youth, a police-sponsored group of students in middle school and high school, targeted 16 stores in the city. Four sold the papers to students who were under 18.

Although youth under 18 weren't allowed to smoke, there was nothing in the law preventing the sale of rolling papers. The group drafted an ordinance and in July 1999, the City Council passed the ban on sell-

☆ *Youth*
Please turn to Page 5B

Youth

Continued from Page 1B

ing the papers to minors. Youth-to-Youth called the program the "Zig-Zag Project," after one of the more popular brand of papers.

Kari Fitch, a high school junior and member of Youth-to-Youth, said members did 20 spot-checks after the ordinance was adopted and none of the stores sold the papers.

Rep. William Knowles, D-Dover, recently met with Youth-to-Youth members and agreed to sponsor legislation to extend the ban statewide.

"There's no legal use for a minor to have rolling papers," said Beth Herlihy, another high school junior and Youth-to-Youth member.

Five high school students and five students from St. Mary Academy traveled to Concord last Wednesday to speak in support of the bill before the House Commerce Committee. On the way, the underage students purchased more rolling papers to show to legislators.

"They seemed pretty amazed by that," Fitch said.

Knowles said last week that the bill received a favorable report by the committee and he believes it has a good chance of passage.

FOSTER'S DAILY DEMOCRAT MONDAY, FEBRUARY 19, 2001

Midnight Madness





Dover kids attend anti-drug event

By ANNALIESE WOLF
Democrat Staff Writer

DOVER — One hundred twenty childre voluntarily locked themselves up Friday nigl to show their participation in the war again drugs.

Starting at 7 p.m. at the Butterfield Gyr children were checking in with Dover Yout to-Youth workers for the Midnight Madne event, tossing their sleeping bags in a corn and running to the basketball court.

Their plans for the evening were to partic pate in games, eat pizza, stay up all night ar avoid drugs.

Dover Youth-to-Youth, which sponsored th event, is a program run by the Dover Poli Department that brings children and poli and anti-drug messages together. The organ zation holds several events during the year.

The night's activities included guest spea ers, who talked about drugs and their live Tony Howard spoke about the consequenc drug users face.

Don Frost, an ex-smoker who develop emphysema, spoke about his experiences wi tobacco.

Gary Repogle, an employee of Southeaste Services, a halfway house in Dover, spo about his work and the rehabilitation proces

Joe Mansi of the Prescriptive Assessme through Comprehensive Evaluations progra in Rochester, also known as PACE, attend with two 14-year-old drug abusers, who spo to their peers.

"The kids had a lot of questions for the (the speakers)" said Mary Cook, preventi coordinator for the Dover Police Departmer "There was a lot discussed about experienc with drugs and building strong relationship

The Dover Youth-to-Youth program start in 1992, according to Capt. Dana Mitchell.

☆ *Anti-drug*
Please turn to Page 5

Tim Boyd/Staff photograph

DETECTIVE BRIAN MILLER, above le twirls Danielle Mendum, 16, during th Annual Dover Youth to Youth Midnig Madness Lock in held Friday night at th Butterfield Gym in Dover. About 30 of th nearly 200 students participated in th swing dance lessons.

At bottom left, Corinne Allaire, from th Corinne School of Dance in Rochest center, offers some guidance to Mar Miller, 17, left, and Rachael Wilkins, 1 during the Annual Dover Youth to You Midnight Madness Lock in.

Anti-drug

Continued from Page 3

"A lot of the kids come back every year," Cook said. "Many of them have been in (the program) for four or five years."

There are 239 students in the program this year, the largest number of students to date, according to Cook.

"In any area, youth getting involved in a program this early helps build healthy relationships in a community with adults and build a core group of kids as friends. They've built a healthy attitude," Cook said.

"(Midnight Madness) has gotten bigger and better every year, as has the program," Mitchell said. "The program is based on kids being activists and aggressively bringing that information to the community. But the other part of a group like that has to be fun and have a social element to it, and that's tonight," Mitchell said. "It's a chance to stop being activists and have a good time."

"It involves kids and lets them have fun, (it's) really effective. Kids can be involved with police, and it lets them realize police are friends," said intern Alex Mitrushi, who attends the University of New Hampshire, majoring in sociology and justice studies.

Most of the children are from the middle school, but many young adults still participate in Dover Youth-to-Youth.

"There are fifty high school kids involved," Cook said. "While it is true that kids start working, get their licenses, we've got a core group of about twenty that stuck with the program ever since they started."

The high school students in attendance said they enjoyed Midnight Madness.

"I want to get the message out to kids younger than me that the drug-free lifestyle is fun," said Mandi Miller, a junior at Dover High School who has been with Dover Youth-to-Youth for three years.

"It gives us a chance to be role models," said Danielle Mendum, who is also a junior at Dover High School and has also been a three-year participant in the program.

Both of the students have participated in Midnight Madness before as well as other Youth-to-Youth events, such as Skate with the Wildcats.

Both Miller and Mendum are interested in pursuing college careers that would involve their drug-free message. Miller is interested in a criminal justice major and Mendum would like to do something with law enforcement.

Several activities were planned to keep the children busy. The pool was open, swing dance lessons were available, floor hockey and pie-eating contests were scheduled later in the evening and the all-time favorite, karaoke, was held between 10 p.m. and midnight.

The most fun is when all the adults in the program have to get up and sing, Cook said. They performed "Stayin' Alive" by the BeeGees.

"When (the kids) see their leaders make fools out of themselves, it lets them realize they're real people," Mitrushi said.

Some of the high school members of Dover Youth-to-Youth also had something up their sleeves: a skit mimicking the police hockey team.

"We're thinking maybe they are going to fade," Cook said about 8 p.m., looking around at the balls flying through the air on the basketball court, "but most of them stay up all night."

Most of the children did make it through the night, and only three or four actually slept, said Cook.

Children can sign up for Dover Youth-to-Youth in September at the Dover High School, Dover Middle School or St. Mary Academy, or parents and children can get in touch with the Drug Abuse Resistance Education and Prevention Bureau at the Dover Middle School or by calling 742-3172, Ext. 1605.

Other people involved in Dover Youth-to-Youth include Detective Brian Miller; police officer Eric Borrin, the student resource officer at Dover Middle School; Sgt. William Simonds; police officer Wayne Sheehan, the student resource officer at Dover High School; Becky Ireland, a prevention specialist; patrol officer Mark Leno and Steve Meserve and Travis Allen, a member of the National Guard.

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Health Insurance Coverage and the Uninsured in New Hampshire







Results from the New Hampshire Health Insurance Coverage and Access Survey

Health Insurance Coverage and the Uninsured in New Hampshire

Results from the New Hampshire Health Insurance Coverage and Access Survey

Jeanne Shaheen, Governor

❖

Donald L. Shumway, Commissioner
Department of Health and Human Services



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November, 1999

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Health Insurance Coverage in New Hampshire

Issue Brief 1999

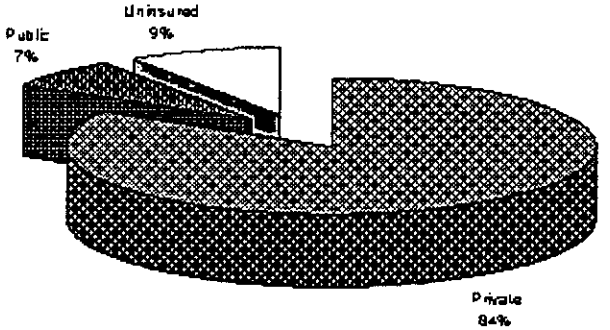
In 1999, the Department of Health and Human Services sponsored the New Hampshire Health Insurance Coverage and Access Survey, a telephone survey of New Hampshire residents under the age of 65 designed to understand health insurance coverage, access to health care, and general medical needs. This issue brief presents key initial findings.

❖ Almost 84 Percent of New Hampshire Residents are Covered Through the Private Sector.

Private insurance - including both employer-based and non-group privately purchased - covers almost 84 percent of all New Hampshire residents (Figure 1). This is significantly higher than the national average. An important question to be addressed is how the state of New Hampshire can build on this success, particularly in a period where trends suggest that employers are finding it more difficult to offer insurance.

❖ An Estimated 96,000 Residents are Uninsured.

Despite broad coverage through the private sector, approximately 9 percent of New Hampshire residents remain uninsured. With a non-elderly population of slightly more than 1 million individuals, approximately 96,000 New Hampshire residents under age 65 are estimated to be currently uninsured. Seven percent of New Hampshire residents are



covered through public programs.

Figure 1: Distribution of Insurance Coverage

❖ Three Quarters of the Uninsured are Adults.

Approximately 74 percent of the uninsured are adults - an estimated 71,000 individuals. Those ages 30-44 account for the largest share of the uninsured (Figure 2). Adults ages 18-29 account for 25 percent of the uninsured individuals in the state.

❖An Estimated 25,000 Children are Uninsured.

Approximately 26 percent of the estimated 96,000 uninsured are children (Figure 2). Many of these 25,000 children may be eligible for existing public programs.

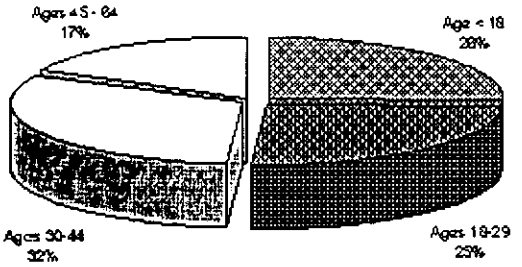


Figure 2: The Currently Uninsured by Age

❖ The Uninsured are Working.

To a large extent the uninsured are working. Almost 73 percent of all uninsured individuals have at least one family member who is working full-time (Figure 3). In addition, approximately 12 percent of uninsured individuals live in families with at least one individual working part-time.

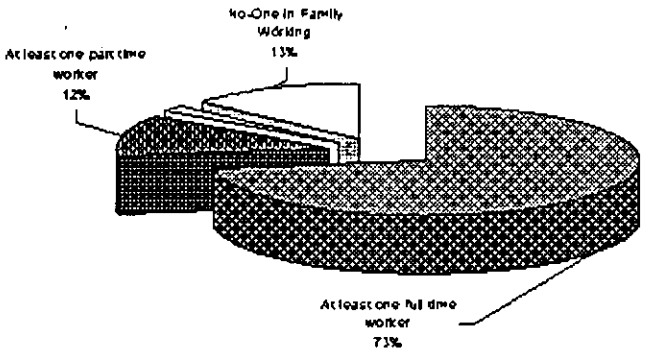


Figure 3: The Uninsured and Family Work Status

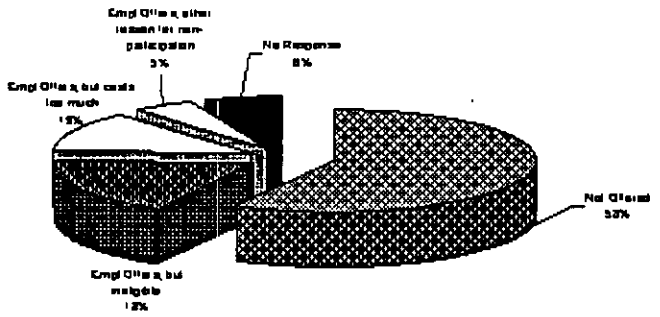


Figure 4:
Working Uninsured and Offer of Employer-Based Insurance

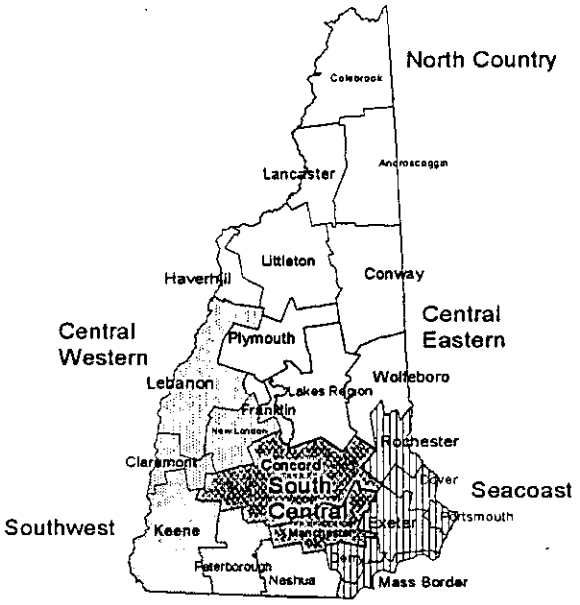
❖ Working Uninsured Report Little Access to Employer-Sponsored Insurance.

Approximately 58 percent of working uninsured adults indicated that they were working in firms that did not offer insurance coverage (Figure 4). An additional 18 percent reported that their employer offered coverage but they were ineligible for that coverage as a result of the length of employment, the part-time nature of the work, or as a result of medical issues which restricted their access to employer-based insurance.

❖ Regional Variation in Uninsurance Exists

The Northern part of the State has significantly higher rates of uninsurance than the Southern regions. Approximately 14 percent of residents are uninsured in the North Country, the area north of 'The Notch.' Approximately 13 percent of residents are uninsured in Central Eastern New Hampshire, including the Mt. Washington Valley and the Lakes Region.

While the uninsurance rate is higher in the North Country and Central Eastern New Hampshire, the more urban areas of New Hampshire - including those centered around Manchester, Nashua, Concord and Portsmouth - account for approximately 70 percent of the total number of currently uninsured individuals.



Future Challenges

In spite of general economic prosperity, an estimated 96,000 New Hampshire residents are uninsured. Given that most job growth is in the retail and service industries - those least likely to offer insurance coverage - the uninsured may increase. The number of uninsured will also increase in the event that there is a downturn in the economic and/or insurance cycles.

Two current initiatives could have a significant effect on the lives of uninsured New Hampshire residents. A portion of the uninsured are children potentially eligible for existing programs. These children will benefit from private and state outreach efforts currently underway. The greatest share of the uninsured - adults - will be the focus of a subcommittee involving a partnership between the Department of Health and Human Services, the Legislature, representatives of health care providers and businesses in New Hampshire and the Healthy Kids Corporation.

These two initiatives have the potential of significantly reducing the rate of uninsurance in New Hampshire.

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Why was a Survey of New Hampshire Insurance Coverage Conducted?

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Why was a Survey of New Hampshire Insurance Coverage Conducted?

In 1995, the New Hampshire Department of Health and Human Services created a statewide Health Care Planning Process, the goal of which was to establish a State Health Plan to promote improvement in the health status of the state's citizens. One of the principal documents to emerge from this planning process - developed through seven community councils, 22 focus groups, 18 town meetings, symposia and a number of reviews of planning reports - was *The New Hampshire Health Care System: Guidelines for Change*. This document provided a series of 27 recommendations for action that reflected the concerns of the citizens of New Hampshire.

While the vision depicted in the Guidelines for Change was broad, the recommendations for initial action were specific. They focused on developing timely and reliable information and data which would allow the state to evaluate the need for, and the benefits and costs of, public policy changes. Recommendation #2 of Guidelines for Change focused on the importance of reliable and timely New Hampshire specific information on the uninsured and underinsured to track the effectiveness of the changing market in addressing health care needs.

This recommendation served as the motivation for the New Hampshire Health Insurance Coverage and Access Survey (NH - HICAS), a telephone survey of New Hampshire residents under the age of sixty-five designed to understand health insurance coverage, access to medical care, and general medical needs. The results from this survey, of which this report is the first product, provide previously unavailable estimates of uninsurance and the ability to assess under-insurance and the effects of uninsurance and under-insurance, and identify common barriers to obtaining adequate health care coverage. Collection of this information benefits state and local leaders, as the survey was designed to provide estimates at both the state level, and (for a more limited set of characteristics) for different regions of New Hampshire.

The NH-HICAS, while a unique initiative in many respects, is built on work being conducted in other states across the country. In 1993, the Robert Wood Johnson (RWJ) Foundation conducted state specific surveys in Colorado, Florida, Minnesota, New Mexico, New York, North Dakota, Oklahoma, Oregon, Vermont and Washington. A number of states, including Minnesota, Florida and Vermont, have continued to conduct state specific surveys using the RWJ methodology in order to understand the impact of market and policy changes. For the NH-HICAS, both the survey instrument and the sample design were adapted from the RWJ study and modified to meet the needs of New Hampshire.

This report is structured around a series of questions raised through the health planning process by the seven district health councils, the legislature, and the Departments of Health and Human Services and Insurance. It is designed to provide basic answers to these questions. While each section may raise questions regarding policy implications, the intent of the report is to set the stage for work to be conducted cooperatively among the Department's partners.

Why is Health Insurance Important?

Last Revised: 11/16/99

Why is Health Insurance Important?

Policy makers are concerned about access to health insurance coverage for a variety of reasons. Most Americans access health insurance through their employer. Nationally, approximately 70 percent of the population has health insurance coverage through their employer. However, changes in the health care market including increases in health care insurance premiums and an increase in jobs which do not offer benefits, have raised concerns about the erosion of the employment-based system. Some researchers believe that changes in the employer market and the increasing un-affordability of health insurance in the United States are the root cause of recent increases in the uninsured. To many, the changes in the employer market are particularly troubling given the current period of economic prosperity and the real potential for economic downturns.

Individuals without health insurance coverage are a policy concern because they often seek medical services later and receive less care than those who do have coverage. This lack of coverage has implications for individuals, families, and communities. Individuals without health insurance potentially face catastrophic costs that can have a significant effect on the economic viability of a family and thus create a negative impact on individuals within that family. Moreover, a lack of insurance coverage can have an impact on communities if individuals do not seek medical care when necessary and, as a result, lose workplace productivity. In addition, uninsurance can have an impact on health care providers, as those providers bear some of the costs of providing care to those individuals in need.

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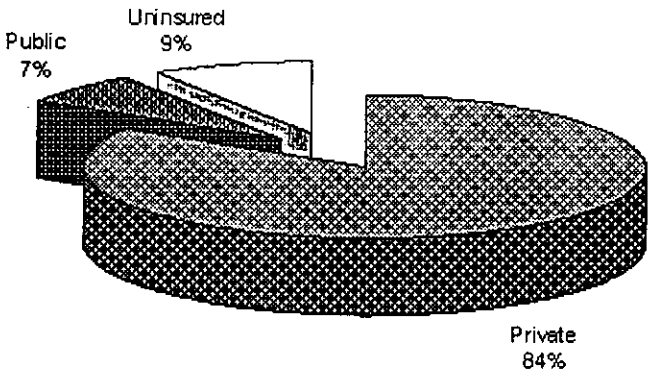
Who is Covered by Health Insurance in New Hampshire?

Last Revised: 11/16/99

Who is Covered by Health Insurance in New Hampshire?

In 1999, approximately 84 percent of the residents of New Hampshire are insured through their employer or through the direct purchase of insurance coverage from an insurance company (Figure 1) [1]. Adults in New Hampshire are more likely to be insured privately (86 percent) than children (78 percent). Compared to the rest of the nation, New Hampshire residents are more likely to be covered privately. A recent national survey indicated that 75 and 69 percent of adults and children respectively were covered privately (Brennan, et. al., 1999, Zuckerman and Brennan, 1999).

Figure 1
Distribution of Health Insurance Coverage



Approximately seven percent of New Hampshire residents are covered through publicly sponsored programs, including Medicare, Healthy Kids Gold, Healthy Kids Silver (subsidized and unsubsidized), Medicaid and other state and federal programs. Reflecting the broad reliance on the private insurance system, New Hampshire residents are much less likely to be covered for public programs than is the case for Americans generally. Recent estimates suggest that 20 percent of children and eight percent of adults respectively are covered by public programs nationally (Brennan, et. al., 1999, Zuckerman and Brennan, 1999)

Table 1
The Currently Uninsured in New Hampshire

	95 Percent Confidence Interval		
	Low End of Range	Estimate	High End of Range
Percent Uninsured [1]	8.4%	9.3%	10.1%
Number of Uninsured [2]	87,112	95,804	104,495

[1] Total number of non-elderly individuals in New Hampshiree from the US Bureau of Census, 1997

compared to 14 percent and four percent for children and adults respectively in New Hampshire.

[2] Low End and High End of 95% confidence interval computed as the estimate + or - 1.96* the standard error.

Despite broad coverage through the private sector, approximately 9.3 percent of New Hampshire residents remain uninsured.[2] With an estimated non-elderly population of slightly more than 1 million individuals, this suggests that approximately 96,000 individuals were uninsured as of September 1999. Based on the precision of the estimate, it is 95 percent certain that the true estimate of the uninsurance rate ranges from 8.4 to 10.1 percent of the non-elderly population in New Hampshire or between approximately 87,000 and 105,000 individuals (see Table 1).[3]lieve that changes in the employer market and the increasing un-affordability of health insurance in the United States are the root cause of recent increases in the uninsured. To many, the changes in the employer market are particularly troubling given the current period of economic prosperity and the real potential for economic downturns.

Individuals without health insurance coverage are a policy concern because they often seek medical services later and receive less care than those who do have coverage. This lack of coverage has implications for individuals, families and communities. Individuals without health insurance potentially face catastrophic costs that can have a significant effect on the economic viability of a family and thus create a negative impact on individuals within that family. Moreover, lack of insurance coverage can have an impact on communities if individuals do not seek medical care when necessary and, as a result, lose workplace productivity. In addition, uninsurance can have an impact on health care providers, as those providers bear some of the costs of providing care to those individuals in need.

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What Do These Results Suggest About Coverage in NH?

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What Do These Results Suggest About Coverage in New Hampshire?

Nationally, 17 and 12 percent of adults and children respectively are uninsured, both significantly higher than New Hampshire's rate of nine percent. There are many factors which could contribute to this difference, one of which is New Hampshire's unique position as one of the wealthiest states in the country. New Hampshire is reported to be the eighth highest state in regards to per capita income in the country (New Hampshire Employment Security, 1999). Individuals with higher incomes can more easily access private sources of insurance coverage. That private plans are an even more important source of health insurance coverage for New Hampshire residents than for all Americans may also speak to the general strength of the employment-based system in New Hampshire (and the behavior of both employers and employees).

However, national trends suggest that while private plans are still the leading source of health insurance coverage for all Americans, employer-based insurance coverage has begun to deteriorate, particularly for the lower-skilled jobs that are an important factor in the recent decline in unemployment rates. This trend is apparent in New Hampshire as well. The occupations projected to add the most jobs in New Hampshire between 1996 and 2006 were retail related (Elliot, 1999), and these positions are often the least likely to offer any insurance coverage. This raises important policy questions. As New Hampshire grows will the uninsurance rate grow as well? Unemployment is currently at a record low and if there is an economic downturn will the number of uninsured increase substantially? Even if the economy stays strong, will sharp increases in the price of healthcare drastically increase the number of uninsured citizens?

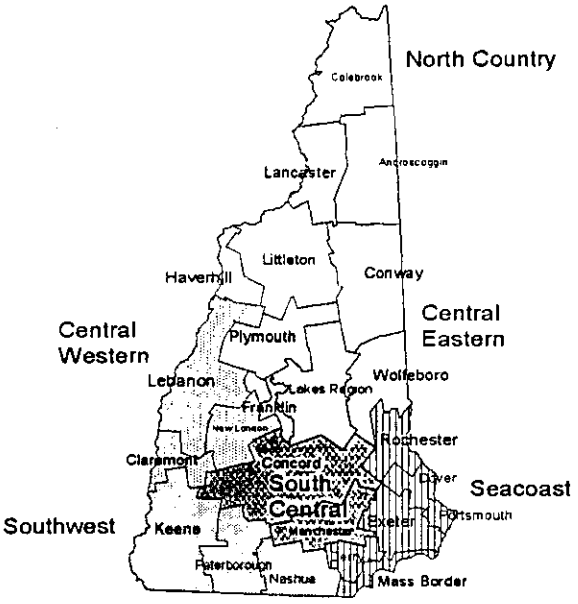
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Are There Regional Differences in Insurance Coverage?

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Are There Regional Differences in Insurance Coverage?

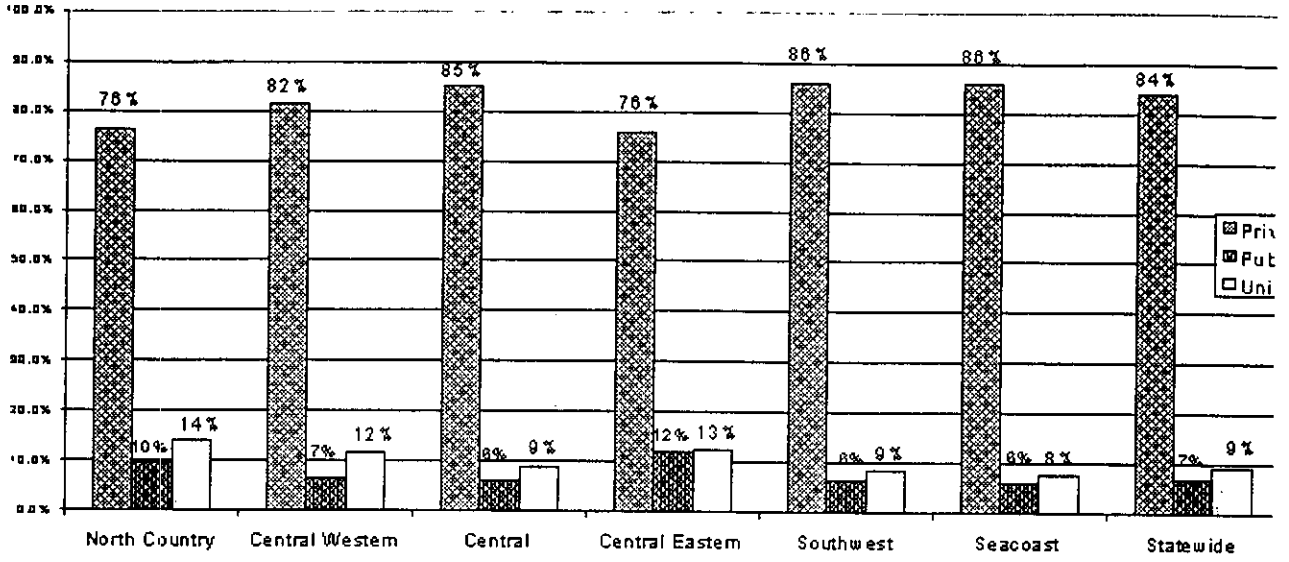
One of the primary purposes for conducting the NH-HICAS was to provide information on regional variation in health insurance coverage in New Hampshire. As a result, the survey was designed to provide information on 24 geographic areas in the state of New Hampshire. These geographic areas - called hospital service areas - were developed by Health Services Planning and Review to capture the patterns of medical care usage across the various regions of New Hampshire. These hospital service areas were grouped together to develop regions. Figure 2 documents these 24 hospital service areas, and how these areas were grouped to develop regions. Other groupings are possible and will be pursued in further work.



With two exceptions, over 80 percent of individuals in all regions of New Hampshire are covered through private insurance coverage (Figure 3).

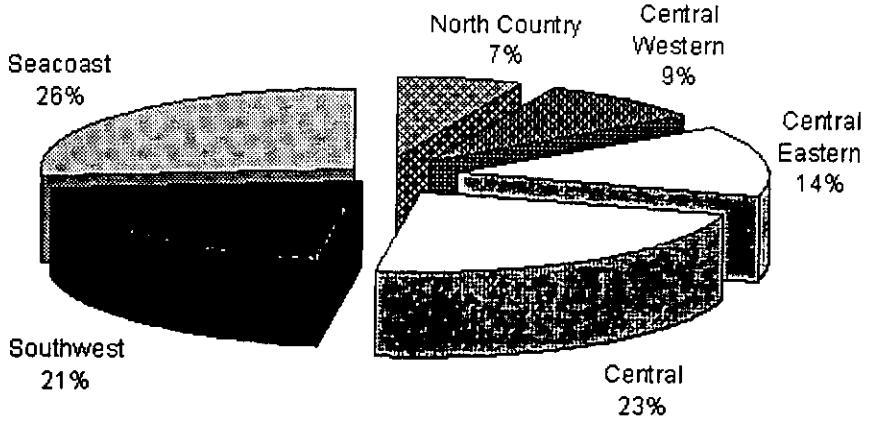
These two exceptions, the North Country (which includes everything North of 'The Notch') and Central Eastern New Hampshire (which includes the Mt. Washington Valley and Lakes Region areas) have a significantly lower percentage of individuals covered by private insurance coverage than that of the rest of the state. Individuals in these two areas are also significantly more likely to be uninsured than in the state. Approximately 14 percent and 13 percent of individuals in the North Country and Central Eastern New Hampshire respectively were uninsured.

Figure 3
Health Insurance Coverage by Region

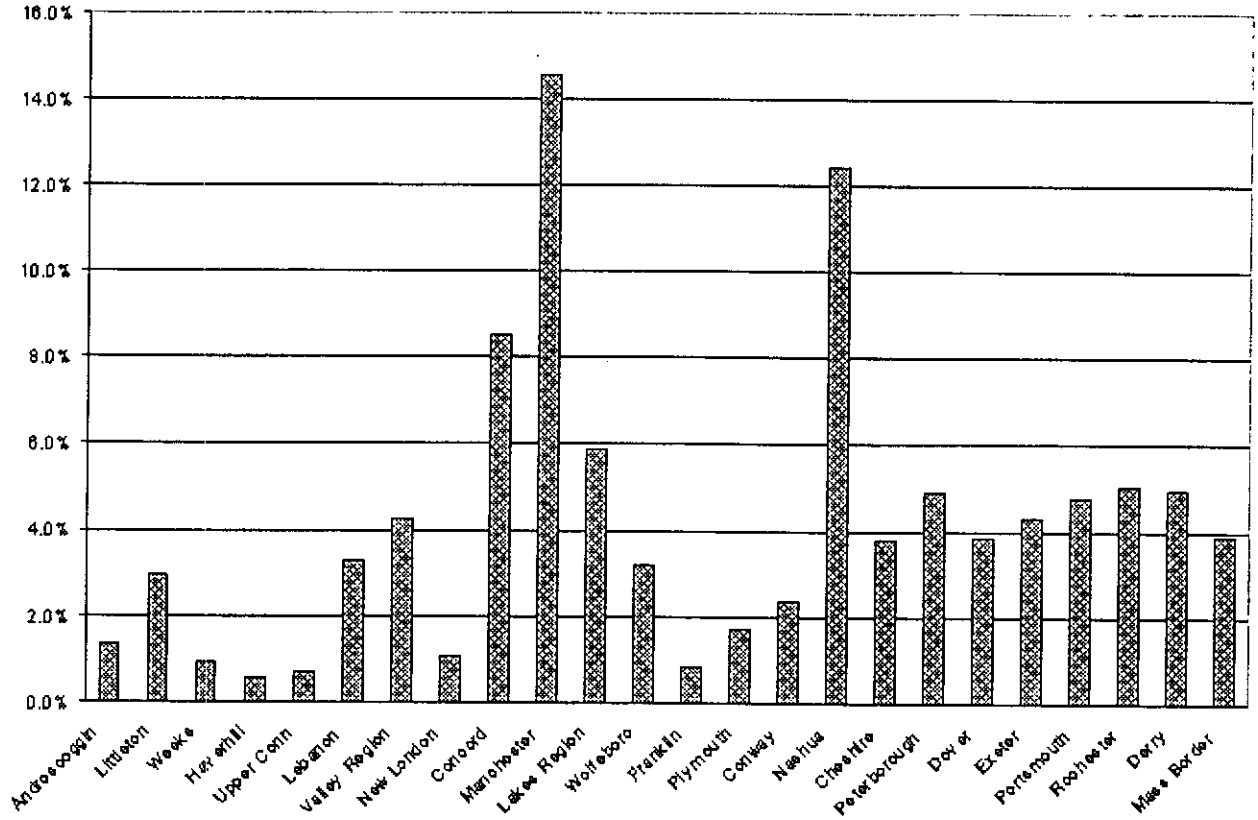


the uninsured account for a disproportionate share of the population in the North Country and Central Eastern New Hampshire, the more urban areas of New Hampshire - South Central, Seacoast, and Southwestern - account for approximately 70 percent of the total number of currently uninsured individuals (Figure 4).

Figure 4
Distribution of the Curently Uninsured Population by Region, 1999



Moreover, slightly more than 34 percent of the uninsured live in three hospital service areas - those centered in the greater Concord, Manchester and Nashua areas (Figure 5). The more rural areas of the state - the North Country, Central Western and Central Eastern New Hampshire - account for approximately 30 percent of the currently uninsured (Figure 4). **Figure 5**
Distribution of Currently Uninsured Population by Hospital Srevice Area, 1999



It is not surprising that the number of uninsured individuals is greatest in the Southern part of the state, as this is where most of the population in New Hampshire resides. But an important question is raised by the fact that individuals in the more rural Northern parts of the state are uninsured at a higher rate than in the state generally. Why are individuals in the North Country and the Central Eastern part of the state more likely to be uninsured? Subsequent analyses will explore employers' offer of insurance, individuals' acceptance of insurance, and the various factors affecting these two behaviors, including the market conditions associated with the health insurance market, and benefit packages offered as well as the costs of coverage.

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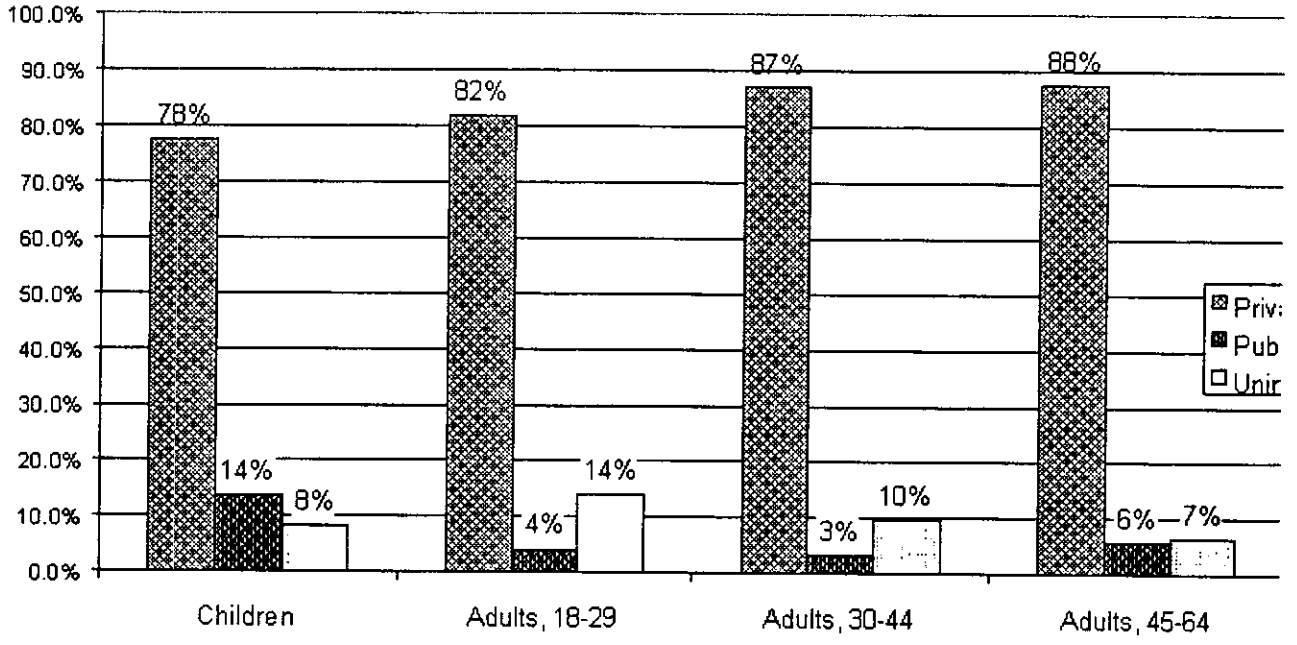
Does Insurance Coverage Vary for Children and Adults?

Last Revised: 11/16/99

Does Insurance Coverage Vary for Children and Adults?

Among those of different ages, young adults (those ages 18 through 29) have the highest uninsurance rates in New Hampshire (See Figure 6). Approximately 14 percent of 18 to 29-year-olds were currently uninsured compared to a state uninsurance rate of nine percent. Children and those ages 30-44 experienced uninsurance rates roughly comparable to the state average. Individuals between the ages of 45 and 64 were the least likely to be uninsured in New Hampshire.

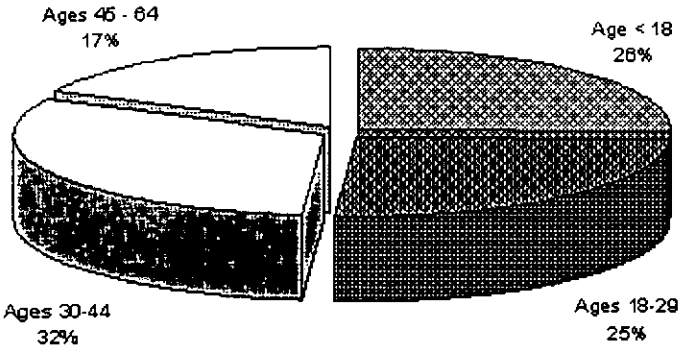
Figure 6
Health Insurance Coverage by Age, 1999



These trends in uninsurance rates by age are consistent with national trends. Nationally, younger adults are significantly more likely to be uninsured. This may reflect the transitional life circumstances of young adults. For example, young adults no longer have access to public coverage, often are no longer eligible under their parents' plans, and may be working at jobs where health benefits are not offered (Cunningham, 1998). As individuals age, uninsurance decreases as both the types of jobs and employment longevity increase the likelihood that individuals will be covered through an employer.

While insurance rates vary by age, individuals of all ages are uninsured. Figure 7 represents the entire group of individuals currently uninsured in New Hampshire. An estimated 74 percent - or approximately 71,000 - of the uninsured are adults, with those ages 30-44 accounting for approximately 32 percent of the uninsured. Adults ages 18-29 - arguably the most vulnerable to uninsurance based on the uninsurance rate - account for 25 percent of uninsured individuals in the state. Children account for approximately 26 percent of the uninsured.

Figure 7
The Currently Uninsured by Age, 1999



These results suggest that uninsurance is an issue for individuals of all ages, but particularly for adults. Almost three out of four uninsured individuals in New Hampshire are 18 years of age or older. The state has taken significant steps toward covering children through the Healthy Kids programs. However, current initiatives focused on children will not have an impact on the individuals who are the most likely to be uninsured (those 18-29), nor on the individuals who account for the greatest share of the uninsured in New Hampshire (adults generally, and those ages 30-44 specifically).

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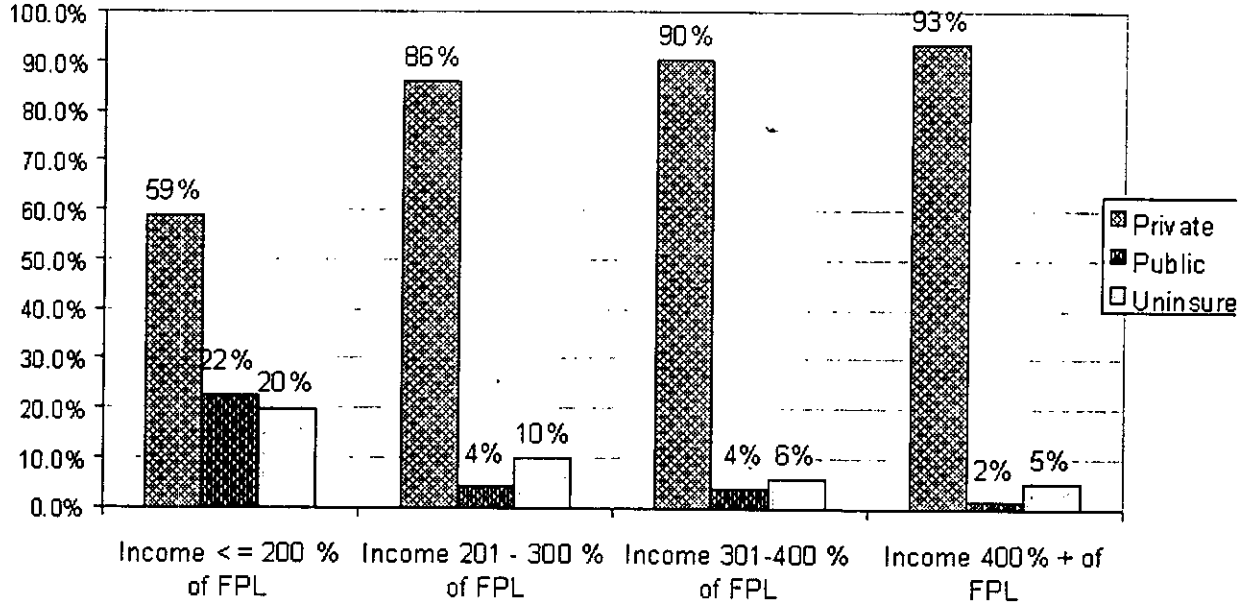
Does Insurance Coverage Vary by Income?

Last Revised: 11/16/99

Does Insurance Coverage Vary by Income? [4]

Lower income families are much more vulnerable to being uninsured than those with higher incomes in New Hampshire. Individuals living in families with incomes less than 200 percent of the federal poverty level ($27,760 for a family of three) are significantly less likely to have coverage through the private sector than any other group. While public programs have clearly offset more limited coverage offered through the private sector, individuals in families with incomes less than or equal to 200 percent of the federal poverty level are significantly more likely to be uninsured. Approximately 20 percent of these lower income individuals were uninsured (Figure 8).

Figure 8
Health Insurance by Family Income as a Percent of the Federal Poverty Level, 1999

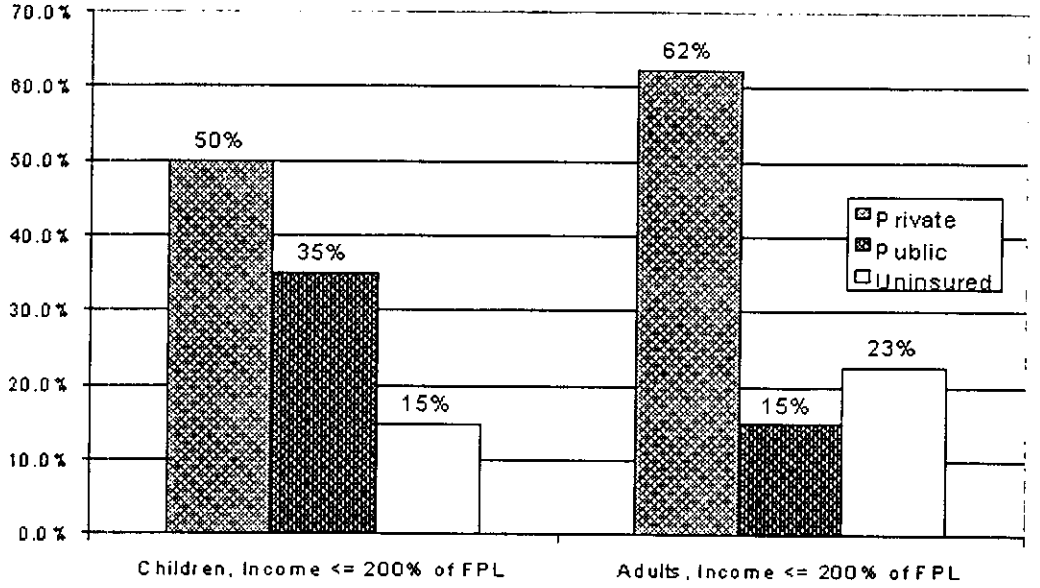


Among those individuals in families with incomes less than or equal to 200 percent of the federal poverty level, adults are the most likely to be uninsured. An estimated 23 percent of adults in families with incomes less than 200 percent of the federal poverty level were uninsured (Figure 9). Nationally, approximately 37 percent of adults with incomes less than or equal to 200 percent of the federal poverty level are uninsured. The difference between New Hampshire and the nation appears to be in part a function of the broad private coverage in New Hampshire. Approximately 62 percent of adults with incomes less than or equal to 200 percent of the federal poverty level are insured privately in New Hampshire compared to 44 percent in the nation (Zuckerman and Brennan, 1999).

Despite significant efforts on the part of the state to expand coverage to lower income children,

children living in families with incomes less than or equal to 200 percent of the federal poverty level remain uninsured. However, public programs designed to provide children with insurance coverage have clearly made inroads into reducing the number of uninsured children (Figure 9).

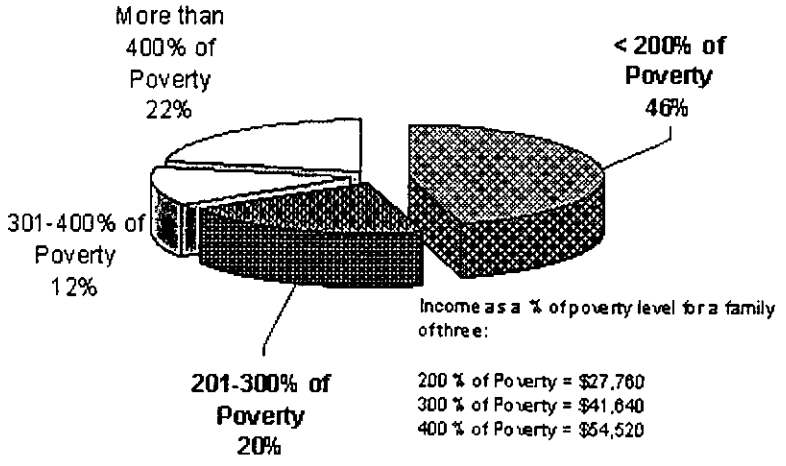
Figure 9
Health Insurance Coverage by Age for Those with Family Incomes Less Than or Equal to 200% of the Federal Poverty Level, 1999



An estimated 35 percent of children in families with incomes less than or equal to 200 percent of the poverty level are covered through public programs. However, approximately 15 percent of these children were uninsured. Nationally, approximately 21 percent of children living in families with incomes less than or equal to 200 percent of the federal poverty level are uninsured (Brennan, Holahan, Kenney, 1999). Similar to adults, the difference between New Hampshire and the nation appears to be in part a function of the broad private coverage in New Hampshire. Approximately 50 percent of children with incomes less than or equal to 200 percent of the federal poverty level are insured privately in New Hampshire compared to 40 percent in the nation (Zuckerman and Brennan, 1999).

While those with incomes less than or equal to 200 percent of the federal poverty level are more likely to be uninsured than higher income individuals, individuals of all incomes are uninsured in New Hampshire. Figure 10 provides the distribution of uninsured by family income as a percent of the federal poverty level. Individuals with incomes less than or equal to 200 percent of the federal poverty level account for 46 percent of the uninsured. An estimated 20 percent of the uninsured are individuals living in families with incomes between 201 and 300 percent of the federal poverty level (approximately $41,460 for a family of three in 1999). Together, those individuals living in families with incomes less than 300 percent of the federal poverty level account for 66 percent of the uninsured.

Figure 10
The Currently Uninsured by Family Income as a Percent of the Federal Poverty Level, 1999



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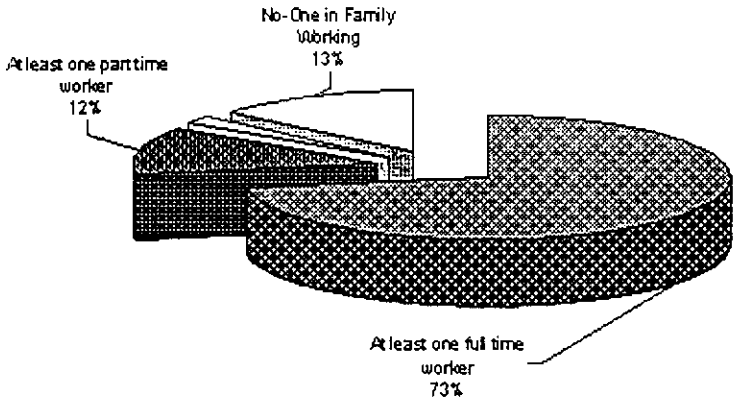
Are the Uninsured Working?

Last Revised: 11/16/99

Are the Uninsured Working?

To a large extent the uninsured are working. Almost 73 percent of all uninsured individuals have at least one family member who is working full- time (See Figure 11). In addition, approximately 12 percent of uninsured individuals live in families with at least one individual working part-time. Approximately 85 percent of the uninsured live in families with an individual working full or part-time.

Figure 11
The Currently Uninsured by Families Work Status, 1999



According to recent analyses of employer coverage, low-wage workers, regardless of whether they work in large or small firms are less likely to have employer coverage than those who are better paid (O'Brien and Feder, 1999). The first step in understanding the role of employer-based insurance is to understand the work status of the uninsured in New Hampshire which is addressed below.

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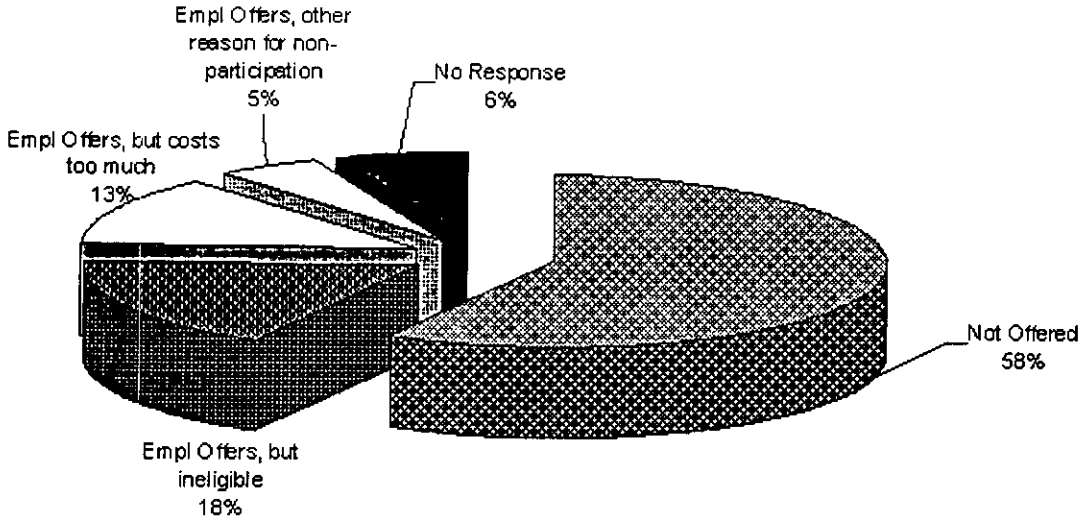
Do the Uninsured Have Access to Employer-Sponsored Insurance?

Last Revised: 11/16/99

Do the Uninsured Have Access to Employer-Sponsored Insurance?

Approximately 58 percent of working uninsured adults indicated that they were working in firms that did not offer insurance coverage (see Figure 12). However, almost 72 percent indicated that they were either not offered insurance coverage, or were ineligible for that coverage as a result of the length of their employment, the part-time nature of their work, or as a result of medical issues which restricted their access to employer-based insurance. Most uninsured individuals in New Hampshire reported little access to employer-based insurance.

Figure 12
Offer of, and Participation in, Employer Based Insurance for Currently Uninsured Working Adults, 1999



Given that such a large share of the uninsured are employed, it is important to determine why these individuals do not have access to, or do not participate in, employer-based insurance. According to a recent analysis of national survey data, almost 70 percent of the uninsured worked in firms that did not offer insurance coverage (Thorpe and Florence, 1999). And for those who were offered insurance, a significant share were ineligible to participate because of medical conditions or the specifics of their employment including length of employment or number of hours worked. For those uninsured who refused coverage when offered, the single most important factor was the cost of that coverage.

Subsequent analyses will assess the extent to which working uninsured individuals are more likely to work in firms or sectors of the economy that are less likely to offer coverage or are self-employed and have difficulty accessing coverage for other reasons. Important policy questions that will be answered in subsequent work include: Why are uninsured individuals ineligible for plans and what

implications does this have for current policies regarding insurance coverage? In addition, from a policy perspective it is important to understand the issue of the costs associated with participation in employer-based insurance.

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What Share of the Uninsured Population Represents Children Who Might be Eligible for Existing State Programs?

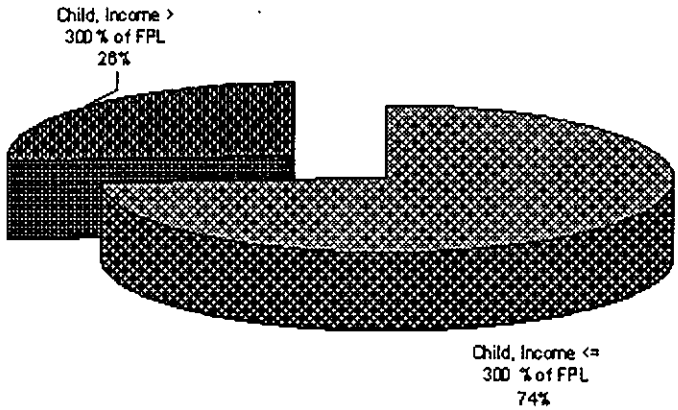
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What Share of the Uninsured Population Represents Children Who Might be Eligible for Existing State Programs?

In 1999, New Hampshire expanded public programs to include all children with incomes up to 300% of the federal poverty level through the state's Medicaid program - Healthy Kids Gold - and through the New Hampshire Healthy Kid's Corporation. Still, both nationally and within New Hampshire, there is growing concern that these expansions in coverage have not resulted in significant increases in enrollment. There are many reasons for this. Parents may be unaware of their children's eligibility, may not believe that insurance is necessary because they have access to basic medical services through safety net providers such as community clinics, or may not enroll their children because of the administrative difficulties associated with eligibility determination and enrollment.

Looking more closely at this eligible but not enrolled population, Figure 13 provides information on the percentage of uninsured children whose families have incomes less than or equal to 300 percent of the federal poverty level, a rough approximation of current state eligibility rules with regards to children.

Figure 13
Distribution of Uninsured Children by Family Income as a Percent of the Federal Poverty Level, 1999



Approximately 74 percent of uninsured children live in families with incomes that would qualify them for existing state programs. Assuming that approximately 26 percent of the uninsured are children, this suggests that there are approximately 18,500 children potentially eligible for publicly sponsored coverage who are not participating.

As work on the subject of uninsurance for children continues, it will be important to continue efforts

to streamline the eligibility determination process, encourage parents to enroll eligible children, and explore other options that encourage enrollment.

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How Many Adults with Incomes Less than 200 Percent of the Federal Poverty Level ($27,760 for a Family of Three) are Uninsured?

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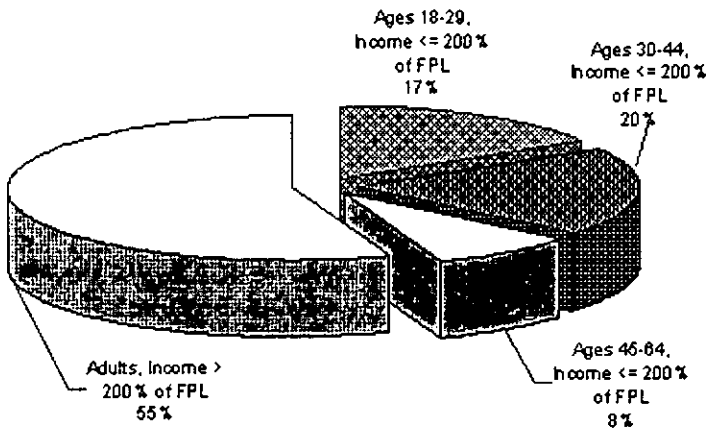
How Many Adults with Incomes Less than 200 Percent of the Federal Poverty Level ($27,760 for a Family of Three) are Uninsured?

In response to changes in the employer- based insurance market, some states have developed strategies to cover lower-income adults. A few states, including Oregon and Tennessee, have expanded their Medicaid programs to offer full coverage to uninsured individuals or families up to certain percentages of the federal poverty level. In Massachusetts, adults with incomes up to 200 percent of the federal poverty level are eligible for subsidies for employer-based coverage if they work for a small employer. Washington State provides subsidized coverage to all individuals with incomes less than 200% of the federal poverty level through its Basic Health Plan.

New Hampshire SB 183 provided the Department of Health and Human Services, the legislature, health care providers, business leadership, and managed care organizations, with the mandate to begin investigating uninsurance for lower-income adults in New Hampshire. To understand what populations would be eligible, this report looks at the distribution of uninsured adults by income. Following those states that have expanded coverage to adults, the report looks at those adults with incomes less than or equal to 200 percent of the federal poverty level and others.

Approximately 45 percent of uninsured adults live in families with incomes less than or equal to 200 percent of the federal poverty level (Figure 14). Given that an estimated 74 percent of the uninsured are adults, this suggests that approximately 32,000 uninsured adults live in families with incomes less than 200 percent of the federal poverty level. Moreover, a program targeted at these uninsured adults would reduce the number of uninsured by approximately one third.

Figure 14
Distribution of Uninsured Adults by Family Income as a Percent of the Federal Poverty Level



These results provide an indication of the magnitude of the population of adults who would be potentially eligible for a program similar to those developed in other states across the country. Further work will explore the characteristics of these adults, their access to services, and the implications of uninsurance both to the individuals themselves as well as to their families and the communities where they live.

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Policy Implications and Future Work

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Policy Implications and Future Work

In all subsequent work, it will be important to understand how to ensure that the major role played by the private sector in health insurance coverage in New Hampshire is maintained. First, it will be important to monitor trends in employment based insurance, as national studies suggest that the employer-based system of coverage is eroding, particularly for lower income individuals. Moreover, given that some children and adults with incomes less than or equal to 200 percent of the federal poverty level are ensured privately, it is important to explore the potential for building on the broad private coverage in New Hampshire for this population.

The results of this report provide additional support for ongoing state initiatives including efforts to enroll children who are eligible for existing state programs. Approximately 26 percent of the total pool of uninsured individuals are children, of whom an estimated 74 percent are children living in families with incomes less than the current eligibility criteria for existing state sponsored health insurance coverage programs. Thus, these estimates suggest that there are potentially 18,500 children who would benefit from continued outreach efforts. If all children who were eligible for existing state programs enrolled, the number of uninsured would be reduced by almost 20 percent.

Future work will explore this eligible but not enrolled population. More in-depth simulation of state and public-private sponsored programs for those with lower incomes will provide communities and policymakers with more precise information on the characteristics of the eligible but not enrolled population and potential explanations for why these individuals are not enrolled.

These results also support the initial efforts undertaken by the subcommittee of the Healthy Kids Corporation mandated by SB 183 to provide recommendations regarding uninsured adults. These results suggest that the greatest share of the uninsured are adults. Moreover, 45 percent of uninsured adults are living in families with incomes less than 200 percent of the federal poverty level - an estimated 32,000 individuals. If these 32,000 individuals were able to access employer- sponsored coverage, the number of uninsured could be reduced by as much as 33 percent. Further work developed through the subcommittee will explore this population of individuals more carefully, with an eye towards understanding access to medical services, as well as access to insurance coverage through private market mechanisms.

Consistent with national results, most uninsured individuals in New Hampshire live in working families but indicate that they do not have access to employer- based insurance coverage. The majority of those who do not have health insurance are living in families with at least one full-time worker. Approximately three out of four of the working uninsured are either not offered coverage through their employer or believe they are ineligible for coverage offered by an employer.

Given that such a large share of the uninsured are living in families with at least one person who is working full-time, it will be very important to develop more information on why these working individuals do not have access to, or do not participate in, employer-based insurance. Future work will focus on employer-based insurance in New Hampshire. One component of this work will focus on the offer of insurance in different industries and firms in New Hampshire where the uninsured are most likely to work.

An important next step in this work will be to assess individuals' access to care in New Hampshire, as this provides another important measure of vulnerability. This work will assess access to a medical home and the utilization of medical services, as well as the role of community clinics, hospitals and other safety net providers in providing free or subsidized care to the uninsured in New Hampshire. To meet the needs of the subcommittee mandated by New Hampshire SB 183, attention will initially be focused on low income working adults.

Future analyses will assess other issues of policy interest with New Hampshire specific information. For example, while this report focuses on insurance coverage at the time of the survey, further work will also assess those individuals who have been uninsured in the previous year, as well as the length of time individuals are uninsured. Other planned evaluations include more focused assessments of insurance coverage, and the need and access for specific groups in New Hampshire including children, women, and working adults.

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What were the Basic Methods Used in Conducting the Survey?

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What were the Basic Methods Used in Conducting the Survey?

The NH-HICAS was a random survey of the non-elderly population of New Hampshire residents conducted by the survey research firm Macro International, Inc. Interviews were conducted in English, and one adult who was most knowledgeable about insurance in the family, was asked the survey questions for him or herself as well as for other family members. Between June 16, 1999 and September 1, 1999, approximately 11,781 family-level interviews were conducted, representing approximately 28,263 persons. A random sample of families in each hospital's market area - called a Hospital Service Area (HSA) - was interviewed.[5]

The overall response rate for the survey, 76 percent, was excellent.[6] In addition, a significant share of those who initially refused to participate later agreed to be surveyed. The refusal conversion rate was 22 percent, or approximately twice Macro International's average rate. This is a good indication that Macro International Inc. was able to convey the importance of this survey to New Hampshire residents in phone calls made subsequent to initial refusals.

A variety of methods were used to ensure the reliability of the data. Macro International followed best-practice protocols that ensured appropriate interviewing and quality data collection. Moreover, Macro International developed weights to adjust for various factors that could, if left unadjusted, introduce bias into the estimates. Various adjustments were made to address the design of the survey (which sub-sampled hospital service areas), non-response (where individuals in certain groups were more or less willing or able to participate in the study), and under-coverage (including an adjustment for those without telephones).[7] Technical assistance was provided by the Robert Wood Johnson Foundation through the Alpha Center for review of important decisions regarding these methods.

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Precision of the Numbers in This Report:

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Precision of the Numbers in This Report

Because not every resident is surveyed, the numbers produced using survey data are estimates of the true values. Thus a survey cannot tell you what the exact insurance rate (or any other measure of interest) is. The standard error, which is based on the characteristics of the survey and how willing different individuals are to respond to the survey, as well as various other factors, can be used to estimate a range in which the true uninsurance rate (or other characteristics of interest) falls. In order to develop a range within which you are 95 percent confident the true estimate lies, you multiply the standard error times 1.96. The product is then added to the estimate to compute the high end of the range or subtracted from the estimate to develop the low end of the range.

The wider this range is, the more care needs to be taken in using the information to understand differences in certain measurable characteristics between different areas and different groups in the state. While much of the narrative in this report refers to graphs, tables which include both the estimates used in the graphs as well as the standard errors used in assessing differences in the state, are included for review. In this report, where comparisons are made across different groups of New Hampshire residents, 95 percent confidence intervals (margins within which we are 95 percent certain that the true rate of interest will fall) are used.

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Endnotes

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Endnotes

[1] The numbers used to produce this graph are in the appendix labeled A-1. Numbers for Figure 2 will be labeled A-2; Figure 3 A-3 and so forth. Percents may not total to 100% due to rounding. Percents in graphs may be slightly different from those in tables due to rounding.

[2] Consistent with other states' experience conducting their own surveys, the estimate of the uninsurance rate from the NH-HICAS is both lower, and more precise, than those produced using data from the Census Bureau's Current Population Survey Data. Though there are a number of potential explanations for why the estimate from the NH-HICAS is lower than that based on the CPS, it is likely driven by differences in the questions about health insurance that were asked.

[3] The number of individuals who are uninsured is computed by multiplying the estimate of current uninsurance in New Hampshire times population figures provided by the New Hampshire Office of State Planning. Numbers provided in the remainder of this document (but not percentages) are based on this computation. Please note that there are margins of error associated with each percentage used to develop estimates of numbers of individuals. See the discussion of margins of error in the methods section.

[4] Because $10 goes a lot farther when there's only one person in a family than for a family of three, individuals are classified based on family income relative to poverty guidelines that account for family size. Table A in the appendix provides the federal poverty guidelines for individuals living in a family with three people. These figures were used to group individuals into categories noting individuals living in families with incomes less than or equal to 200, 201-300, 301-400 and 400 plus percent of the federal poverty level.

[5] Hospital service areas are based on inpatient utilization data. Each hospital in the state has a non-overlapping market area that includes all towns in which a given hospital has the most admissions of any hospital in New Hampshire. Please contact the Department of Health and Human Services for a listing of each town in a hospital service area.

[6] For more information on response rates, please contact the Department of Health and Human Services. The response rate provided represents the number of families who responded to the survey as a percent of all those families who were eligible to be interviewed.

[7] Weights were developed which adjusted for age, sex, and race and ethnicity and the under-coverage associated with the fact that the survey was a telephone survey and missed households

Supporting Tables Appendix

Last Revised: 11/16/99

Supporting Tables Appendix

Table A

Poverty Level Guidelines *

(Income Guidelines as Published in the Federal Register on March 18, 1999)

	Annual Guidelines			
Family Size	200%	300%	400%	500%
3	$27,760.00	$34,700.00	$41,640.00	$55,520.00

Table A-1 and Table A-3

Distribution of Health Insurance Coverage in New Hampshire
New Hampshire Health Insurance Coverage and Access Survey, 1999*

	Private Insurance		Public Insurance		Other Insurance		Uninsured	
	% of Tot	Std Err	% of Tot	Std Err	% of Tot	Std Err	% of Tot	Std Err
Statewide	83.7%	0.63%	7.0%	0.45%	0.0%	0.01%	9.3%	0.43%
North Country	**76.3%**	1.19%	**9.6%**	0.70%	0.1%	0.04%	**14.0%**	0.82%
Central Western	81.6%	1.83%	6.6%	0.73%	0.0%	0.03%	11.8%	1.68%
Central	84.9%	1.12%	6.1%	0.67%	0.0%	0.02%	9.1%	0.87%
Central Eastern	**75.8%**	2.10%	**12.2%**	2.04%	0.1%	0.11%	**12.6%**	0.87%
Southwest	85.8%	1.66%	6.4%	1.25%	0.0%	0.01%	8.5%	1.09%
Seacoast	86.0%	1.04%	6.2%	0.68%	0.0%	0.00%	7.8%	0.75%

Table A-4

The Distribution of the Currently Uninsured by Hospital Service Area
New Hampshire Health Insurance Coverage and Access Survey, 1999*

	For the Currently Uninsured	
	Estimate	Std Err
North Country	6.5%	0.5%
Central Western	8.6%	1.3%
Central Eastern	13.9%	1.0%
South Central	23.1%	2.0%
Southwest	21.1%	2.3%
Seacoast	26.8%	2.2%

Table A-5

The Distribution of the Currently Uninsured by Hospital Service Area
New Hampshire Health Insurance Coverage and Access Survey, 1999*

Hospital Service Area	For the Currently Uninsured	
	Estimate	Std Err
Lebanon	3.3%	0.47%
Concord	8.6%	1.26%
Manchester	14.6%	1.68%
Nashua	12.4%	2.21%
Lakes Region	5.9%	0.78%
Dover	3.9%	0.69%
Cheshire	3.8%	0.78%
Exeter	4.3%	1.01%
Portsmouth	4.8%	1.68%
Rochester	5.0%	0.67%
Valley Regional	4.3%	1.19%
Androscoggin	1.4%	0.22%
Peterborough	4.9%	0.88%
Littleton	3.0%	0.26%
Wolfeboro	3.2%	0.33%
Derry	5.0%	0.95%
Weeks	0.9%	0.15%
Franklin	0.8%	0.11%
Plymouth	1.7%	0.20%
New London	1.1%	0.17%
Conway	2.3%	0.25%
Haverhill	0.6%	0.06%
Upper Connecticut	0.7%	0.08%
Mass Border	3.8%	0.78%

Table A-6

Health Insurance Coverage by Age*

	Private Insurance		Public Insurance		Other Insurance		Uninsured	
	% of Tot	Std Err	% of Tot	Std Err	% of Tot	Std Err	% of Tot	Std Err
Children	**77.6%**	1.2%	**13.7%**	1.1%	0.0%	0.0%	8.4%	0.7%
Adults, 18-29	81.9%	1.4%	**4.1%**	0.6%	0.0%	0.0%	**13.9%**	1.2%
Adults, 30-44	**87.0%**	0.9%	**3.1%**	0.5%	0.0%	0.0%	9.9%	0.5%
Adults, 45-64	**87.6%**	1.0%	5.9%	0.9%	0.0%	0.0%	**6.5%**	0.5%
Total	83.7%	0.6%	7.0%	0.5%	0.0%	0.0%	9.3%	0.4%

**** Numbers in bold indicate where values were tested and found to be statistically different from***

statewide estimates.

Table A-7

Distribution of Currently Uninsured by Age
For the Currently Uninsured

	Percent of Total	Std Err
Age < 18	25.66%	1.60%
Ages 18-29	25.45%	1.83%
Ages 30-44	31.44%	1.96%
Ages 45 - 64	17.45%	1.42%

Table A-8

Health Insurance Coverage by Income*

	Private Insurance		Public Insurance		Other Insurance		Uninsured	
	% of Tot	Std Err	% of Tot	Std Err	% of Tot	Std Err	% of Tot	Std Err
Income < = 200 % of FPL	**58.8%**	1.8%	**22.4%**	1.6%	0.0%	0.0%	**19.8%**	1.2%
Income 201 - 300 % of FPL	85.9%	1.1%	4.3%	0.6%	0.1%	0.1%	9.9%	0.9%
Income 301-400 % of FPL	90.2%	1.2%	3.9%	0.7%	0.0%	0.0%	5.9%	1.0%
Income 400% + of FPL	93.4%	0.6%	1.6%	0.2%	0.0%	0.0%	5.0%	0.5%

** Numbers in bold indicate where values were tested and found to be statistically different from statewide estimates.*

Table A-9

Health Insurance Coverage by Adult Status and Income*

	Private Insurance		Public Insurance		Other Insurance		Uninsured	
	% of Tot	Std Err	% of Tot	Std Err	% of Tot	Std Err	% of Tot	Std Err
Children, Income <= 200% of FPL	**49.9%**	2.7%	**35.0%**	2.8%	0.2%	0.2%	**15.0%**	1.8%
Adults, Income <= 200% of FPL	**62.3%**	0.2%	**15.1%**	1.9%	0.0%	0.0%	**22.6%**	1.4%
Children, Income > 200%	88.5%	0.9%	5.6%	0.6%	0.0%	0.0%	5.8%	0.6%
Adults, Income > 200%	91.5%	0.5%	1.8%	0.2%	0.0%	0.0%	6.6%	0.5%

**** Numbers in bold indicate where values were tested and found to be statistically different from statewide estimates.***

Table A-10

The Distribution of the Currently Uninsured by Family Income

Uninsured by Income	For the Currently Uninsured	
	Percent of Total	Std Err
< 200% of Poverty	45.6%	2.4%
201-300% of Poverty	20.5%	1.7%
301-400% of Poverty	12.0%	1.9%
More than 400% of Poverty	21.9%	2.0%

Table A-11

Family Work Status of the Currently Uninsured

For the Currently Uninsured	Estimate	Std Err
At least one full time worker	72.3%	2.34%
At least one part time worker	12.1%	1.68%
Worker : Unknown Hours	2.0%	0.53%
No one in Family Working	13.2%	0.37%
No Response	0.4%	0.32%

Table A-12

Employer Offer of Insurance for the Working Uninsured

	For Currently Uninsured Working Adults	
	Estimate	Std Err
Not Offered	57.9%	2.46%
Employer offers but ineligible	17.7%	2.02%
Employer offers, but costs too much	13.0%	1.55%
Employer offers, other reason for non-participation	4.9%	1.11%
No Response	4.9%	1.17%

Table A-13

Distribution of Uninsured Children by Income

	For Uninsured Children	
	Estimate	Std Err
Family Income < = 300 % of the Federal Poverty Level	74.3%	3.08%
Family Income > 300 % of the Federal Poverty Level	25.8%	3.08%

Table A-14

Distribution of Uninsured Adults by Income

	For Uninsured Adults	
	Estimate	Std Err
Family Income < = 300 % of the Federal Poverty Level	44.3%	2.42%
Family Income > 300 % of the Federal Poverty Level	55.7%	2.42%

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New Hampshire Adult Coverage Subcommittee

Report to the Governor,
Speaker of the House, and
Senate President

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Report on the Adult Uninsured Issue in New Hampshire

The 1999 New Hampshire Legislature created a committee of the Healthy Kids Board to study the adult uninsured issue and to make recommendations to the Governor, Speaker of the House, and Senate President. This committee, chaired by Representative John Hunt, met during 1999 and 2000. Among their activities, the committee researched characteristics of the uninsured, explored possible models for coverage expansions, projected costs of those expansions, and identified potential sources of funding.

The Committee gained new knowledge about the rate of uninsurance across the state and characteristics of New Hampshire's uninsured. Data collected through the 1999 New Hampshire Health Insurance Coverage and Access Survey (NH-HICAS) provided detailed information on the uninsured in the state, including access to employer-based insurance and variation across geographic areas and demographic groups.

The survey showed that approximately 91% of the residents of New Hampshire have health insurance coverage, 84% from employer-based or private coverage and 7% from publicly sponsored programs, such as Medicaid and Healthy Kids. The data indicate there are approximately 96,000 uninsured, which consists of 70,000 adults and 26,000 children. At the time of the survey, it is estimated that 65% of the uninsured children were eligible but not enrolled in Healthy Kids. Since the survey was conducted, 7,000 more children have been enrolled in Healthy Kids. Given this success, the uninsured problem becomes primarily an issue of uninsured adults. However, recommendations are included in this report to maximize enrollment in Healthy Kids and extend coverage to underinsured children through enhancements to the State Children's Health Insurance Program (Title XXI).

Based on this information and to focus its work, the committee developed a Statement of Need:

> ***"While most New Hampshire residents are able to take advantage of the state's strong employment based insurance coverage system, there are a significant number of low income adults in New Hampshire who cannot access or have difficulty accessing insurance coverage through an employer. As un-insurance and under-insurance have an impact on the use of timely and appropriate services and thus on the costs of the health care system as well as worker productivity, lower-income individuals need affordable health care coverage that emphasizes preventive services and care coordination. State policy should promote the development of creative solutions to address this significant need."***

The most significant factor affecting insurance status is the financial ability of individuals to purchase health insurance. Recognizing this, the committee searched for quantifiable data to determine at what income level a family or individual has the resources to pay for health coverage. The committee reviewed research published in a report, "New Hampshire Basic Needs and Livable Wage," by the Josiah Bartlett Center for Public Policy. The report reveals the level of wages necessary for families in New Hampshire to meet basic needs. Basic needs are identified as food, rent and utilities, basic telephone service, clothing and household expenses, transportation, childcare, health care, and a small allowance for personal expenses. The resulting "livable wage" varies based on family characteristics such as size and the need for outside childcare.

The committee further developed this data by excluding savings and expenditures for health coverage to calculate the minimum income needed before an individual or family can begin to pay for health coverage. The data show that New Hampshire families need to earn wages at about 200% FPL or higher to meet their basic needs. It is particularly troubling to note that at these income levels, the full cost of comprehensive health insurance in the non-group market would require as much as 37% to 57% of total family income. Based upon this information, the committee concluded that families with incomes less than 300% of the FPL would not be able to purchase adequate health insurance without assistance. (See Appendix C for current federal poverty income levels.)

In evaluating current programs and possible models for expansion, the committee established a set of values and guiding principles that should be considered in the design of any program to expand coverage:

- Extend coverage to low income uninsured;
- Foster independence and self-reliance (especially for those transitioning off the TANF program);
- Encourage cost consciousness;
- Respect confidentially and personal dignity;
- Respond to real life issues of maintaining a household budget on a modest income;
- Build on the current public and/or private system;
- Be administratively simple;
- Emphasize the relationship between children's health insurance and adult's health insurance coverage by requiring any eligible parent to insure their child first;
- Where possible, ensure that lower income parents and their children can be insured through similar funds;
- Leverage resources (federal, private and community based) and maximize federal funding;
- Provide for portable coverage;
- Focus on preventive and primary care services and care coordination.

The committee also researched and discussed a number of health care issues that confront the state of New Hampshire and the rest of the country.

- The members are acutely aware of the difficulties that many individuals have with purchasing prescription drugs.
- It was recognized that the state is probably at the peak of the insured cycle with predicted increases in health care costs likely to result in a rise in the number of uninsured. It is also anticipated that individuals will pay more out-of-pocket in the form of deductibles, co-insurance and co-pays.
- The committee is aware of the need to keep safety-net providers financially viable as they provide uncompensated or reduced-fee care to the uninsured.
- It was also clear that federal programs are not available to assist in providing coverage to many of uninsured.

The group realized that they could not realistically address all of these issues. Therefore, attention was focused on researching the methods of expanding health coverage that are available to states under current law and regulations.

The committee's research pointed to three primary models of expansion, which meet many of the guiding principles detailed previously. The three models expand coverage to:

1) Parents of children eligible for Medicaid/Healthy Kids Gold with income up to 185% of the Federal Poverty Level (FPL – see Appendix E). This model uses Medicaid and Title XXI as a funding source.
2) Parents of children eligible for S-CHIP/Healthy Kids Silver with income between 186% and 300% FPL. This model uses Title XXI as a funding source.
3) Adults without children eligible for either Medicaid or Title XXI with income first up to 100% FPL, with further expansion to 185% FPL. No federal funding exists for this group.

The first two models are designed to maximize federal reimbursement available under current federal regulations. For New Hampshire, Medicaid federal funding (Title XIX) matches state funds on a 50:50 basis. The State Children's Health Insurance Program (Title XXI) provides an enhanced federal match of 65%. Both programs allow states to cover the parents of eligible children, provided certain requirements have been met. Coverage of parents up to 100% FPL under the Medicaid program is a prerequisite to covering parents with higher income levels under Title XXI. For parents above 100% and up to 300% FPL, Title XXI funding would be available with the enhanced federal match of 65%.

There are currently no federal programs that fund health insurance for adults without children. Therefore, any option to cover adults without children is strictly a state model, and would require 100% state and/or community funding.

The committee believes it would be inappropriate to provide coverage to adults with children at higher income levels for which federal funds are available (parents), without providing coverage for adults without children at lower income levels for which no federal funds are available. Therefore, an expansion for adults without children at low incomes should precede the implementation of a program to cover parents at higher incomes even though a federal funding source is available.

The committee also recommends that, to the greatest extent possible, any expansions should be consistent with current programs in regard to eligibility levels, benefits and cost-sharing. Doing so will streamline program administration and outreach and simplify access for NH citizens seeking assistance.

The following tables provide a summary of the three models including projections of the number of participants and costs, broken down by state and federal sources. The models assume benefits commensurate with the comprehensive package currently provided by Medicaid. The cost projections recognize an 18-to-36 month phase-in of enrollment, depending upon the group, before the anticipated caseload is reach.

In the two models that tap federal resources, the potential impact of crowd-out has been anticipated. Since a program to provide coverage to adults without children would not qualify for federal funding, the state would have greater flexibility in implementing eligibility criteria to prevent crowd-out. Because of this, crowd-out eligibles have not been included in the participation projections for this group.

Crowd-out (as it is broadly defined) occurs when an individual drops private insurance to enroll in a public program or when an employer drops coverage as a result of the availability of public coverage and the employee subsequently seeks the public coverage. Crowd-out is often viewed as a negative occurrence. The committee challenges the notion that all occurrences of crowd-out are to be avoided. Doing so overlooks circumstances where individuals must choose between basic living needs and health care, or where access to preventive and primary care remains an issue because the purchased insurance provides "catastrophic-only" coverage.

Data used to estimate crowd-out are based on national information provided by the Urban Institute. Given a more thoughtful definition of crowd-out as suggested above, it is the consensus of the committee that the crowd-out numbers may be overstated. The committee believes it is essential to develop New Hampshire data to better evaluate the impact of unwanted crowd-out, particularly as its relates to the loss of private comprehensive insurance that covers preventive and primary care and the termination of coverage by employers forcing employees to enroll in public programs. Additional research on this issue will be conducted under a grant from the Health Resources and Services Administration (HRSA is a federal agency) that is detailed later in this report.

The following tables project costs for each model based upon the current average cost of providing health care in the tri-state area of Maine, New Hampshire and Massachusetts. This data is compiled from the Medical Expenditure Panel Surveys (MEPS) conducted by the Agency for Healthcare Research and Quality (AHRQ). Increases in medical costs of 8% per year are included in the projections.

Table 1
Coverage of Adults with Children in Title XIX and Title XXI
Income Up to 100% of the Federal Poverty Level

	Number of Uninsured Participating	Crowd-Out Eligibles	Total Participation	Cost Per Person Per Year	Expenditures in Millions		Total
					State	Federal	
Year 1	* 506	254	760	$2,675	$1.015	$1.015	$2.03
Year 2	* 1,306	657	1,963	$2,889	$2.835	$2.835	$5.67
Year 3	* 1,437	723	2,160	$3,120	$3.370	$3.370	$6.74

* Assumes an 18-month phase-in of caseload, with a 3% annual growth rate thereafter

Table 1a
Coverage of Adults with Children in Title XIX and Title XXI
Income Between 101% to 185% of the Federal Poverty Level

	Number of Uninsured Participating	Crowd-Out Eligibles	Total Participation	Cost Per Person Per Year	Expenditures in Millions		Total
					State	Federal	
Year 1	* 1,231	621	1,852	$2,675	$1.73	$3.22	$4.95
Year 2	* 3,191	1,608	4,799	$2,889	$4.85	$9.01	$13.86
Year 3	* 3,511	1,769	5,280	$3,120	$5.76	$10.71	$16.47

*Assumes a 18-month phase-in of caseload, with a 3% annual growth rate thereafter

Table 2
Coverage of Adults with Children in Title XXI
from 186% to 300% of the Federal Poverty Level

	Number of Uninsured Participating	Crowd-Out Eligibles	Total Participation	Cost Per Person Per Year	Expenditures in Millions		Total
					State	Federal	
Year 1	* 223	44	267	$2,325	$.218	$.403	$.621
Year 2	* 633	125	758	$2,515	$.666	$1.240	$1.906
Year 3	* 1,044	205	1,250	$2,716	$1.189	$2.207	$3.396

*Assumes a 36-month phase-in of caseload, with a 3% annual growth rate thereafter

Table 3
Coverage of Adults without Children
Up to 100% of the Federal Poverty Level

	Number of Uninsured Participating	Cost Per Person Per Year	Expenditures in Millions		Total
			State/Local	Federal	
Year 1	* 1,612	$2,675	$4.31	0	$4.31
Year 2	* 4,174	$2,889	$12.06	0	$12.06
Year 3	*4,606	$3,120	$14.37	0	$14.37

* Assumes an 18-month phase-in of caseload, with a 3% annual growth rate thereafter

There are several aspects of these models that should be noted. The expansion of Medicaid to parents with income less than 100% FPL is provided for by Section 1931 of the Social Security Act. This allows for a state to expand coverage by amending the Medicaid State Plan. While this is relatively simple compared to a waiver, it does require policy, rule, and system changes that can be time consuming.

Coverage of parents from 101% to 185% of the FPL would be accomplished under the Title XXI program. This would require an 1115 demonstration waiver that must be approved by the Health Care Financing Administration (HCFA). The waiver must show how coverage of the entire family (parents) would increase enrollment of eligible children under Title XXI. The benefits must be equivalent to the benefits and cost sharing must be consistent with Title XXI rules. An 1115 waiver involves a negotiated process with HCFA and approval may take several months to secure. The advantage of the Title XXI program is that federal matching funds are available at 65%, compared to 50% under Medicaid.

Finally, state-only programs provide much greater flexibility to design eligibility requirements benefits and cost-sharing that are consistent with state law without regard to federal regulations. Therefore, the State would have greater control over the costs and the number of eligible participants. For purposes of modeling costs, it is assumed that no individual could enroll in this program unless they have been uninsured for six months. Again, there is no current federal funding available under for these individuals.

Recommendations

The committee realizes that an expansion of coverage will be incremental in approach, largely due to the financial resources needed. The committee reached consensus on these recommendations to expand coverage and lay the groundwork for future action.

1. **Expand coverage to parents with children eligible for Healthy Kids with incomes up to 185% FPL.** For parents with incomes up to 100% FPL this would be accomplished under Medicaid and the state would receive 50% matching funds. For parents with incomes from 101% to 185% FPL coverage would be provided under S-CHIP/Title XXI to take advantage of enhanced federal matching funds. This program could be phased in by expanding coverage first to families with incomes up to100% FPL and later to 185% FPL.

2. **Conduct further research and explore innovative options to provide coverage to low-income adults without children.** These activities should be included in the work plan of the State Planning Grant received by the New Hampshire Department of Health and Human Services from the Health Resources and Services Administration (HRSA). This comprehensive grant project is intended to further study the characteristics of the uninsured and develop detailed, operational options for expanding health coverage to the uninsured.

3. **Authorize the committee to continue its work on this issue.** This committee is well informed on the issue of uninsurance and can provide insight and community input to the Governor and Legislature as new information becomes available. The committee will report to the Governor and the Legislature annually on its progress, specifically recommending innovative expansion strategies and exploring ways to leverage additional funds to cover the uninsured. This authorization can be accomplished through an amendment to RSA 126H, the Healthy Kids Act.

4. **Authorize the Department of Health and Human Services, in collaboration with the Healthy Kids Corp., to seek funding and implement a demonstration project under a newly announced Robert Wood Johnson Foundation initiative to expand coverage to the uninsured.** The primary target of this project would be to implement new coverage options for adults that are identified in the HRSA planning grant. Our hope is to develop and implement a public-private partnership that builds on the success and experience of the Healthy Kids model and community-based programs, such as Lakes Region General Hospital's HealthLink program and Seacoast HealthNet, as well as successful public-private partnerships in other parts of the country.

5. **Advocate for federal action to further support efforts to expand coverage.** The committee urges the State Legislature, the Governor's office, the Department of Health and Human Services and all interested stakeholders to work with New Hampshire's Congressional delegation and other federal officials to further the issue of the uninsured and seek additional measures from the federal level to assist the state. Specific action includes requesting that, under Title XXI, states be allowed to:
    - extend coverage to young adults (age 18 to 24)
    - provide preventive and primary care services to underinsured children
    - increase outreach by raising the 10% cap on administrative expenses to 25%
    - make grants to reimburse Community Health Centers (CHC's) for services to people who do not have health insurance coverage.

Appendix A

Creation of Adult Coverage Committee – excerpted from Chapter 324

Appendix B

Insurance Coverage in New Hampshire

The 1999 New Hampshire Health Insurance Coverage and Access Survey (NH-HICAS) documents the most recent and reliable information on health insurance in New Hampshire. Of Approximately 91% of New Hampshire residents have health insurance coverage. Eighty-four percent (84%) have insurance coverage through their employer or through direct purchase of insurance coverage. Seven (7%) are covered by publicly sponsored programs, including Medicaid and Healthy Kids. This leaves about 96,000 individuals uninsured, of whom 74% are adults. New Hampshire's overall uninsured rate of 9% for both adults and children, compares favorably to the national average of 17% for adults and 12% for children.

New Hampshire has a higher percentage of individuals that are privately insured, relative to the national average. In New Hampshire 86% of adults and 78% of children are privately insured compared to the national averages of 75% and 69%, respectively. It then follows that New Hampshire would have a lower percentage of individuals covered by public programs. Estimates are that public programs cover 20% of children and 8% of adults nationally, while the numbers for New Hampshire are 14% and 4%, respectively.

The state has taken significant steps toward covering children through the Healthy Kids program. Children in families with incomes up to 300% of the FPL are eligible for coverage under Medicaid/Healthy Kids Gold and S-CHIP/Healthy Kids Silver. There were approximately 26,000 children who were uninsured at the time of the study in 1999. Of those, it is estimated that 16,500 were eligible but not participating in these publicly sponsored programs. Since that time, nearly 7,000 children have been enrolled.

The Healthy Kids initiative does not address health care access for uninsured adults. While the data indicate that 85% of the uninsured live in a family with at least one family member working full or part-time, their income levels are relatively low. Approximately 45%, or 32,000 uninsured adults live in families with incomes less than 200% of the FPL.

There are regional variations in health insurance coverage in New Hampshire. Seventy percent (70%) of uninsured residents live in the southern, more urban areas of the state However, rural areas have a higher percentage of uninsured. In these rural areas of the state, including Colebrook, North Conway, Littleton, Haverhill, Wolfeboro, and Claremont, the uninsured rates range from 13% to as high as 21%.

Uninsured individuals in the state report a lack of access to insurance through their employment. Approximately 58% of working uninsured adults indicated they work in a firm that does not offer insurance coverage. However, the percentage without access jumps to 72% when employees are either not offered insurance coverage, or are ineligible for coverage as a result of length of employment, part-time status, or pre-existing medical conditions. Thus, most uninsured adults in New Hampshire do not have access to employer-based insurance. Those who have access but decline employer-based coverage cite cost as the single most important reason they are uninsured.

There are safety-net providers that provide care to the uninsured. However, this does not provide an adequate substitute to health insurance. Individuals without health insurance typically are unable to improve their health through preventive care. Studies show that the uninsured delay needed medical services and are less likely to receive follow-up care. The lack of coverage has implications for individuals, families, and communities. Individuals without health insurance are generally in poorer health. A serious illness or injury can mean financial disaster for their family. The community suffers from a loss of job productivity and the cost of uncompensated care.

As previously noted, New Hampshire has a relatively low rate of uninsured when compared to national averages. However, it is not realistic to believe that the 9% of residents who are uninsured will ultimately be covered by employer-based or non-group insurance without intervention by public programs. Unemployment is currently at record lows, with projections pointing to the many jobs being created in service industries, which traditionally do not provide access to health insurance for all employees.

With the uninsured rate at its lowest level ever, and considering the factors above, the logical conclusion is that the state is likely at or near the peak of insurance coverage. An economic downturn and expected increases in the cost of health insurance will increase the number of uninsured, perhaps significantly.

The full report on the uninsured in New Hampshire is available by contacting the Office of Planning and Research at the Department of Health & Human Services.

Appendix C

2000 Federal Poverty Level Guidelines
All States (Except Alaska and Hawaii) and DC

Income Guidelines as Published in the Federal Register on February 15, 2000
Effective Date: February 15, 2000
ANNUAL GUIDELINES

Family Size*	100% Poverty	150%	185%	200%	250%	300%
1	$8,350.00	$12,525.00	$15,447.50	$16,700.00	$20,875.00	$25,050.00
2	$11,250.00	$16,875.00	$20,812.50	$22,500.00	$28,125.00	$33,750.00
3	$14,150.00	$21,225.00	$26,177.50	$28,300.00	$35,375.00	$42,450.00
4	$17,050.00	$25,575.00	$31,542.50	$34,100.00	$42,625.00	$51,150.00
5	$19,950.00	$29,925.00	$36,907.50	$39,900.00	$49,875.00	$59,850.00
6	$22,850.00	$34,275.00	$42,272.50	$45,700.00	$57,125.00	$68,550.00
7	$25,750.00	$38,625.00	$47,637.50	$51,500.00	$64,375.00	$77,250.00
8	$28,650.00	$42,975.00	$53,002.50	$57,300.00	$71,625.00	$85,950.00

MONTHLY GUIDELINES

Family Size*	100% Poverty	150%	185%	200%	250%	300%
1	$695.83	$1,043.75	$1,287.29	$1,391.67	$1,739.58	$2,087.50
2	$937.50	$1,406.25	$1,734.38	$1,875.00	$2,343.75	$2,812.50
3	$1,179.17	$1,768.75	$2,181.46	$2,358.33	$2,947.92	$3,537.50
4	$1,420.83	$2,131.25	$2,628.54	$2,841.67	$3,552.08	$4,262.50
5	$1,662.50	$2,493.75	$3,075.63	$3,325.00	$4,156.25	$4,987.50
6	$1,904.17	$2,856.25	$3,522.71	$3,808.33	$4,760.42	$5,712.50
7	$2,145.83	$3,218.75	$3,969.79	$4,291.67	$5,364.58	$6,437.50
8	$2,387.50	$3,581.25	$4,416.88	$4,775.00	$5,968.75	$7,162.50

Appendix D

New Hampshire Basic Needs and a Livable Wage

The Josiah Bartlett Center for Public Policy published a study in June 2000 that identified the basic needs of the residents of New Hampshire and the income that is required to meet those needs. The study incorporated New Hampshire specific data and calculated how much each working adult in the family would have to earn to meet the basic needs of the family.

A livable wage is defined as income sufficient to meet a household's basic needs, including:

- Food, but not restaurant meals;
- Rent, and utilities such as heat, lights, and water, but not cable TV service;
- Basic telephone service;
- Clothing and household services;
- Transportation;
- Child care,
- Health care;
- A small allowance for personal expenses (3% of income);
- Savings (5% of income).

The costs of these basic needs were estimated for seven different household types:

- Single person;
- Single parent and one child;
- Single parent and two children;
- Two parents with one child and one parent working;
- Two parents with one child and both parents working;
- Two parents with two children and one parent working; and
- Two parents with two children and both parents working.

The committee was interested in the study to ascertain the income levels needed to provide for the essentials of living; such as food, rent, utilities, and clothing. By excluding expenses for health coverage and savings, the committee was able to determine what income is required to meet basic needs before there are dollars available to purchase health insurance. Such information is seen as useful in determining appropriate income eligibility levels and cost-sharing for uninsured adults. The results of the study as shown in the following table.

New Hampshire Basic Needs and a Livable Wage

Family Unit	NH Average Hourly Wage	Annual Livable Wage not including Healthcare and Savings	Percent of FPL	Percent of Income to Purchase Health Insurance
Two parents & two children (both parents working)	$11.42	$40,655.20	238%	36.9%
Two parents & two children (one parent working)	$16.74	$28,555.20	167%	52.6%
Two parents & one child (both parents working)	$9.77	$34,655.20	245%	43.3%
Two parents & one child (one parent working)	$15.45	$26,532.00	188%	56.6%
Single person & two children	$18.92	$34,505.60	244%	43.5%
Single person & one child	$15.72	$28,713.60	255%	NA
Single person	$9.01	$16,880.80	202%	43.0%

Living Wage represents the average annual salary below which individuals have to make choices about basic necessities as defined by the Josiah Bartlett Center.

Policies in Individual market are Indemnity with a $2,000 deductible, co-pay of 80/20, with a $5,000 limit on out-of-pocket expenditures.

These results essentially show that households require incomes that range from 167% to 255% FPL to meet basic needs. With the cost of a comprehensive health policy at 36.9% to 56.6% of their income, wages would need to be significantly higher (from a low of 253% to a high of 327%) to purchase health insurance without assistance. These findings confirm that low-income households do need financial assistance in purchasing health care insurance. Households with incomes below 185% of the FPL would require a great deal of financial assistance while those with incomes above that level would require less. This information provides clear and convincing support for the options being addressed by the committee. Households with incomes less than 300% of the poverty level are an appropriate target population.

Appendix D

Presentation to the New Hampshire Adult Coverage Subcommittee

October 16, 2000

Table 1
Coverage of Adults with Medicaid or S-CHIP
up to 185% of the Federal Poverty Level

	Number of Eligibles	Participation Rate	Number Participating	Crowd-Out Eligibles	Total Participation	Cost Per Person Per Year	Expenditures in Millions		
							State	Federal	Total
Year 1	10,480	45%	* 1,737	875	2,612	$2,675	$2.745	$4.235	$6.980
Year 2	10,480	45%	* 4,497	2,265	6,762	$2,889	$7.685	$11.845	$19.530
Year 2	10,794	45%	* 4,948	2,492	7,440	$3,120	$9.130	$14.080	$23.210

Service Delivery System: The Medicaid and Healthy Kids process, which currently determines eligibility, would be used to determine eligibility for parents, and the current provider network of Medicaid and S-CHIP would be used to deliver services.

Federal Requirements: Coverage to 100% of the FPL would be accomplished through a Medicaid expansion allowed for under Section 1931 of the Social Security Act. The state would be allowed to use "less restrictive methodologies" to compute a family's income or assets. This would provide coverage for adults with children in Medicaid to 100% of the FPL. To cover parents from 101% to 185% under S-CHIP, approval would be required by HCFA under an 1115 demonstration project. The demonstration must be designed to foster the coverage of children by enrolling the entire family (parents). Several requirements must be met in regard to eligibility. The state must address how expanded coverage will be improved or promoted through the demonstration. States must provide coverage for parents to 100% of the FPL under Medicaid before covering parents above the FPL under S-CHIP.

Benefits: For parents under the FPL, the Medicaid benefit package would be used. For parents from 101% to 185% FPL, a benefits package with equivalent value to the current Healthy Kids Silver package must be provided. Benefits will possibly differ, e.g. EPSDT not required, perhaps mammograms and prostrate screenings will be covered. Agreement with HCFA on the package would be part of the demonstration approval process.

Other: Medicaid provides federal matching funds at 50% of total expenditures and does not require a Medicaid waiver, can be accomplished through a state plan amendment. The program does become an entitlement for adults with children enrolled in Medicaid. Eligibility could be set at various income levels, such as 80% or 100% of the FPL, at the state's discretion. If the state wishes to cover parents under an S-CHIP waiver at higher incomes, parents must be covered first under Medicaid up to 100% of the FPL. S-CHIP provides for federal matching funds of 65%. Approval requires an 1115 Demonstration waiver, which must be approved by the Health Care Financing Administration. This would allow the state to use more of the federal allotment for S-CHIP. Cost sharing would be allowed, subject to Federal approval.

*Assumes 18- month phase-in of caseload.

Table 1a
Medicaid Coverage of Uninsured Adults
with Children Enrolled in or Eligible for Medicaid/Healthy Kids Gold
(0-100% of FPL)

	Average Participants	Cost Per Person Per Year	Expenditures in Millions		
			State	Federal	Total
Year 1	760	$2,675	$1.015	$1.015	$2.03
Year 2	1,963	$2,889	$2.835	$2.835	$5.67
Year 3	2,160	$3,120	$3.370	$3.370	$6.74

Detail of Caseload Growth

	July	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June	Average
Year 1	117	234	351	468	585	702	819	936	1,053	1,170	1,287	1,404	760
Year 2	1,521	1,638	1,755	1,872	1,989	2,097	2,102	2,107	2,112	2,117	2,122	2,127	1,963
Year 3	2,132	2,137	2,142	2,147	2,152	2,157	2,162	2,167	2,172	2,177	2,182	2,187	2,160
Assumes 18-month phase-in of caseload and 3% annual increase thereafter.													
Assumes 8% increase in costs per year.													

Table 1b
S-CHIP Coverage of Uninsured Adults with Children Enrolled in or Eligible for Medicaid/Healthy Kids Gold (101-185% of FPL)

	Average Participants	Cost Per Person Per Year	Expenditures in Millions		Total
			State	Federal	
Year 1	1,852	$2,675	$1.73	$3.22	$4.95
Year 2	4,799	$2,889	$4.85	$9.01	$13.86
Year 3	5,280	$3,120	$5.76	$10.71	$16.47

Detail of Caseload Growth

	July	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June	Average
Year 1	285	570	855	1,140	1,425	1,710	1,995	2,280	2,565	2,850	3,135	3,420	1,852
Year 2	3,705	3,990	4,275	4,560	4,845	5,130	5,142	5,154	5,166	5,178	5,190	5,202	4,799
Year 3	5,214	5,226	5,238	5,250	5,262	5,274	5,286	5,298	5,310	5,322	5,334	5,346	5,280

Assumes 18-month phase-in of caseload and 3% annual increase thereafter.

Assumes 8% increase in costs per year.

Table 2
Coverage of Adults with S-CHIP Children
from 185% to 300% of the Federal Poverty Level

	Number of Eligibles	Participation Rate	Number Participating	Crowd-Out Eligibles	Total Participation	Cost Per Person Per Year	Expenditures in Millions		
							State	Federal	Total
Year 1	4,335	28%	* 223	44	267	$2,325	$.218	$.403	$.621
Year 2	4,335	28%	* 633	125	758	$2,515	$.666	$1.240	$1.906
Year 3	4,465	28%	* 1,044	206	1,250	$2,716	$1.189	$2.207	$3.396

Service Delivery System: The Healthy Kids process, which currently determines eligibility, would be used to determine eligibility for parents, and the current provider network of S-CHIP would be used to deliver services.

Federal Requirements: Approval would be required by HCFA under an 1115 demonstration project. The demonstration must be designed to foster the coverage of children by enrolling the entire family (parents). Several requirements must be met in regard to eligibility. The state must address how expanded coverage will be improved or promoted through the demonstration. States must provide coverage for parents to 100% of the FPL under Medicaid before covering parents above the FPL under S-CHIP/Title XXI.

Benefits: An equivalent benefits package used under current S-CHIP/Title XXI must be provided to the parents. Benefits will possibly differ, e.g. EPSDT not required, but perhaps mammograms and prostrate screenings will be. Agreement with HCFA on the package would be part of the demonstration approval process. There is a $20 per member per month cost sharing requirement for individuals in the 186-250% of FPL group and $40 for those in the 251-300% group.

Other: This provides for federal matching funds of 65%. Approval requires an 1115 Demonstration waiver, which must be approved by the Health Care Financing Administration. This would allow the state to use more of the federal allotment for S-CHIP. Cost sharing would be allowed, subject to Federal approval.

*Assumes 36-months phase-in of caseload.

Table 2a
S-CHIP Coverage of Uninsured Adults with Children
Enrolled in S-CHIP or Eligible for S-CHIP
(186-250% of FPL)

	Average Participants	Cost Per Person Per Year	Expenditures in Millions		Total
			State	Federal	
Year 1	150	$2,435	$.128	$.237	$.365
Year 2	425	$2,630	$.390	$.727	$1.117
Year 3	701	$2,840	$.697	$1.294	$1.991

Detail of Caseload Growth

	July	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June	Average
Year 1	23	46	69	92	115	138	161	184	207	230	253	276	150
Year 2	299	322	345	368	391	414	437	460	483	506	529	552	425
Year 3	575	598	621	644	667	690	713	736	759	782	805	826	701
Assumes 36-month phase-in of caseload.													
Assumes 8% increase in costs per year.													

Table 2b
S-CHIP Coverage of Uninsured Adults with Children
Enrolled in S-CHIP or Eligible for S-CHIP
(251-300% of FPL)

	Average Participants	Cost Per Person Per Year	Expenditures in Millions		Total
			State	Federal	
Year 1	117	$2,195	$.090	$.166	$.256
Year 2	333	$2,370	$.276	$.513	$.789
Year 3	549	$2,560	$.492	$.913	$1.405

Detail of Caseload Growth

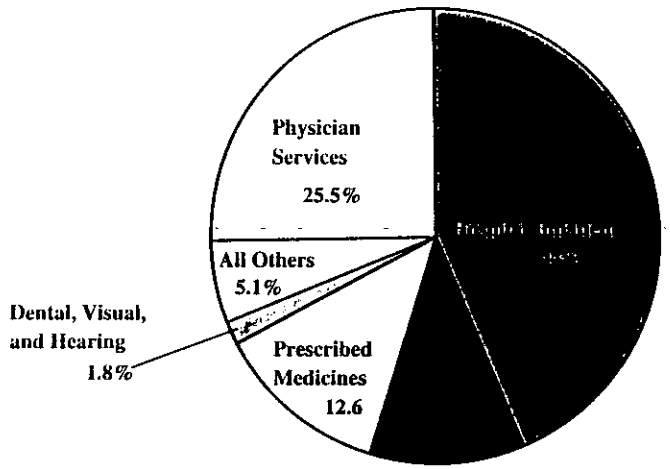
	July	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June	Average
Year 1	18	36	54	72	90	108	126	144	162	180	198	216	117
Year 2	234	252	270	288	306	324	342	360	378	396	414	432	333
Year 3	450	468	486	504	522	540	558	576	594	612	630	649	549
Assumes 36-month phase-in of caseload.													
Assumes 8% increase in costs per year.													

Covered Benefits for Adult Expansions

Major Benefits

- Physician Services
- Hospital Inpatient Services
  Limited to Medically Necessary Days
- Hospital outpatient Services
  Limited to 12 per year
- Prescribed Medicine
- Lab and X-Ray Services
  Limited to 15 X-Rays per year
- Family Planning Services and Supplies
- Home Health Care Visits
- Dental
  Limited to treatment of acute pain or infection
- Hearing Aid Services
- Vision Care (Eyeglasses)
  Limited to one refraction per year
- Durable Medical Equipment
  Prior Authorization Required

Estimated Costs by Category of Service



SMOKE-FREE NEW ENGLAND SURVEY

EXECUTIVE SUMMARY

New Hampshire Survey

The Smoke-Free New England Survey was conducted by the University of New Hampshire Survey Center for the American Cancer Society, New England Division. The major purposes of the survey were to assess the attitudes of New England voters about programs designed to reduce smoking by youth, attitudes toward limiting smoking in public, attitudes toward cigarette taxes, and how to spend tobacco settlement monies. Two-thousand, four-hundred eighty registered voters from Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont (approximately 410 from each state) were interviewed by telephone between August 2 and August 28, 2000. Four-hundred thirteen (413) registered voters from New Hampshire were interviewed. The margin of sampling error for all of New England is +/- 2.0% while the margin of sampling error for the New Hampshire sub-sample is +/- 4.8%. (See Appendix A, Technical Report, for a more detailed description of survey methods.) The following figures display survey results for New England and New Hampshire, detailed tabular results can be found in Appendix B, Appendix C contains the survey instrument.

The major findings of the survey include:

Proposals to Reduce Smoking Among Youth

- New Hampshire voters strongly favor all six proposals designed to reduce smoking by youth. Even smokers favor these proposals.
  - 94% favor requiring that all tobacco products be placed behind store counters.
  - 76% favor banning all cigarette vending machines.
  - 75% favor making all public places, including restaurants, smoke-free.
  - 73% favor banning give-aways of cigarettes and other tobacco products.
  - 60% favor raising the age that tobacco can be purchased from 18 to 19.
  - 53% favor raising the smoking age from 18 to 21.

Cigarette Taxes

- More than 3 in 5 New Hampshire voters (62%) say they would be more likely to vote for their State Legislator if he or she voted to increase the state tax on cigarettes by 25¢ per pack. Less than one-fifth (18%) say they would be more likely to vote against their State Legislator if he or she voted to increase the state tax on cigarettes by 25¢ per pack.
  - The amount of the tax increase is not critical in voters' decision. 83% of New Hampshire voters who said they would vote for a State Legislator who voted for a 25¢ per pack increase in taxes on cigarettes say they would also be more likely to vote for that legislator if the proposal were for a 50¢ per pack increase.

- When asked what cigarette tax revenues should be spent on, New Hampshire voters prefer using cigarette tax revenues for tobacco control, though at slightly lower levels than most other states.
  - 62% strongly favor using cigarette tax revenues for tobacco control programs and programs that discourage young people from smoking.
  - 51% strongly favor using cigarette tax revenues to help senior citizens pay for prescription drugs.
  - 46% strongly favor using cigarette tax revenues for increasing health care access for the uninsured and under-insured.

Second-hand Smoke

- The overwhelming majority of New Hampshire voters (87%) prefer to call smoke in public places "second-hand smoke".

- 64% of New Hampshire voters are exposed to cigarette smoke at sometime during the week and 19% say they are exposed 10 or more hours.
  - Current smokers and young voters are most exposed to smoke.
  - 60% of voters say they make a special effort to avoid places where people smoke.

- Smoking in the workplace is not a problem for most New Hampshire voters — only 9% say smoking is allowed inside the building where they work.
  - 2 in 5 of those voters who work in buildings where smoking is allowed (41%) say they would prefer to work in a smoke-free environment.
  - Only 13% percent of working voters say they have wanted to complain about someone's smoking where they work in the past year.

- New Hampshire voters are much more likely to eat at a restaurant that does not allow smoking.
  - 52% say they would be much more likely and another 16% say they would be somewhat more likely to eat at a smoke free restaurant.
  - Not surprisingly, smokers say they are less likely to eat at a restaurant that does not allow smoking.

- 15% of New Hampshire voters say they would eat out more often if their state or community had smoke-free restaurants, only 4% say they would eat out less often.

- 4 in 5 New Hampshire voters (79%) say they ask for non-smoking tables when dining out. Only 5% ask for smoking tables.

- 2 in 5 of New Hampshire voters (40%) believe that laws limiting smoking in public "have not gone far enough" and 46% think they are "just about right." Only 13% believe these laws "have gone to far."
  - 37% of New Hampshire voters who smoke think that laws limiting smoking in public "have gone too far."

- More than half of New Hampshire voters (58%) say they would be more likely to vote for a State Legislator who wanted to ban smoking in all restaurants in their state, only 19% say they would be more likely to vote against, and 20% say it would make no difference in their vote.

Smoking Behavior

- 14% of New Hampshire registered voters report they currently smoke or use regularly use smokeless tobacco, 44% are former smokers, and 43% say they have never smoked.
  - New Hampshire voters under age 30 and those who have only high school educations are most likely to be current smokers.
  - 3 in 5 smokers (60%) have been smoking for more than 20 years.
  - 28% of former smokers smoked less than 10 years.
  - 60% of current smokers and 47% former smokers began smoking at age 16 or younger.

- 17% of New Hampshire smokers report that a smoker lives in their household, most often a spouse (10%).
  - Current smokers are significantly more likely to report another smoker in their household.

- Most New Hampshire voters do not allow smoking in their homes (72%) or in their cars (79%).

Quitting Smoking

- 4 in 5 current smokers (82%) say they have made at least one serious attempt to quit smoking with 40% making 3 or more serious attempts.

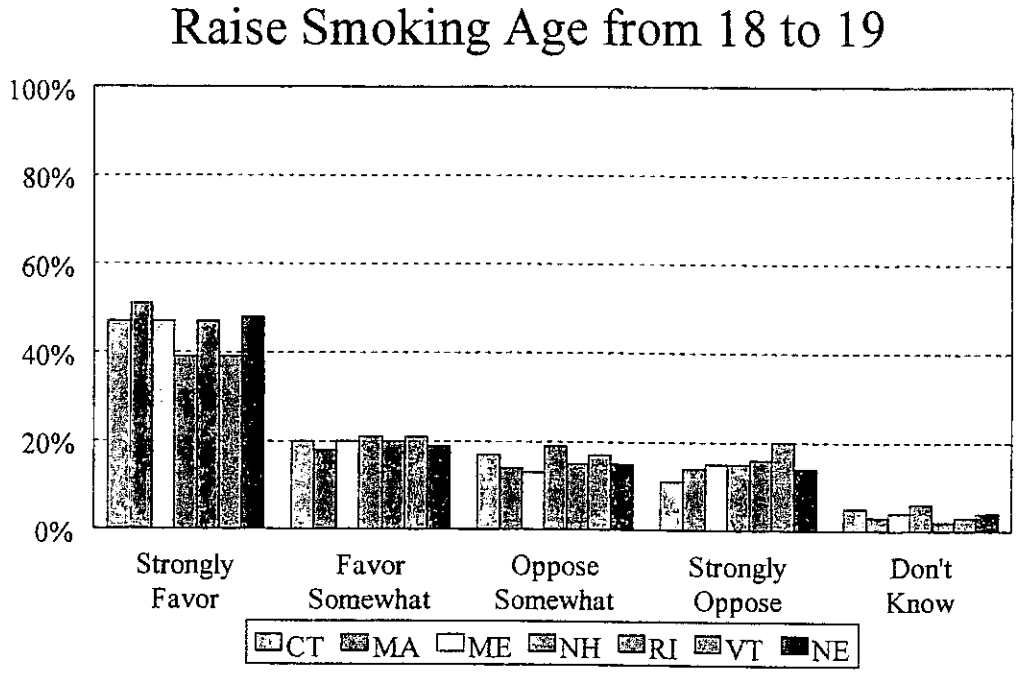
- Three-quarters of current smokers say they plan to make a serious attempt to quit smoking in the next 12 months.
  - The most helpful options to quitting smoking, as reported by current smokers, are raising the price of cigarettes by $1 or a loved one's advice to quit.
  - The stop smoking aids which would be most helpful are nicotine patches.

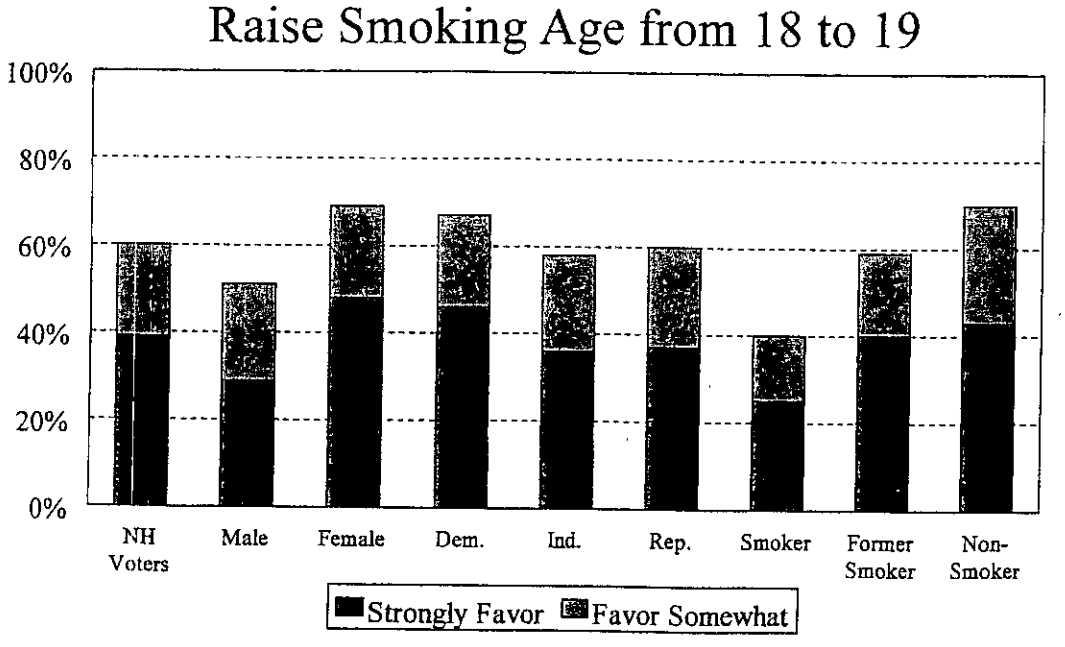
Smoking's Impact

- More than half (53%) of all New Hampshire voters say that a family member or a close friend has been affected by a smoking related illness.
  - Smokers are significantly less likely to report a family member or close friend being affected by a tobacco related illness.

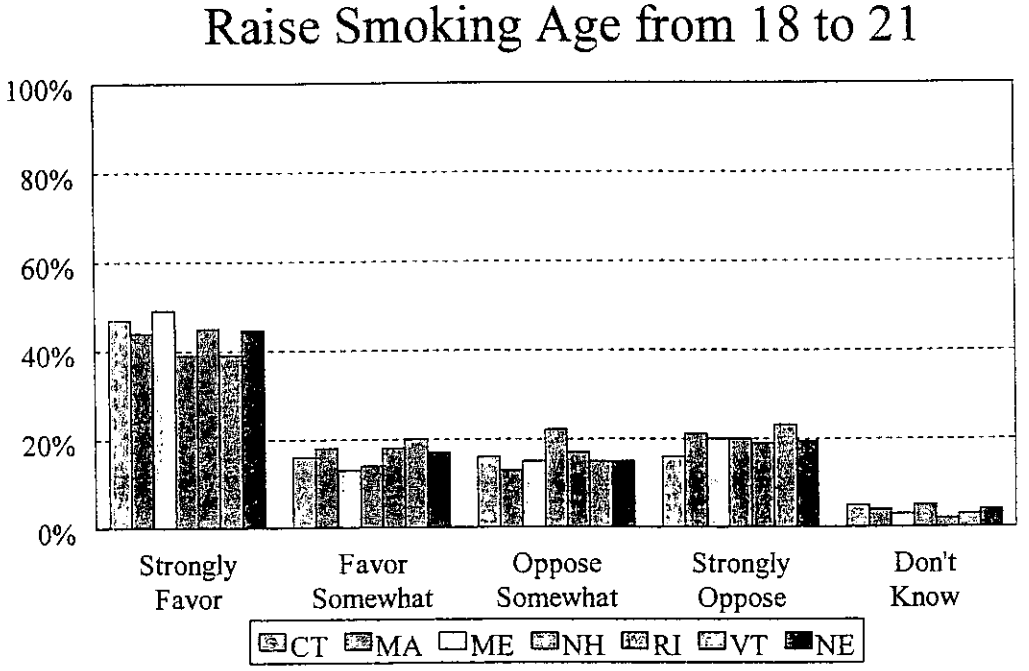
- 42% of New Hampshire voters report that a family member or a close friend has died because of a smoking related illness.
  - Again, smokers are less likely to report a family member or close friend dying because of a smoking related illness.

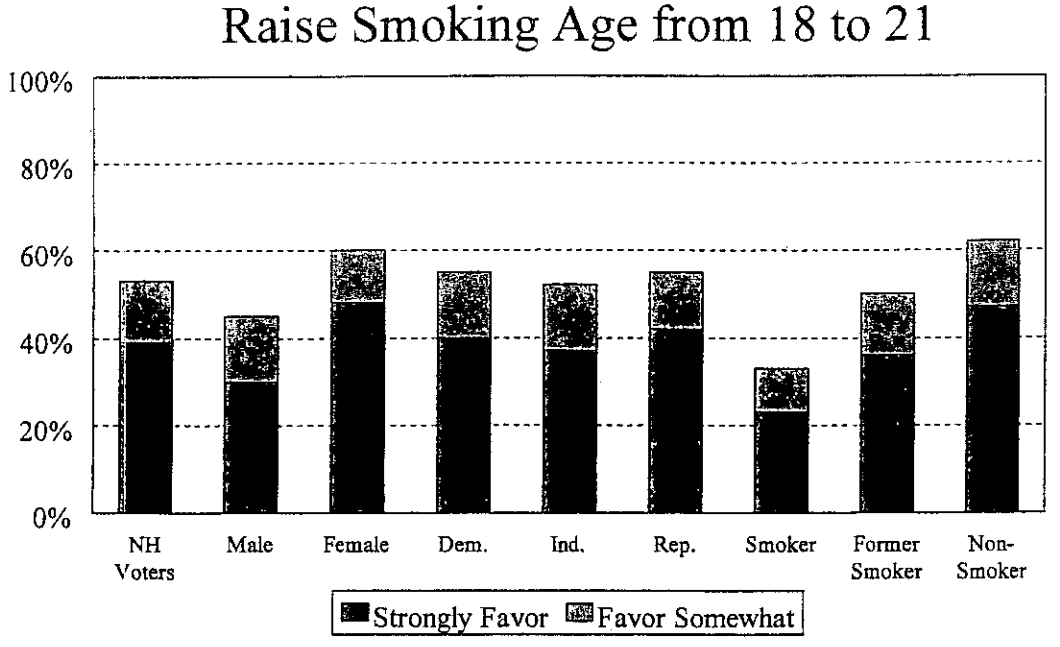
YS1: "There have been several policies proposed to reduce smoking by youth. I'm going to read you several proposals and I want you to tell me if you favor or oppose this method of reducing smoking by youth." "First, there has been a proposal to raise the age that teens can buy cigarettes from 18 to 19 years old. Some people favor this proposal and some oppose it. What about you ... do you strongly favor raising the smoking age from 18 to 19 ... favor somewhat ... oppose somewhat ... or strongly oppose raising the smoking age from 18 to 19?" (N = 405)



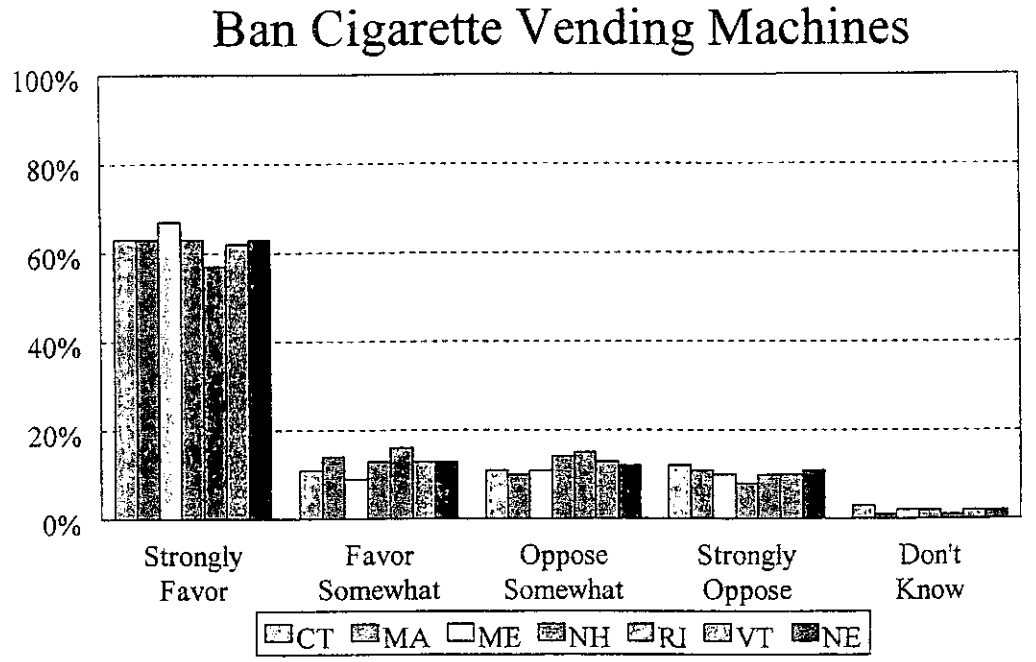


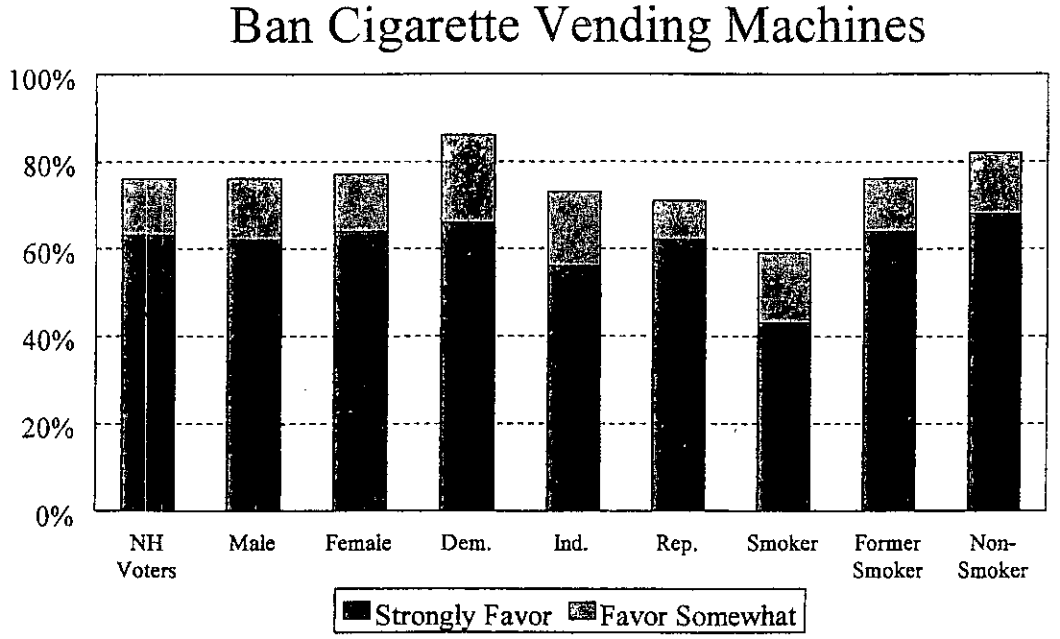
YS2: "What about raising the smoking age from 18 to 21 ... do you strongly favor raising the smoking age from 18 to 21 ... favor somewhat ... oppose somewhat ... or strongly oppose raising the smoking age from 18 to 21?" (N = 406)



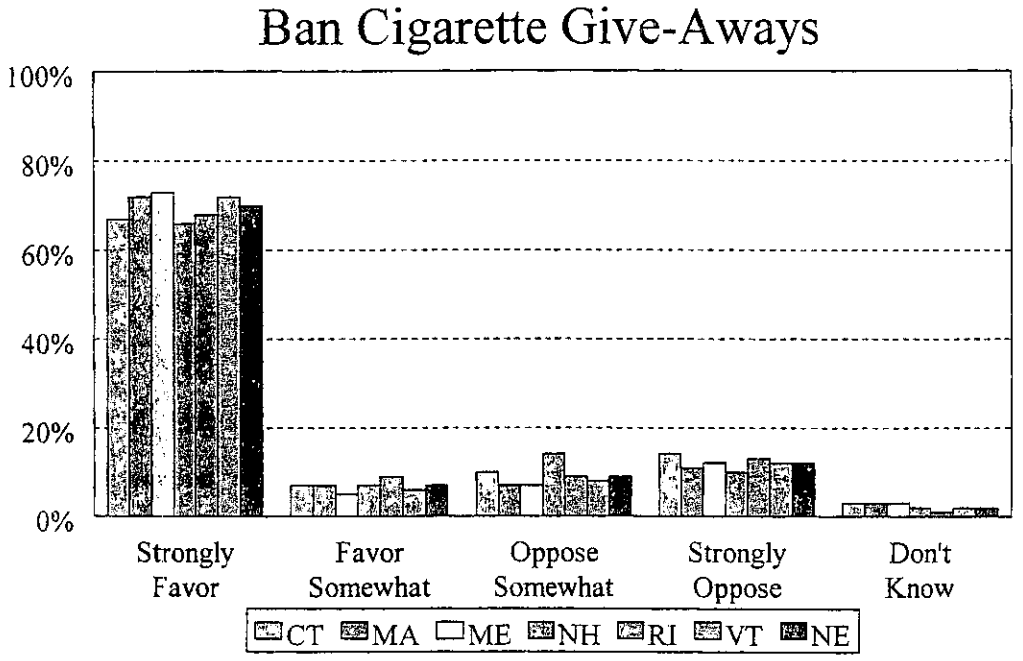


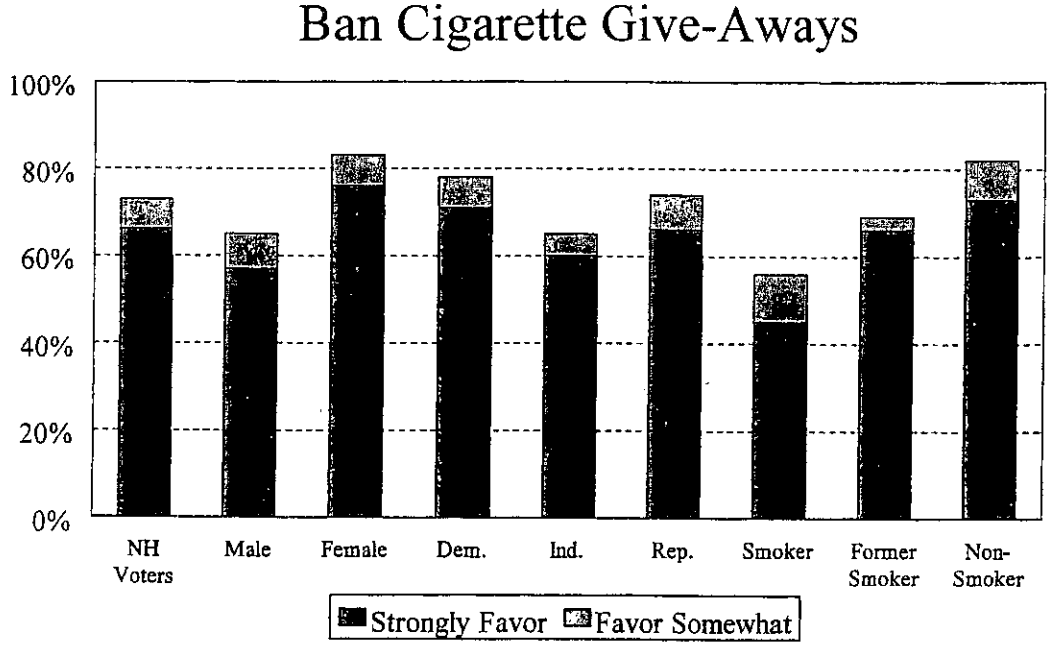
YS3: "What about banning all cigarette vending machines ... do you strongly favor banning all cigarette vending machines ... favor somewhat ... oppose somewhat ... or strongly oppose banning all cigarette vending machines?" (N = 405)



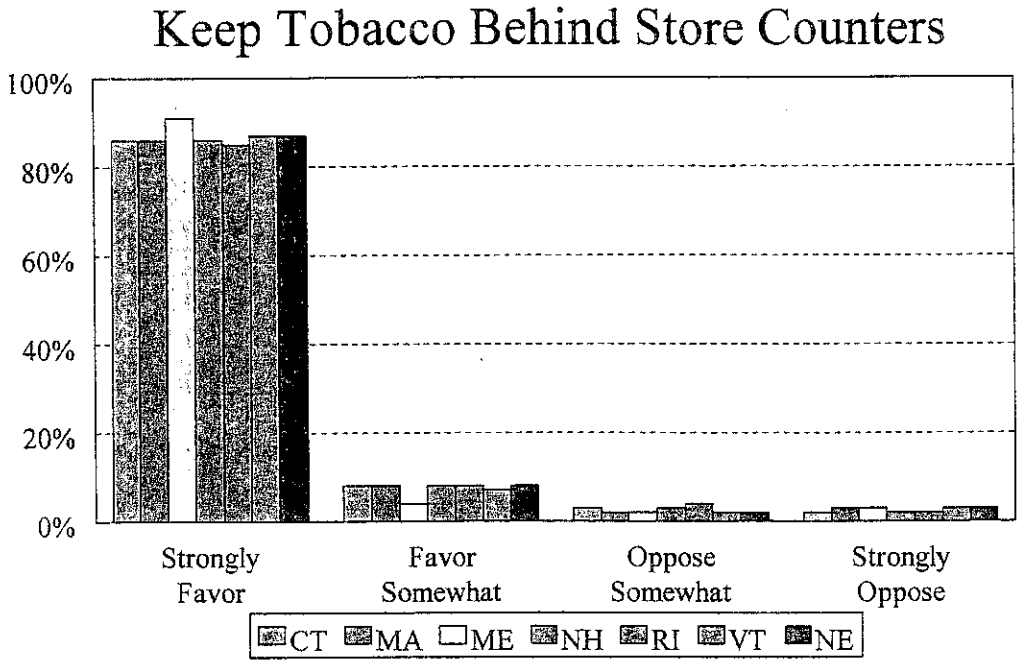


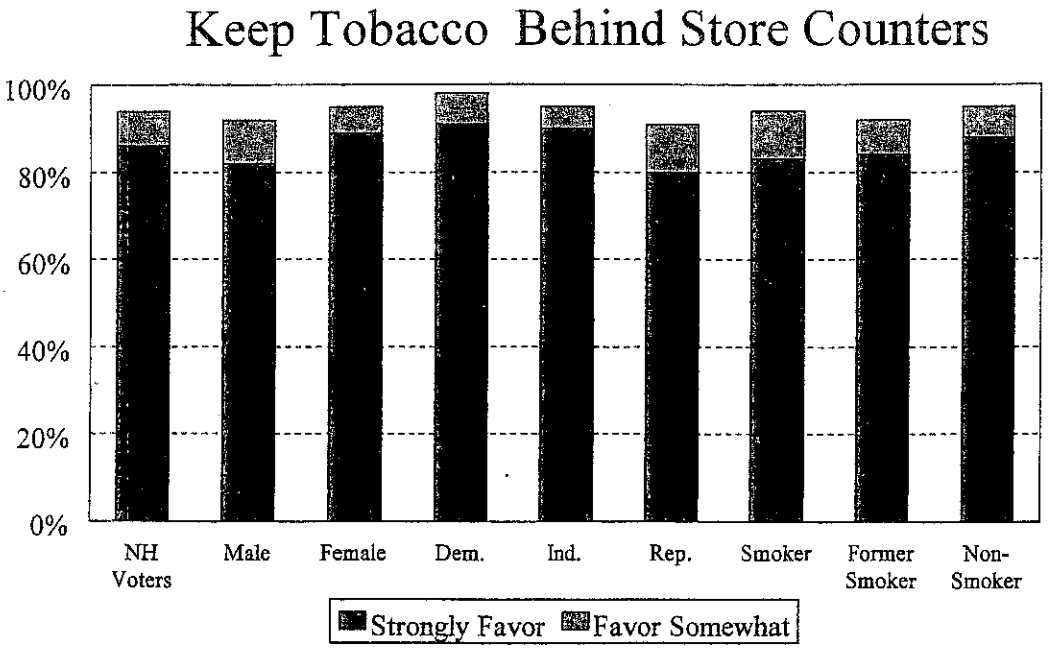
YS4: "What about banning free give-aways of cigarettes and other tobacco products ... do you strongly favor banning free give-aways of cigarettes and other tobacco products ... favor somewhat ... oppose somewhat ... or strongly oppose banning free give-aways of cigarettes and other tobacco products?" (N = 406)



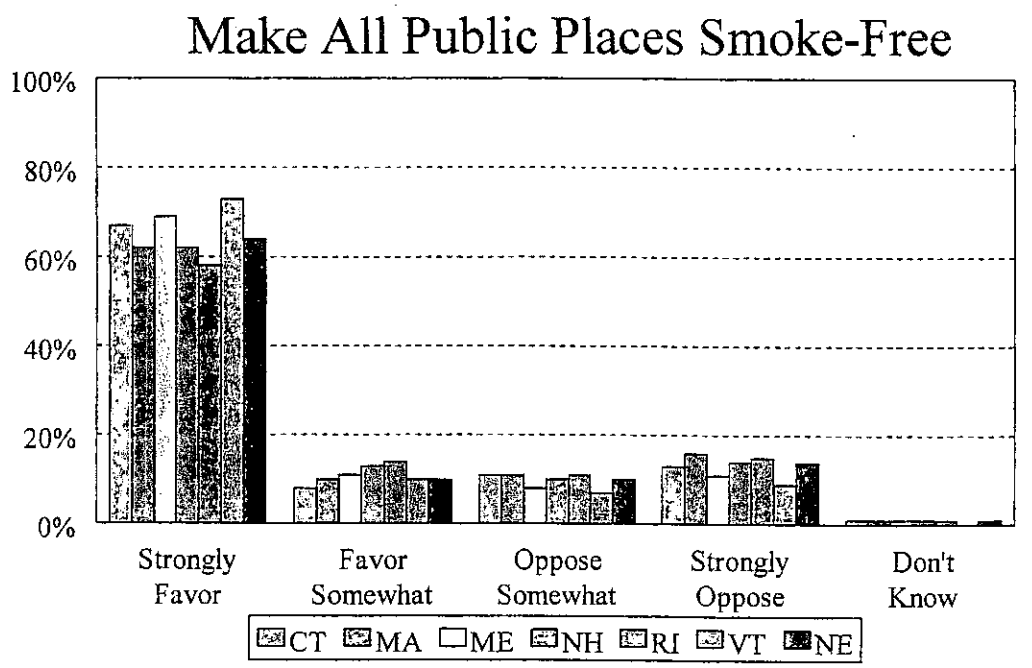


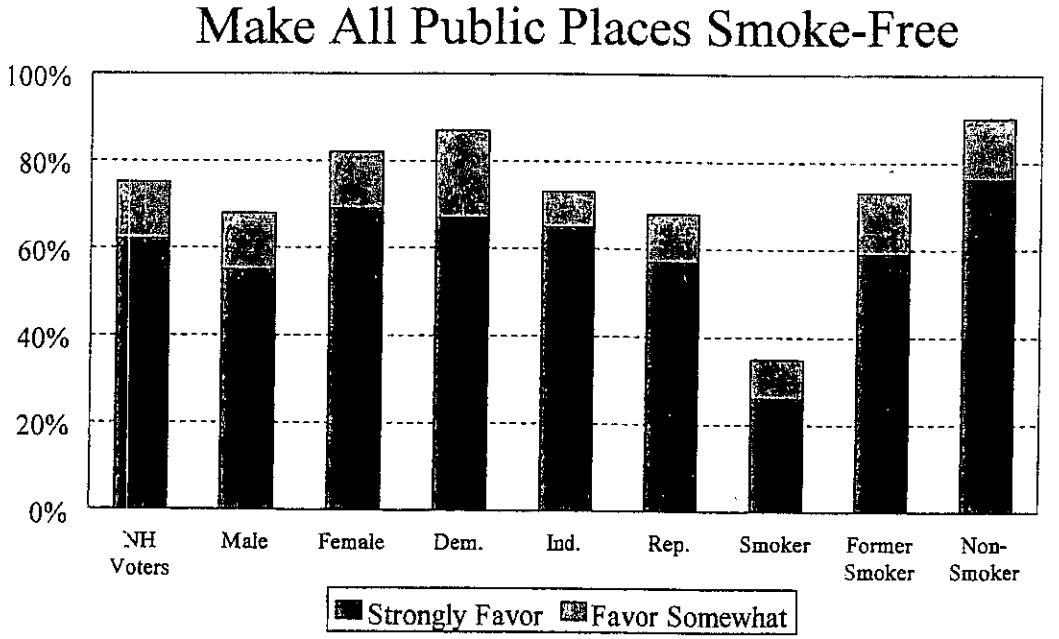
YS5: "What about requiring that all tobacco products be placed behind the counter in stores, out of the reach of children ... do you strongly favor requiring that all tobacco products be placed behind the counter in stores ... favor somewhat ... oppose somewhat ... or strongly oppose requiring that all tobacco products be placed behind the counter in stores?" (N = 407)





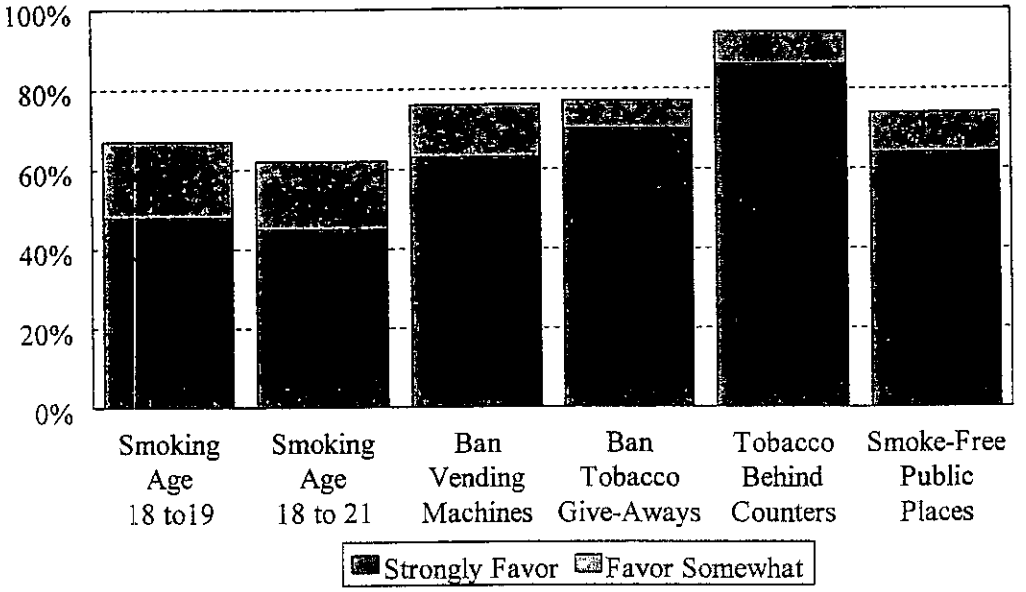
YS6: "What about making all public places, such as restaurants, smoke-free ... do you strongly favor making all public places smoke-free ... favor somewhat ... oppose somewhat ... or strongly oppose making all public places smoke-free?" (N = 407)



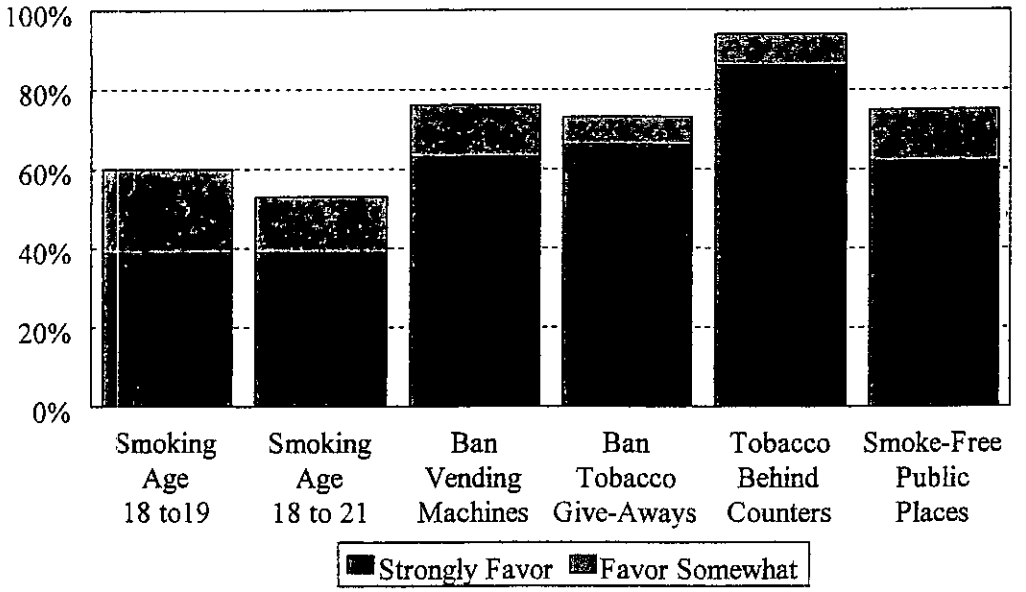


YS1 thru YS6:

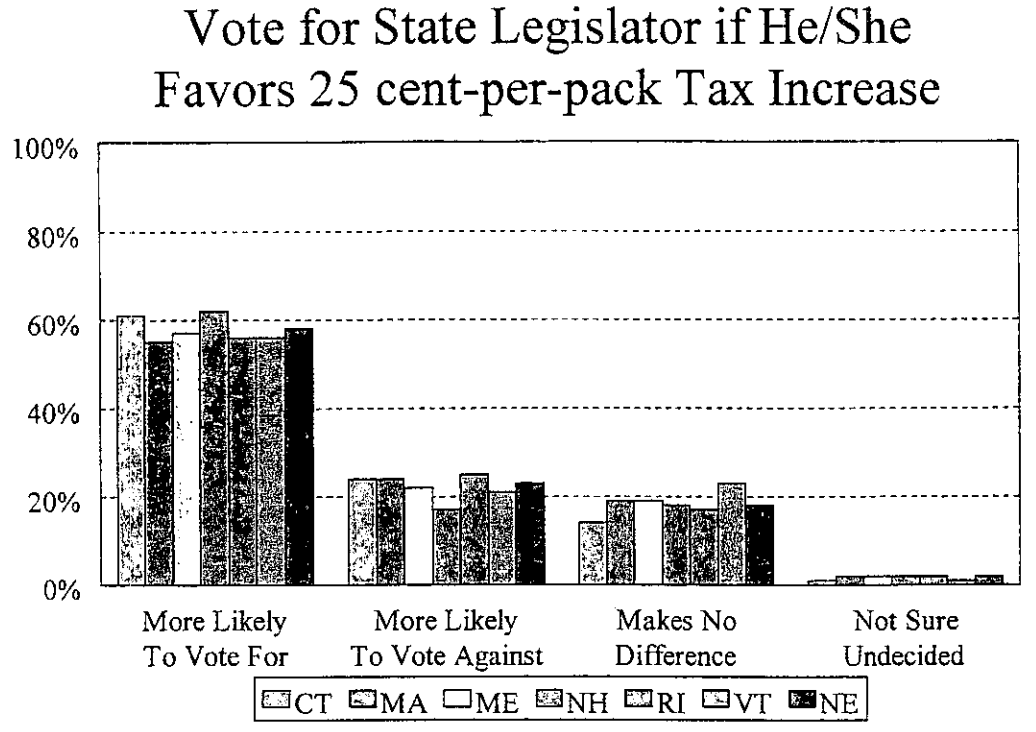
Support for Public Policies to Reduce Youth Smoking
(All New England Voters)

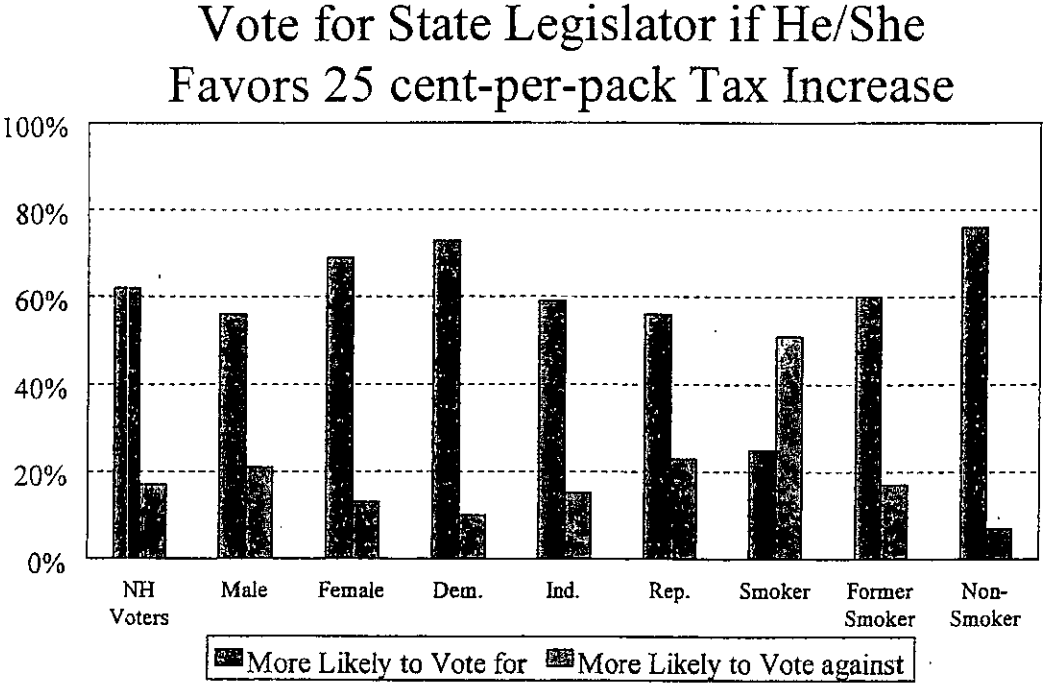


Support for Public Policies to Reduce Youth Smoking
(NH Voters)

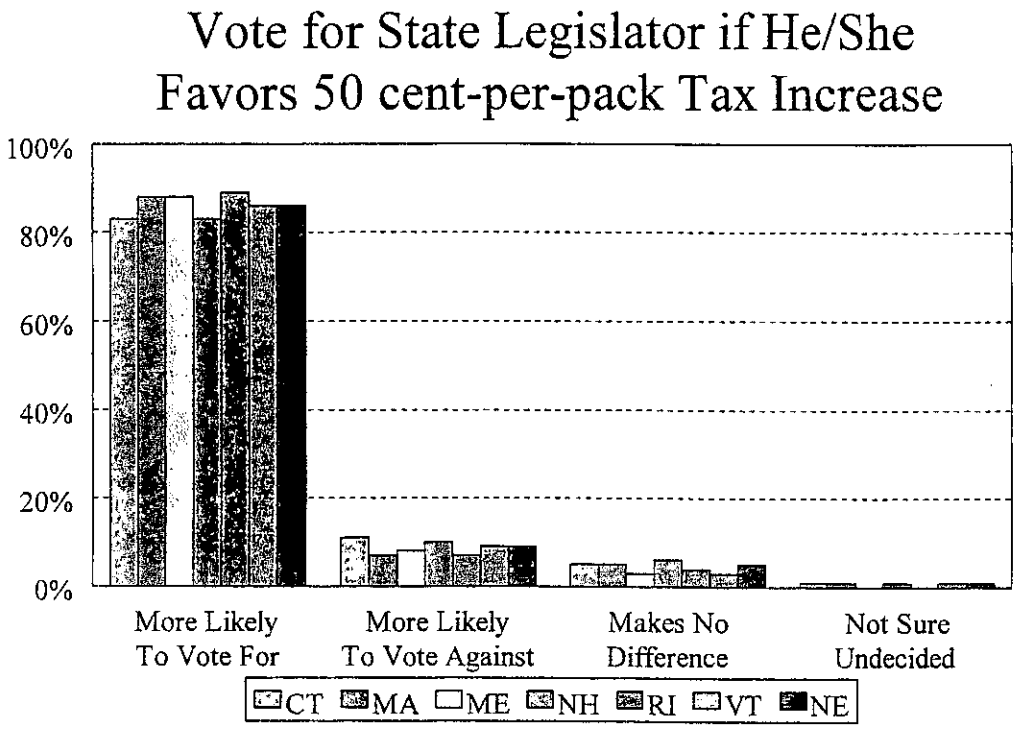


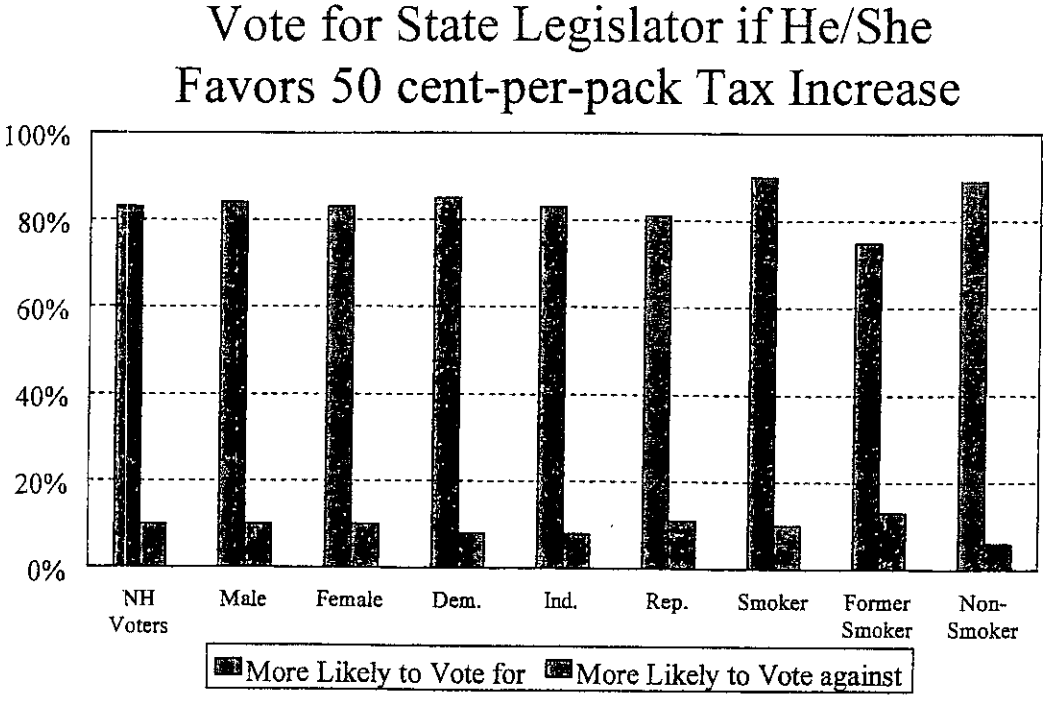
CT1: "What if the proposal were to increase the state tax on cigarettes by 25 cents per pack ... would you be more likely to vote for or against your State Legislator if they voted to increase taxes on cigarettes by 25 cents per pack?" (N = 406)



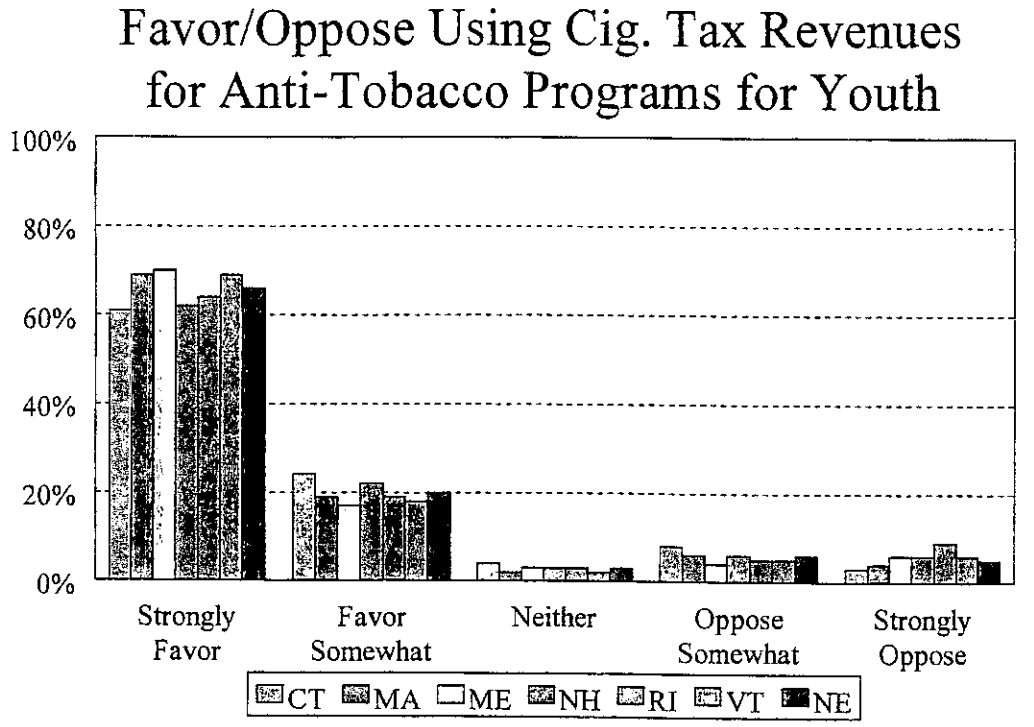


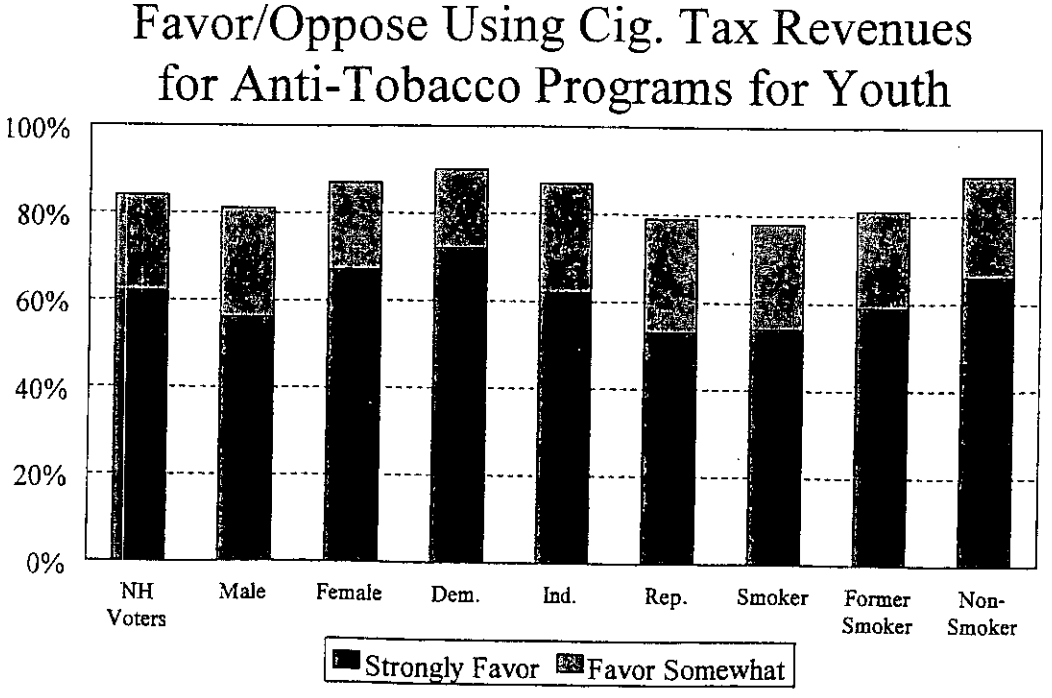
CT2: "What if the proposal were to increase the state tax on cigarettes by 50 cents per pack ... would you be more likely to vote for or against your State Legislator if they voted to increase taxes on cigarettes by 50 cents per pack?" (ASKED ONLY TO VOTERS "MORE LIKELY TO VOTE FOR" LEGISLATOR FAVORING 25 CENT CIGARETTE TAX INCREASE.) (N = 252)



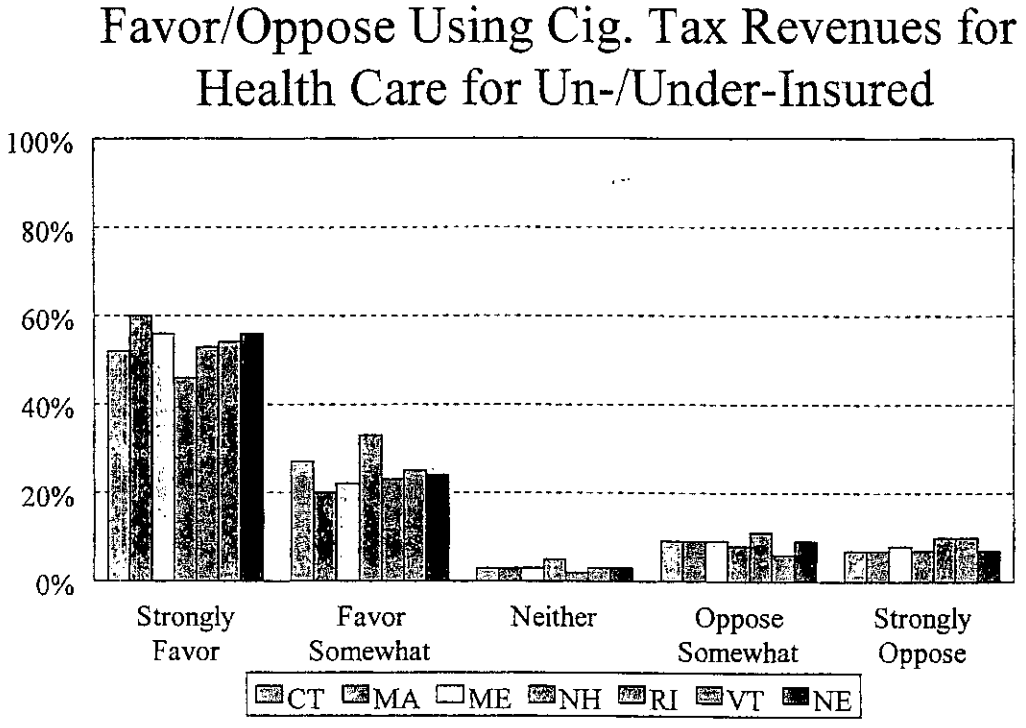


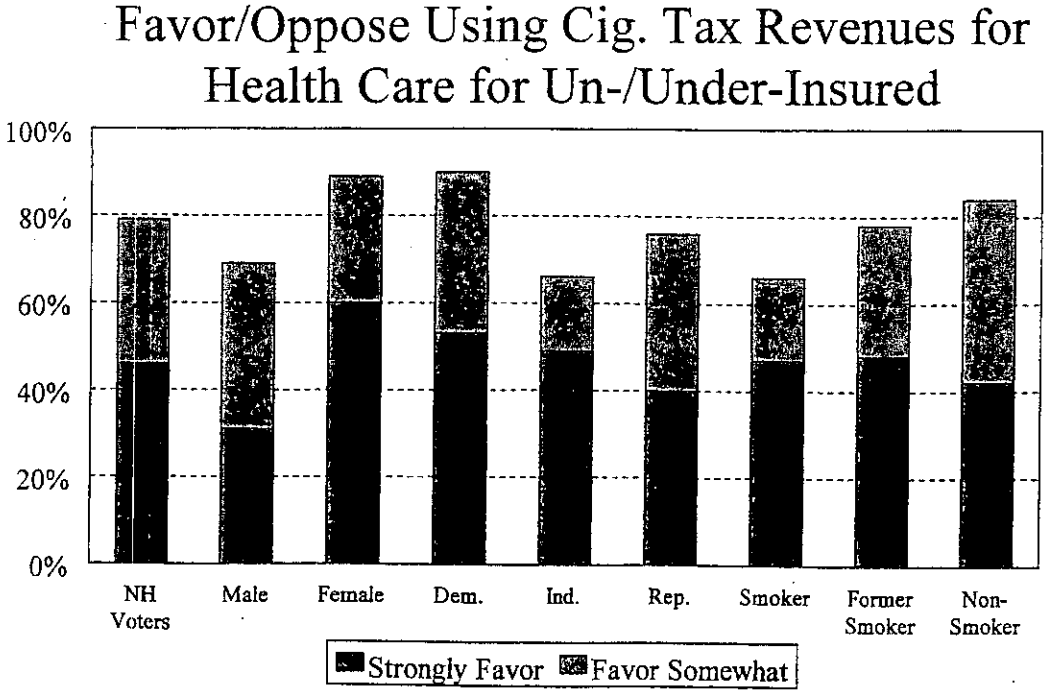
CT3A: "Do you favor or oppose using cigarette tax revenues for tobacco control programs and programs that discourage young people from starting smoking?" (N = 406)



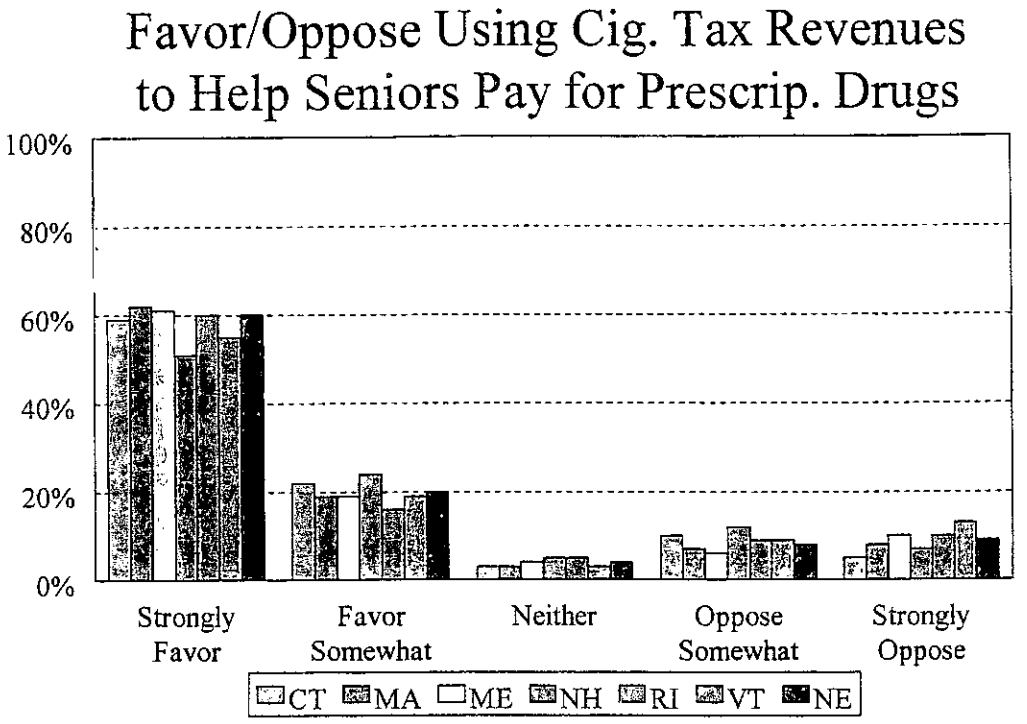


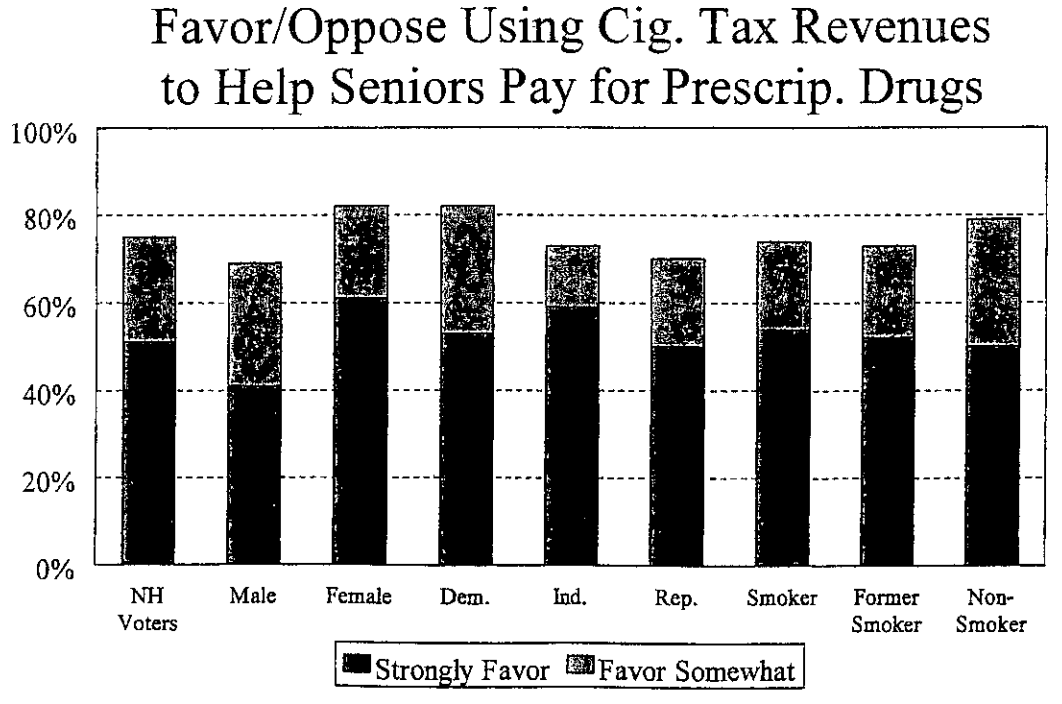
CT3B: "Do you favor or oppose using cigarette tax revenues for increasing health care access for the un-insured and under-insured?" (N = 404)



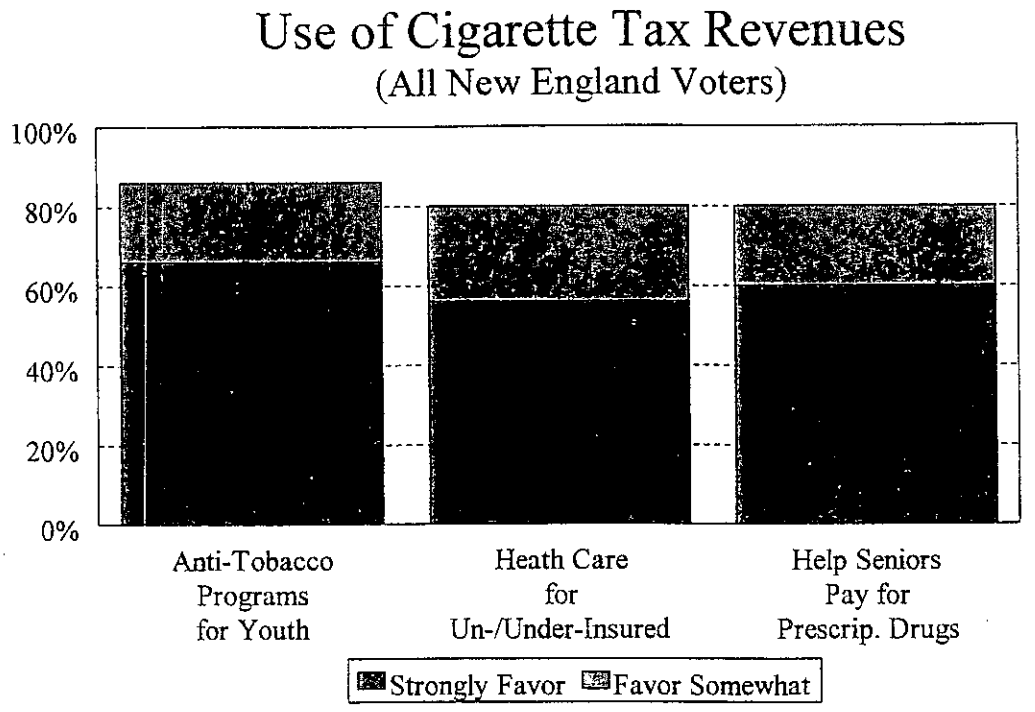


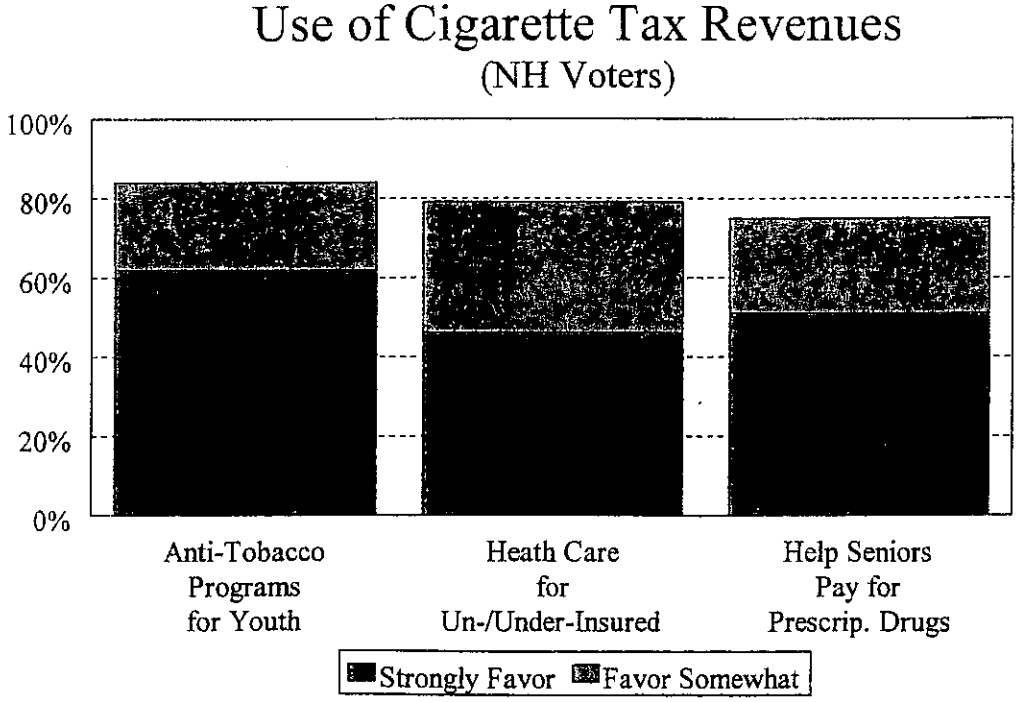
CT3C: "Do you favor or oppose using cigarette tax revenues for helping senior citizens pay for prescription drugs?" (N = 406)



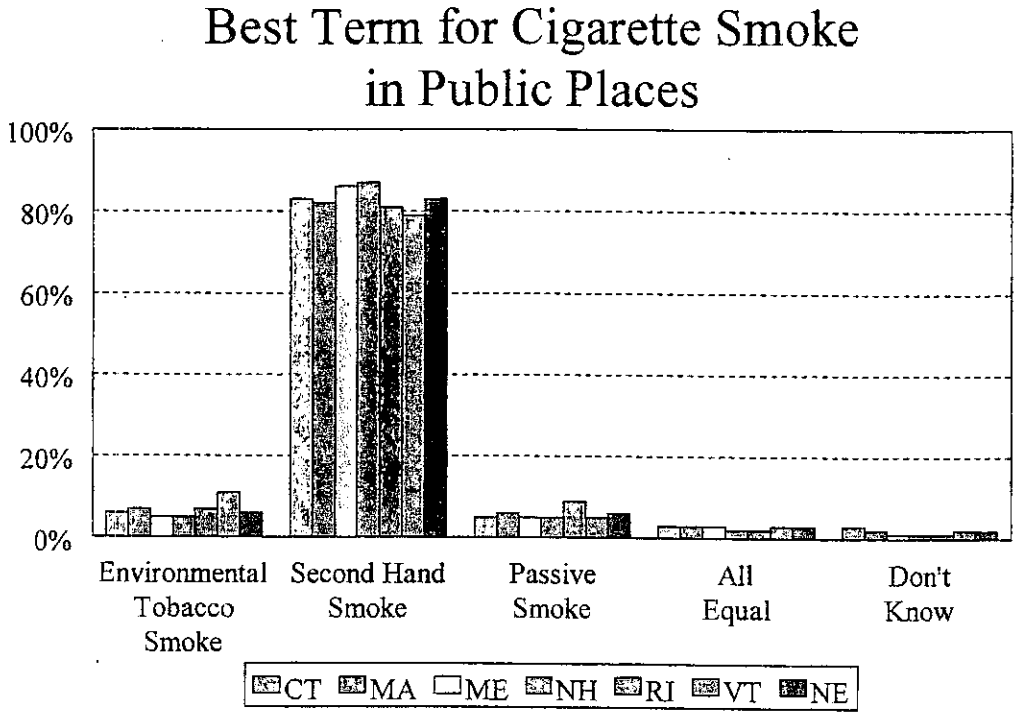


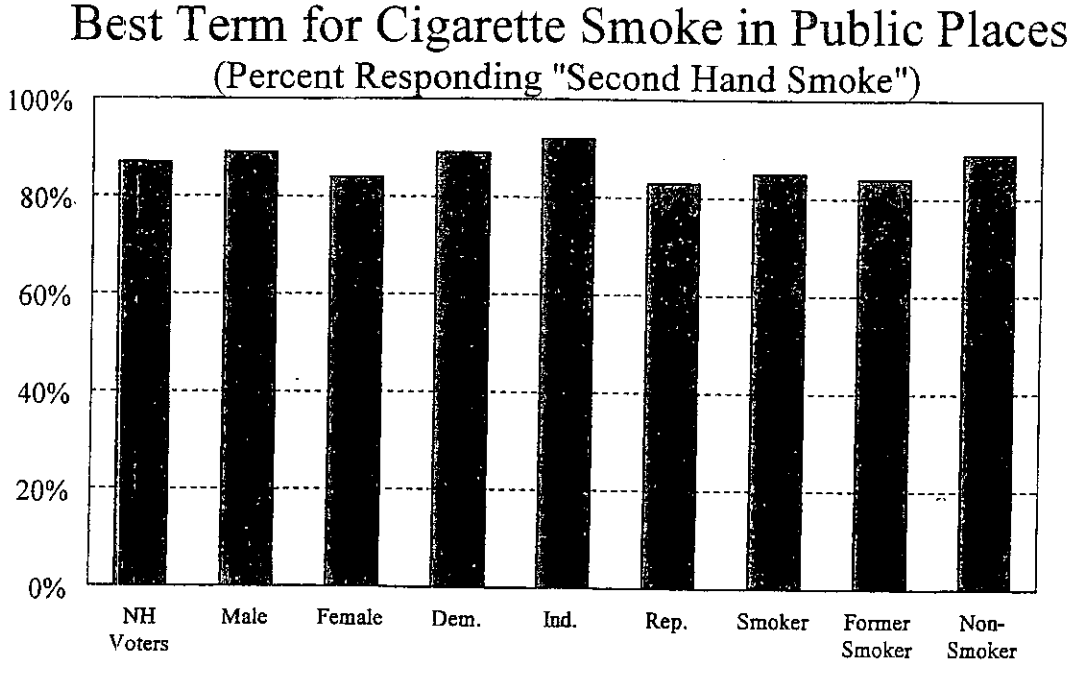
CT3A thru CT3C:



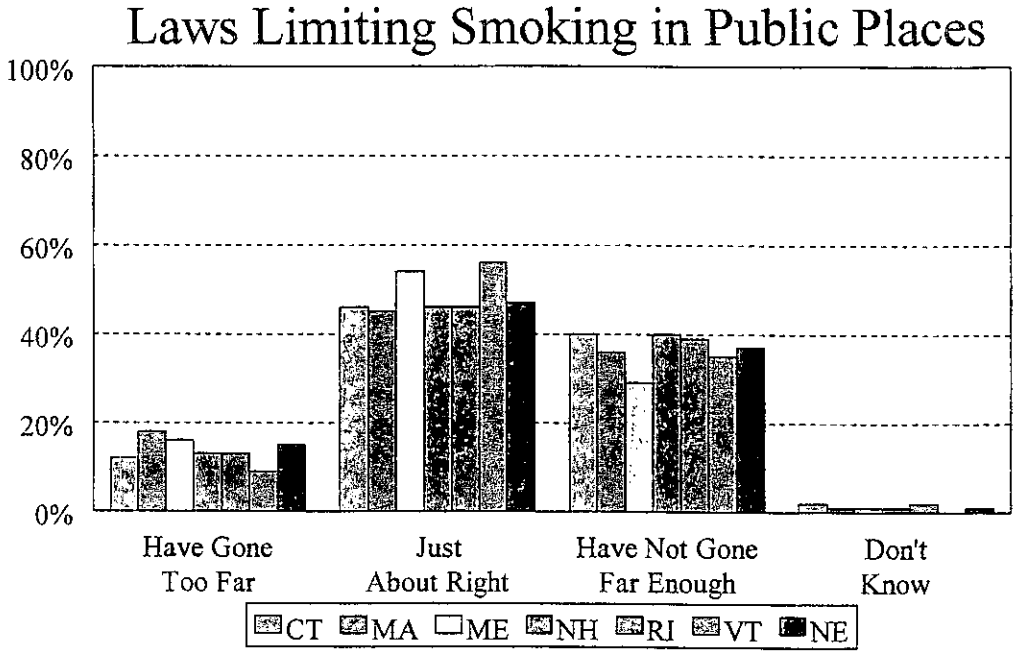


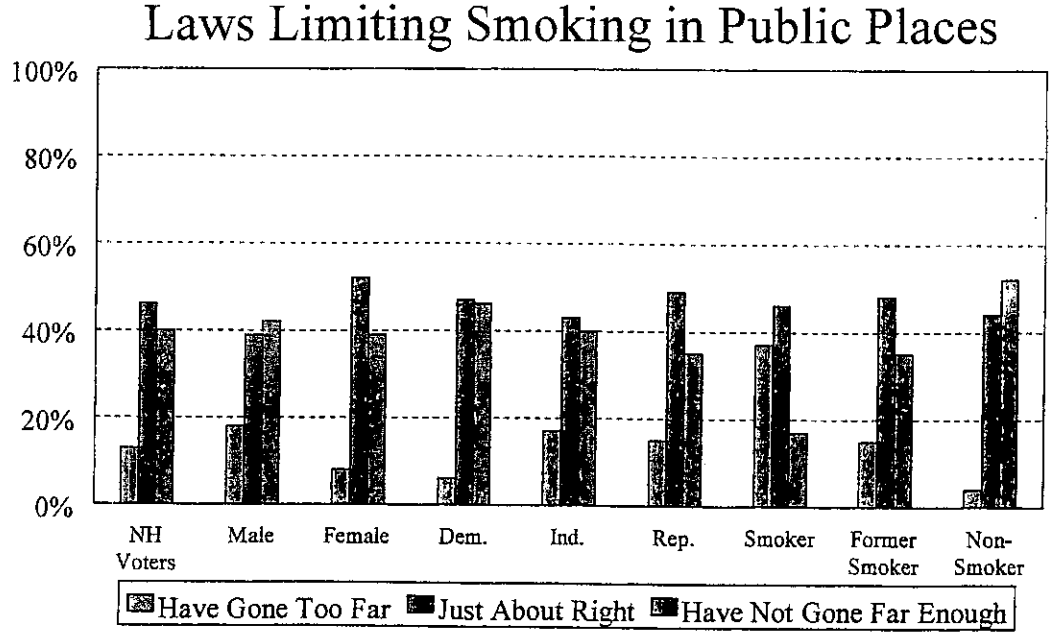
SHS1: "Now think about the problem of cigarette smoke in public places. Which of these terms do you think MOST people would understand to refer to the problem of cigarette smoke in public places ... 'environmental tobacco smoke' ... 'second hand smoke' ... or 'passive smoke'?" (N = 404)



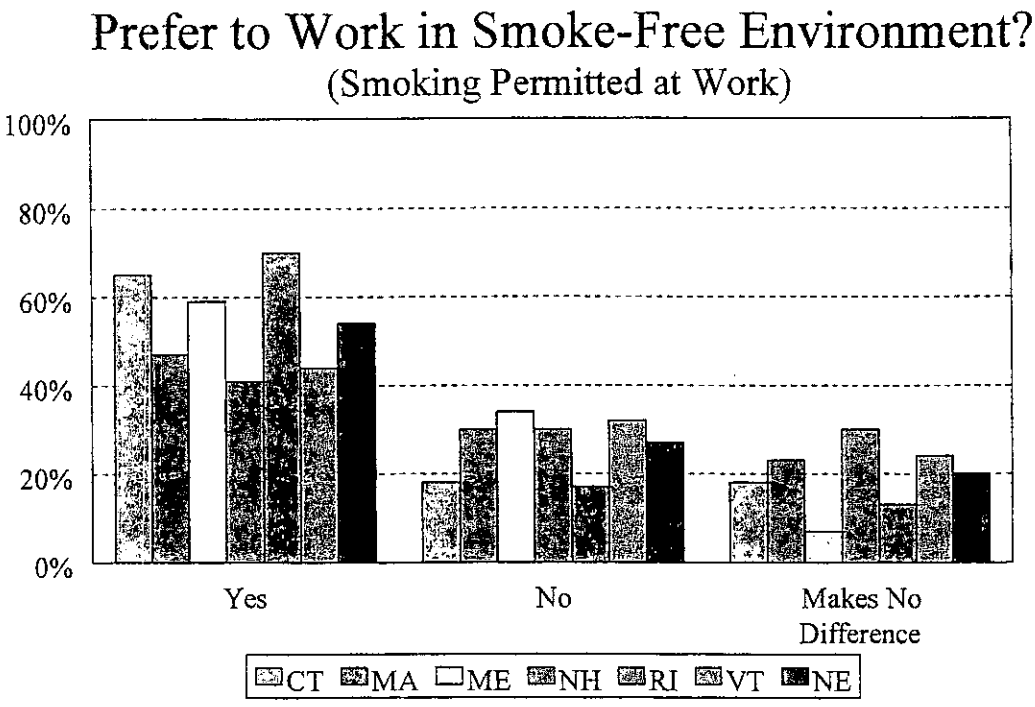


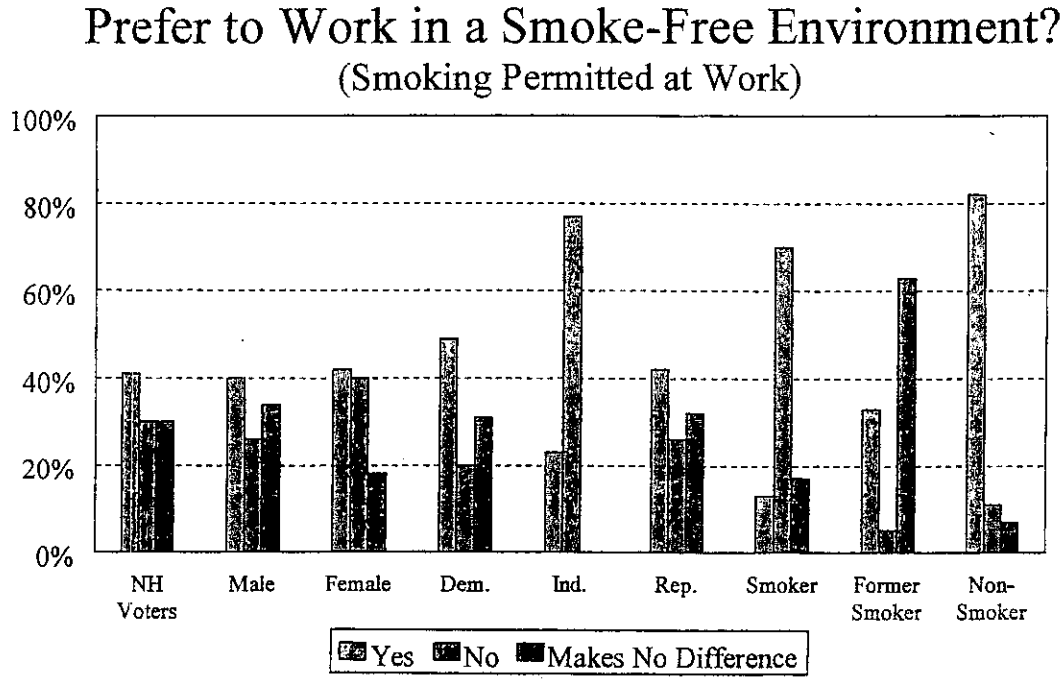
E1: "In general, do you feel that the laws limiting smoking in public places, such as restaurants, schools, and government buildings, have gone too far ... have not gone far enough ... or are just about right?" (N=404)



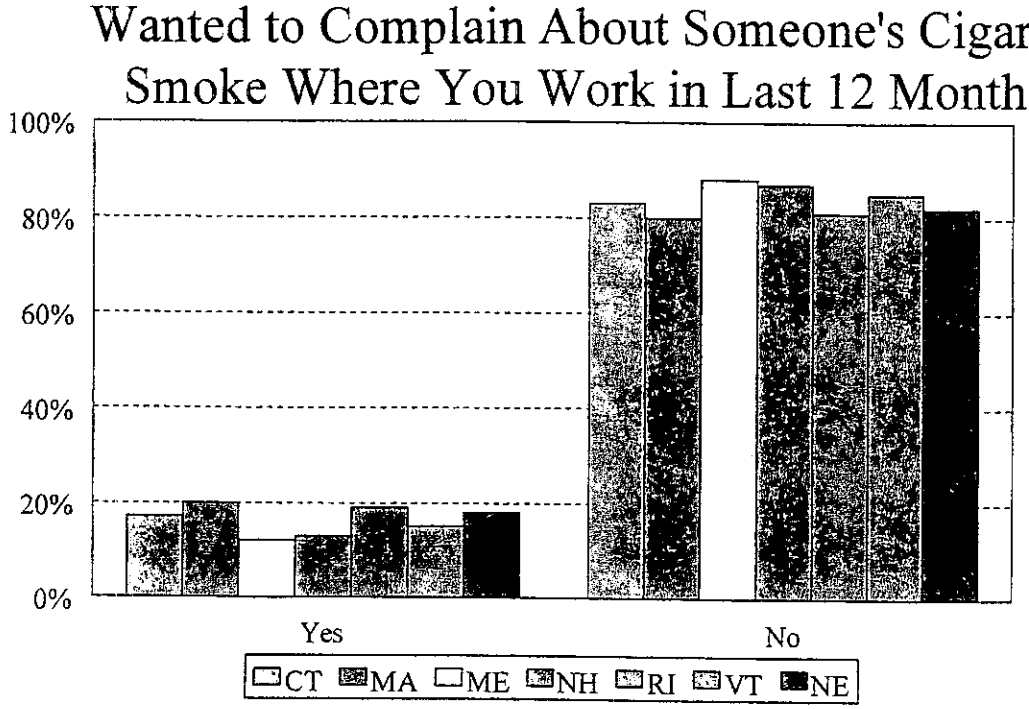


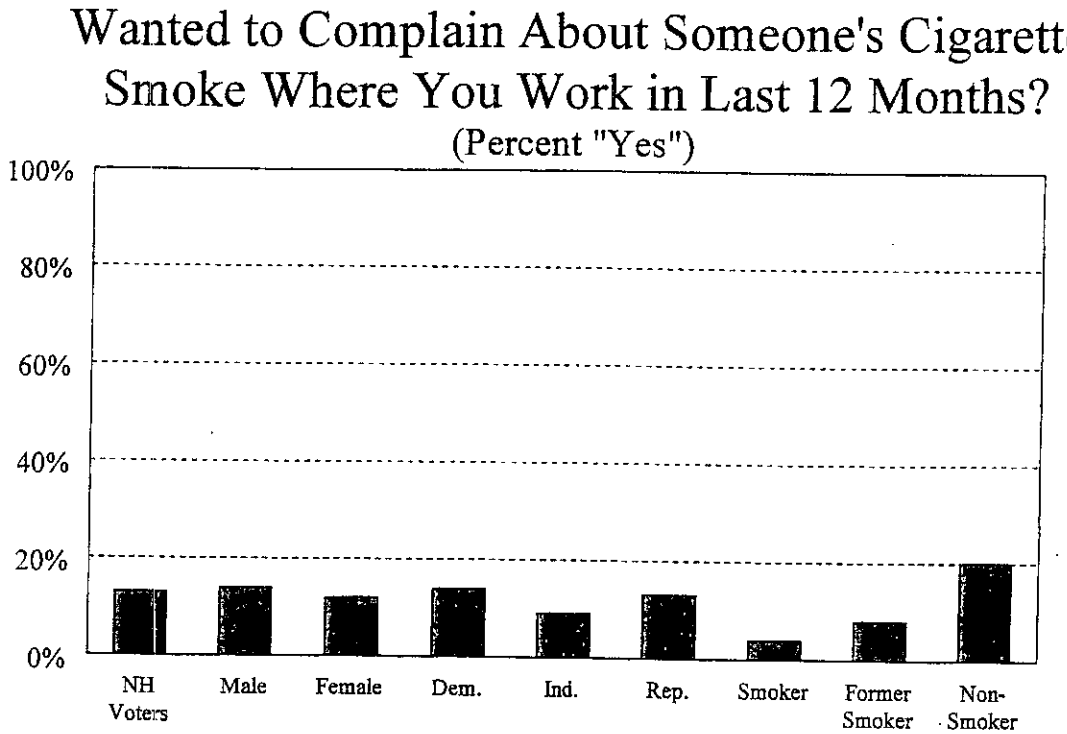
E3: "Would you prefer to work in a smoke-free environment?" (N = 35)



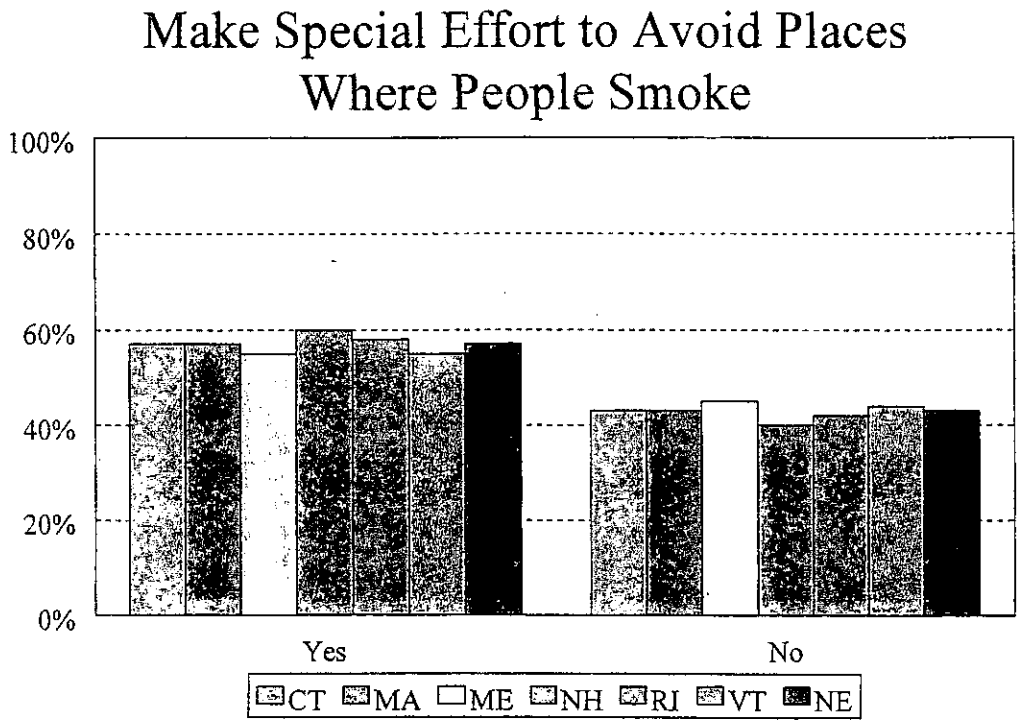


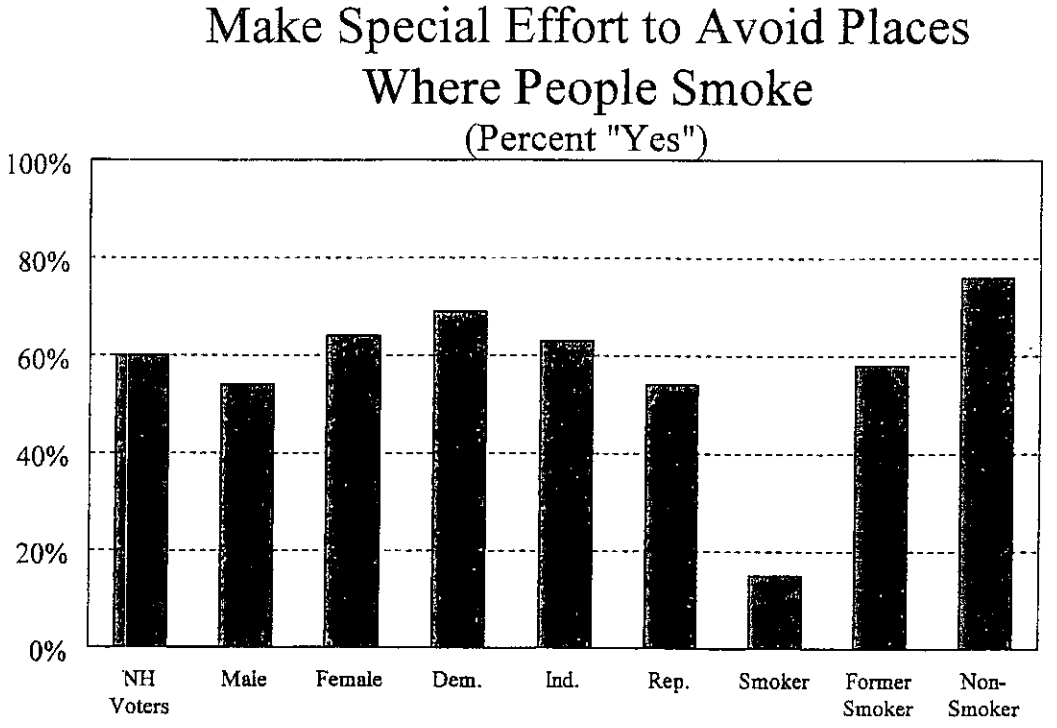
E4: "During the past 12 months, have you ever wanted to complain about someone else's cigarette smoke WHERE YOU WORK?" (N = 284)



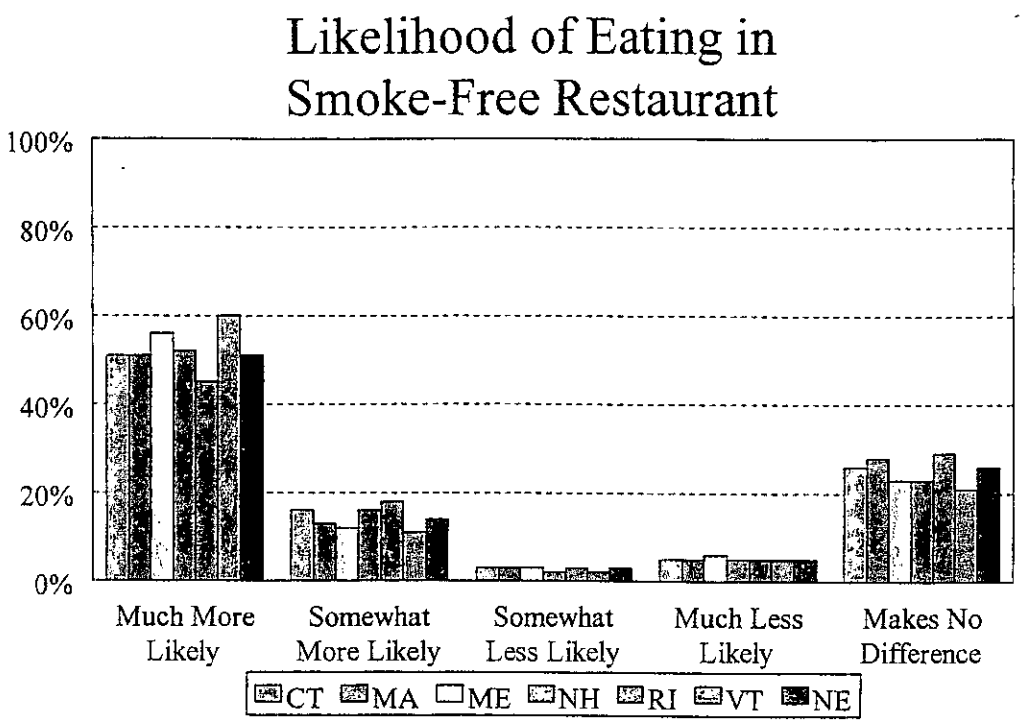


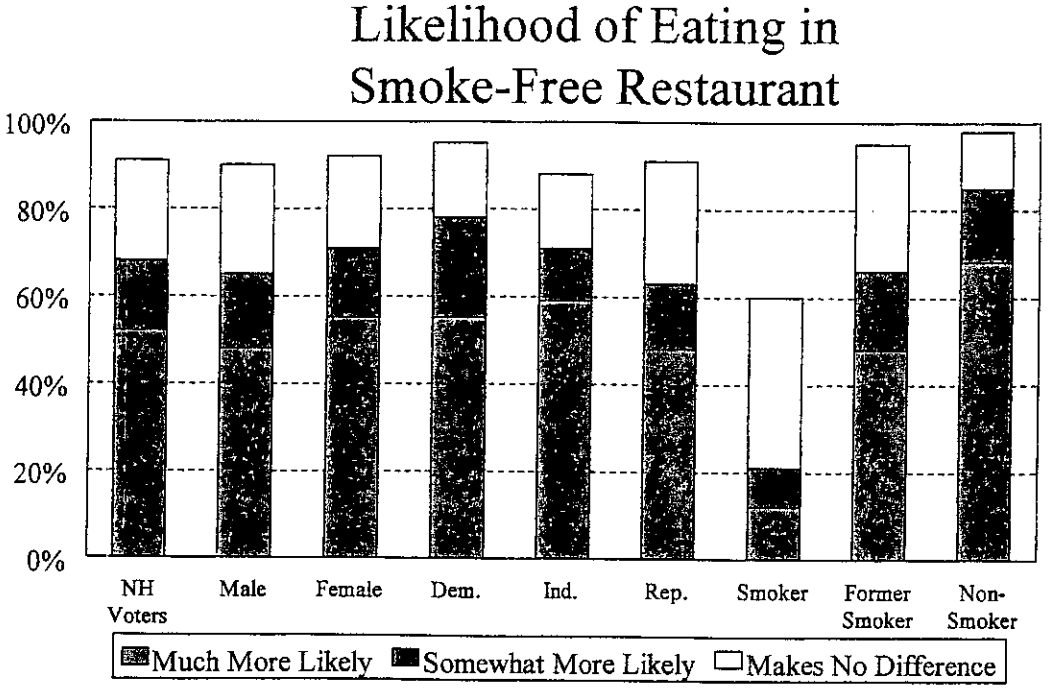
E6: "Do you make any special effort to avoid places where people smoke?" (N = 403)



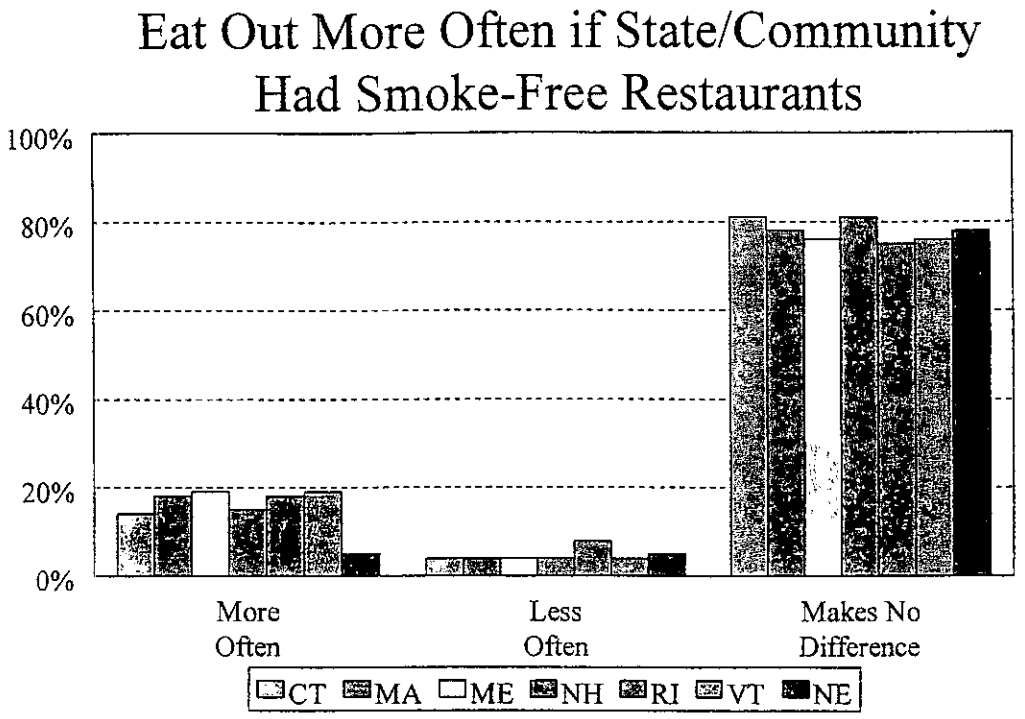


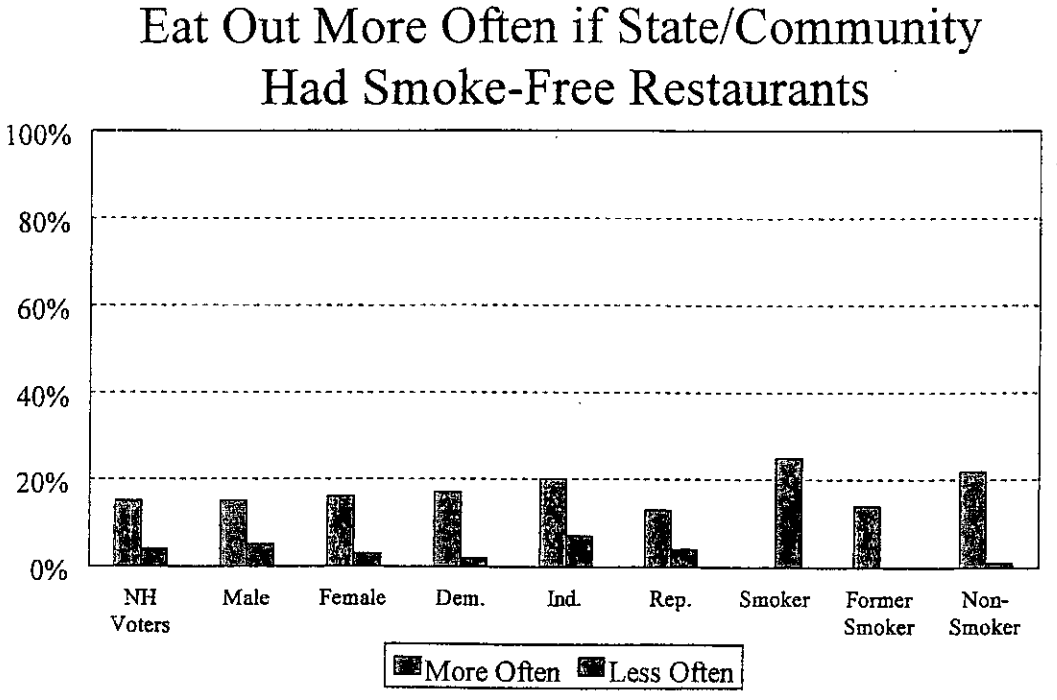
E7: "Now let's talk about smoking in restaurants ... Are you more likely or less likely to eat at a restaurant that is smoke-free, that is, a restaurant that does not allow smoking?" (N = 403)



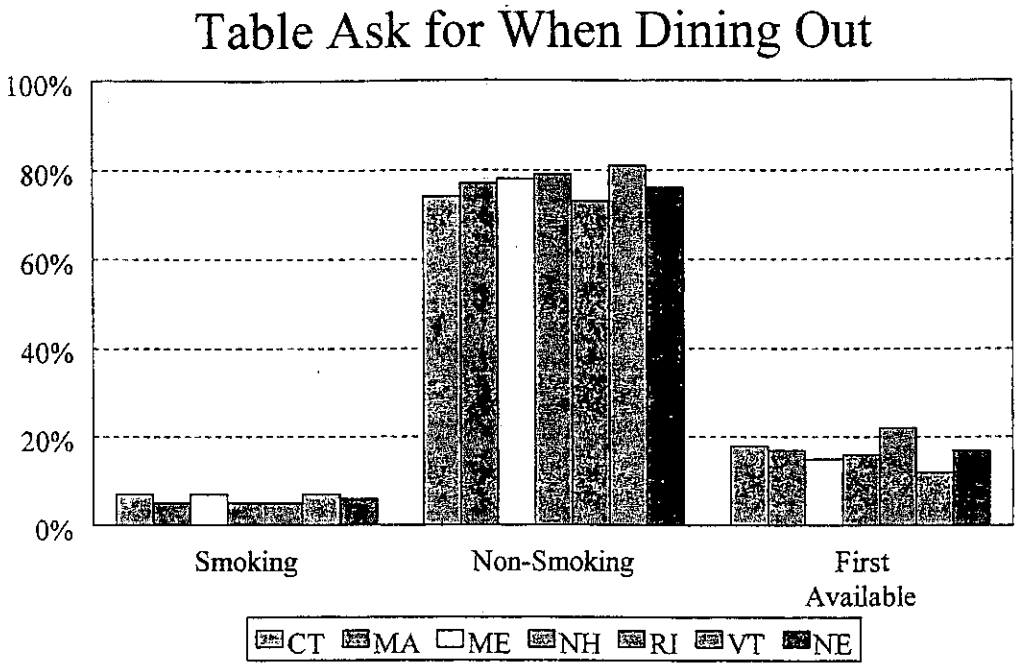


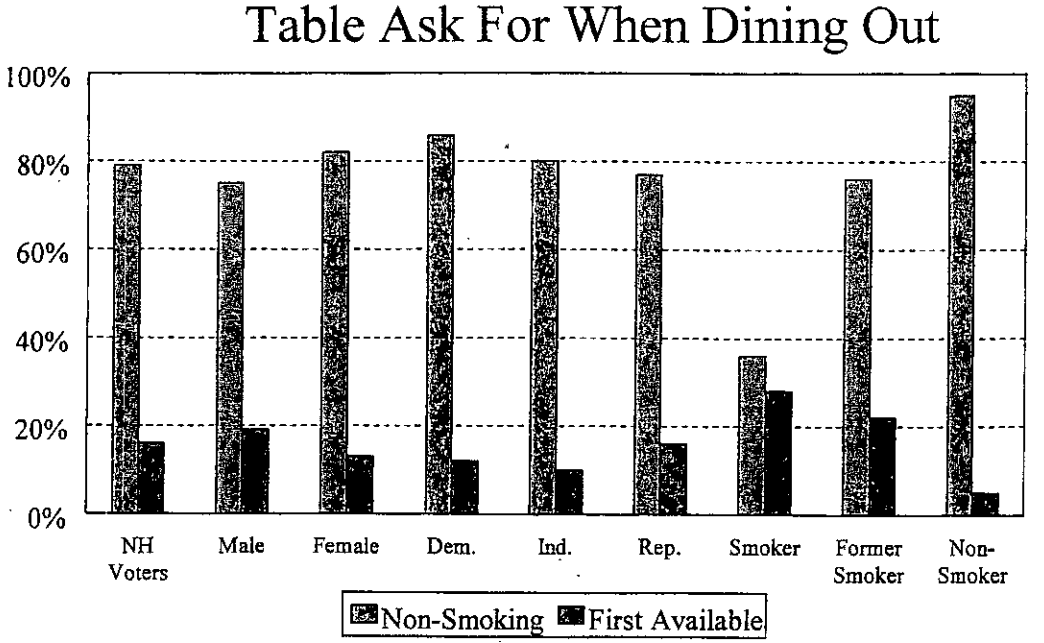
E8: "If your state or community had smoke-free restaurants, do you think you would eat out more often ... less often ... or would it not make any difference?" (N = 403)



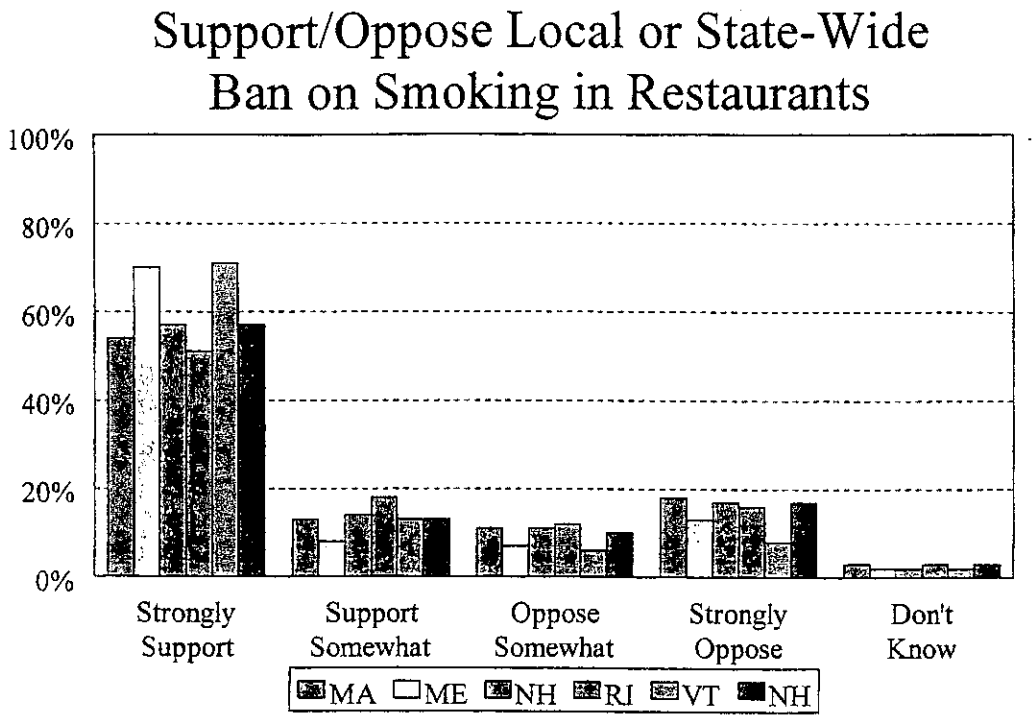


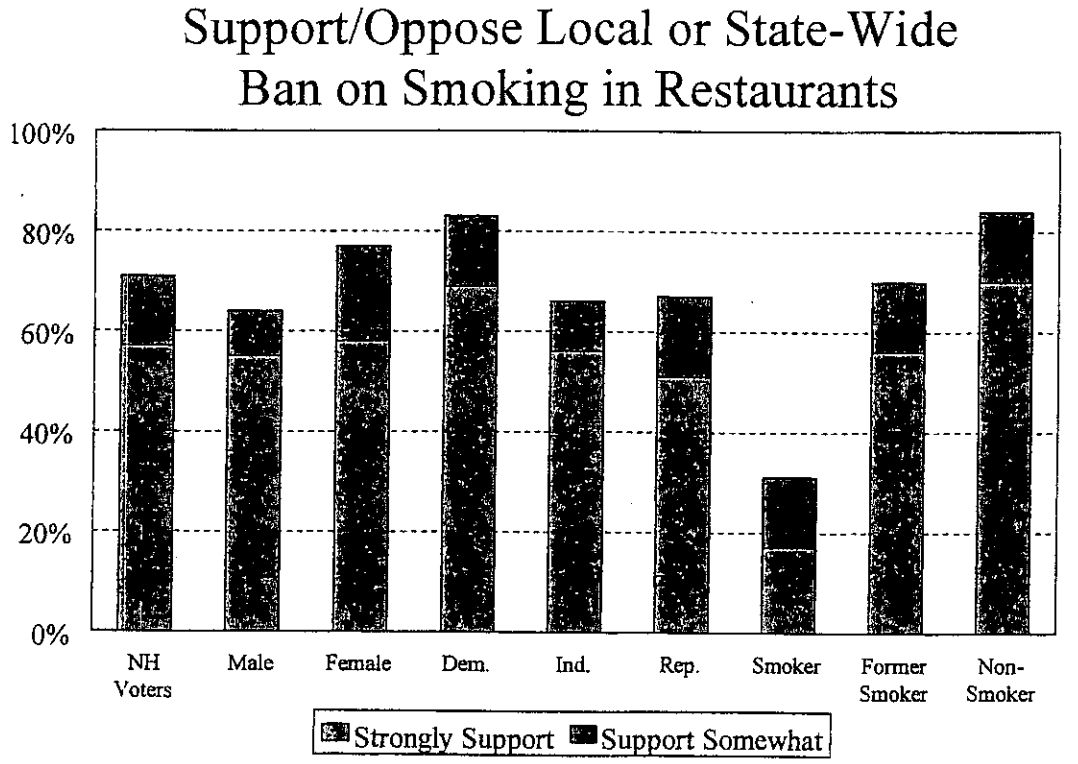
E9: "When dining out, would you ask for a smoking table ... a non-smoking table ... or the first table available?" (N = 402)



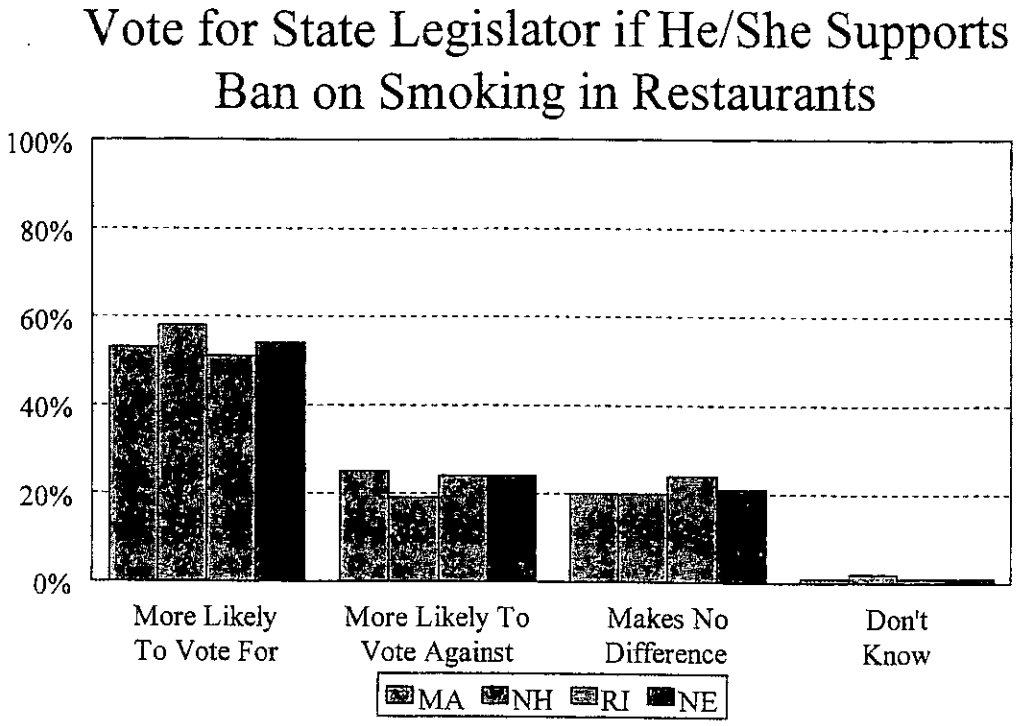


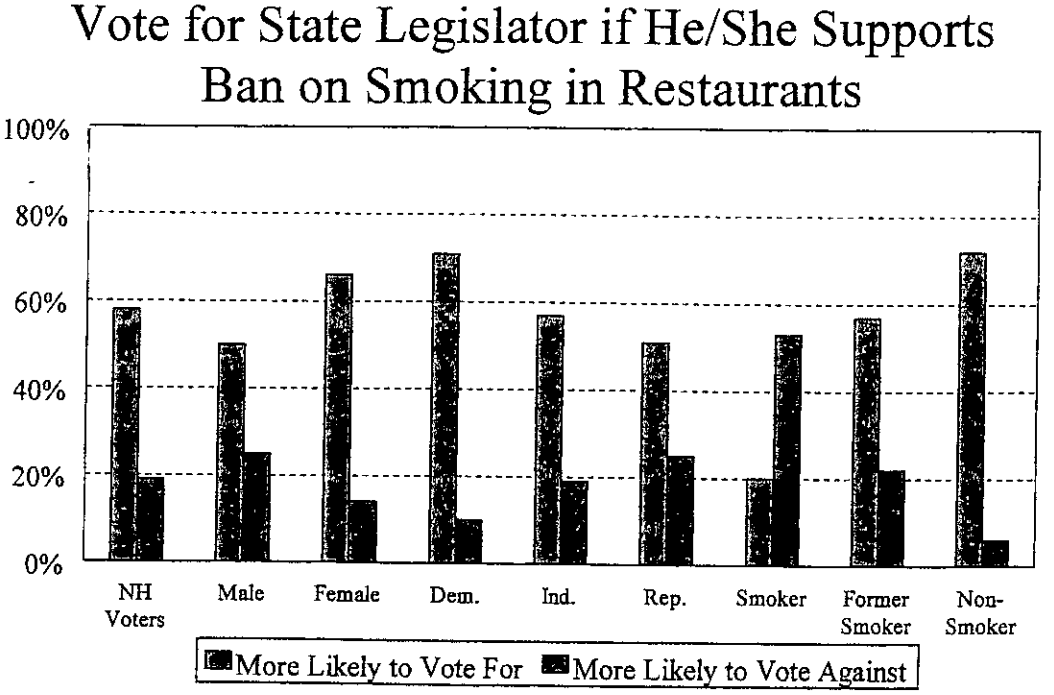
E12: "Would you support or oppose a local or state-wide ban on smoking in restaurants in your town or city?" (N = 402)



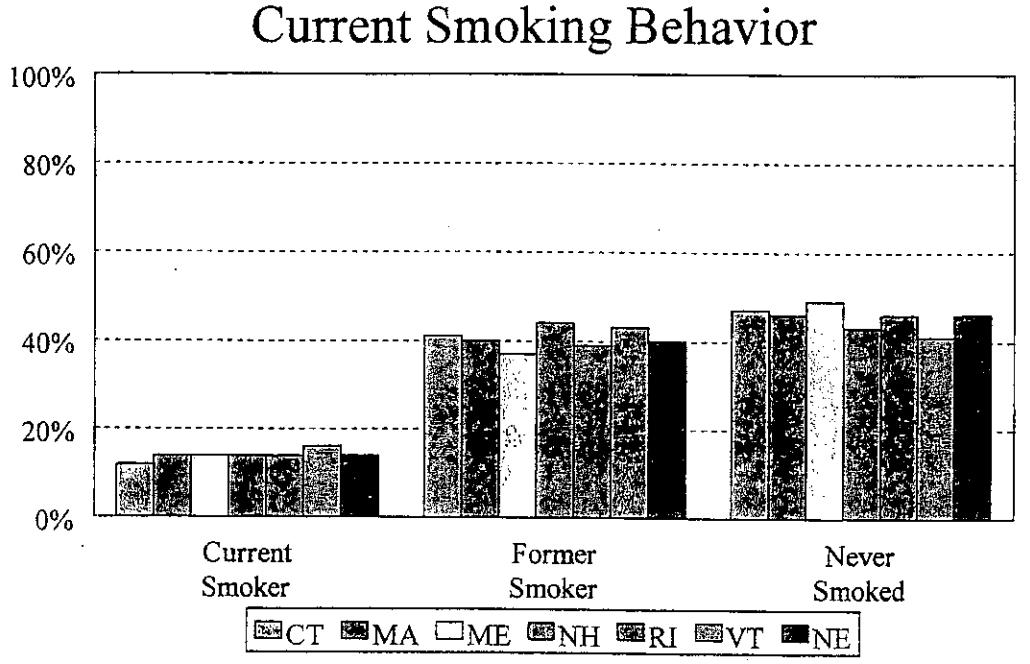


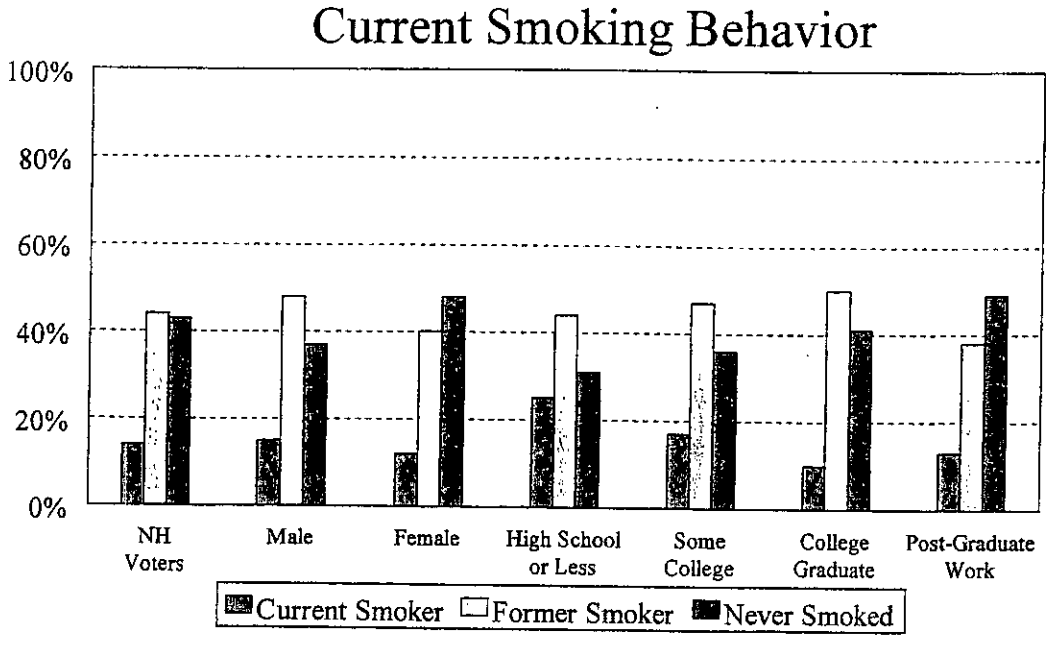
E13: "Suppose a State Legislator favored a law which banned smoking in all restaurants in New Hampshire ... would you be more likely to vote for or more likely to vote against a State Legislator who wanted to ban smoking in all restaurants in New Hampshire?" (N = 402)



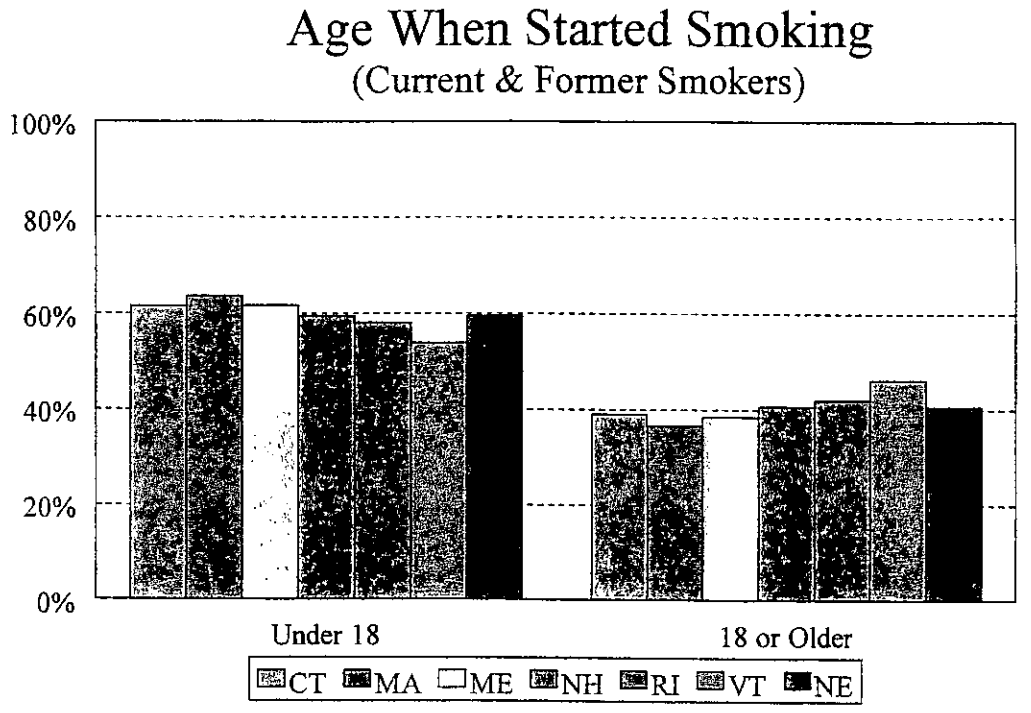


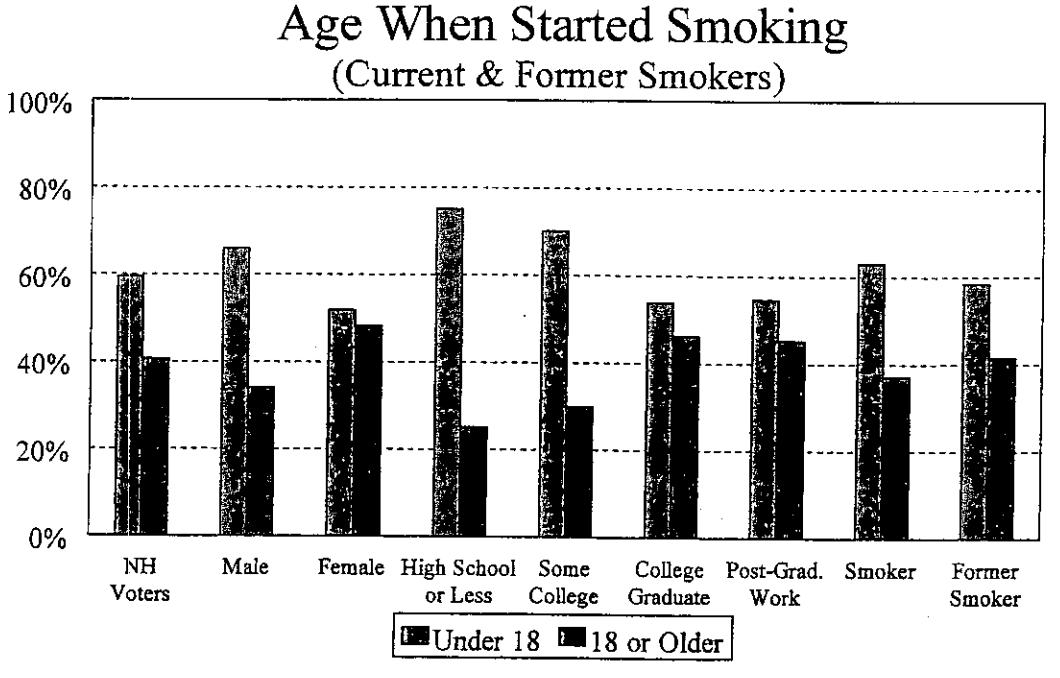
SB1: "Which of the following describes your use of tobacco products ... I currently smoke cigarettes or regularly use smokeless tobacco ... I USED to smoke cigarettes or regularly use smokeless tobacco, but I've quit ... or I have never been a cigarette smoker or used smokeless tobacco." DEFINITION OF SMOKELESS TOBACCO: "By smokeless tobacco, I mean such things as chewing tobacco or snuff." (N = 402)



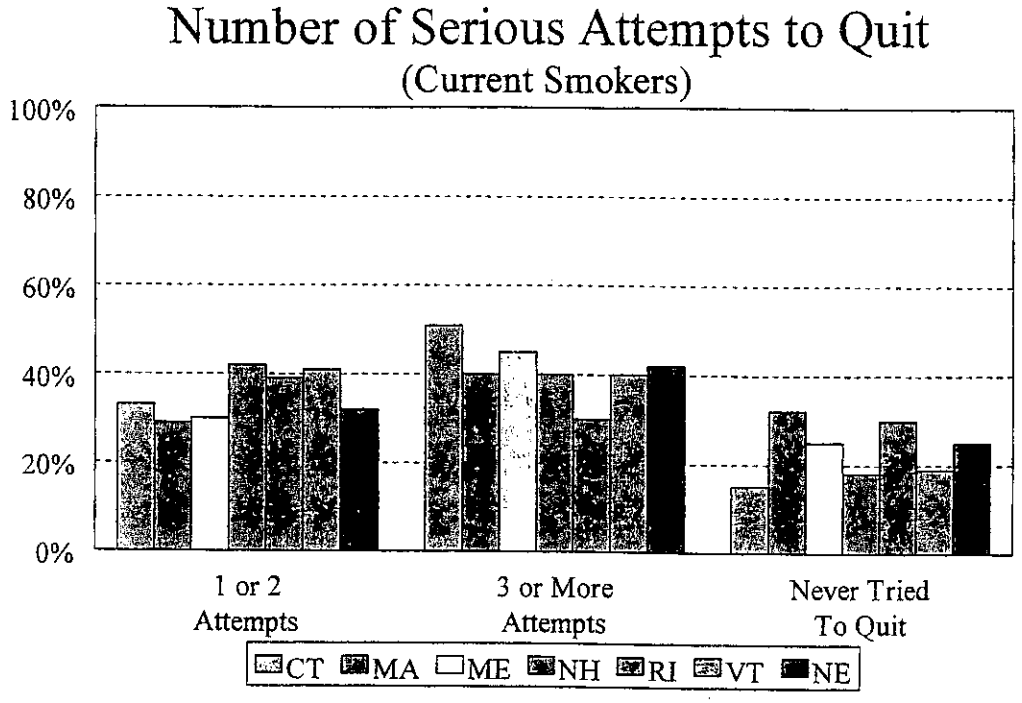


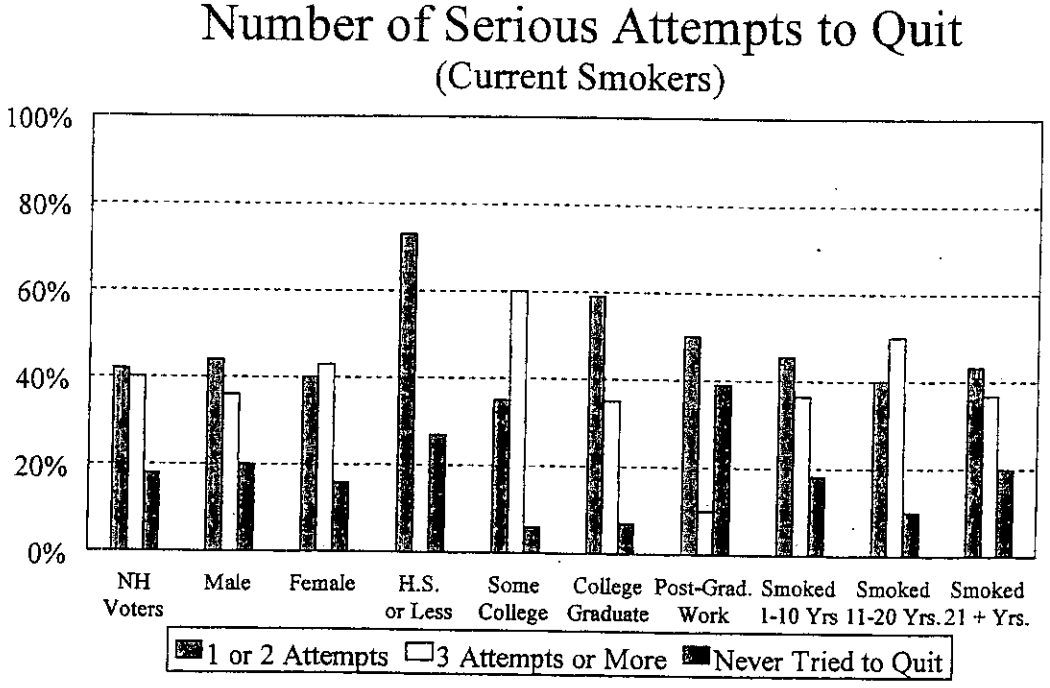
SB3: "How old were you when you first started smoking?" (N = 231)





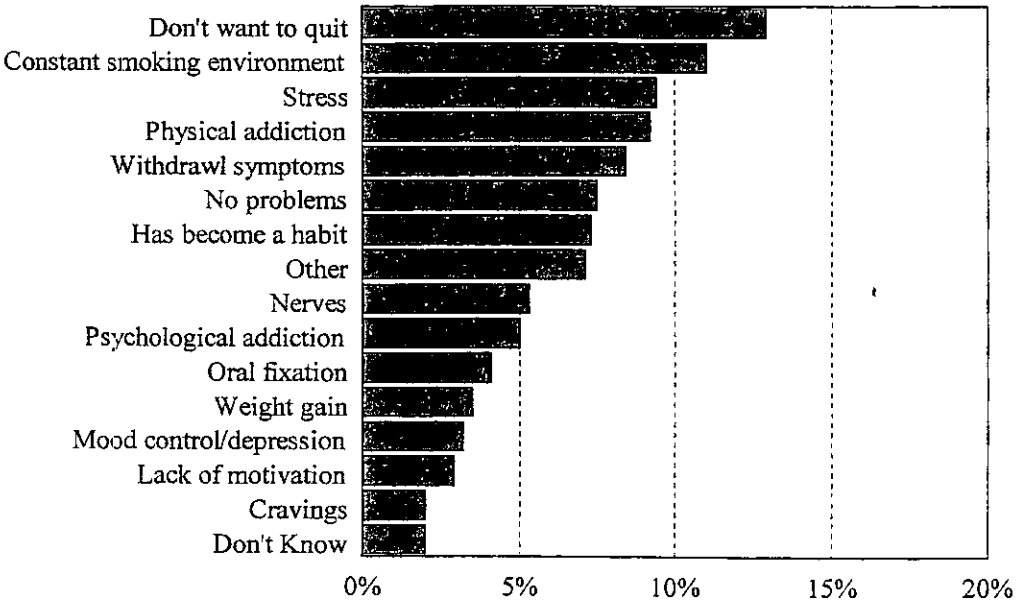
SB4: "Have you ever made a serious attempt to quit smoking?" IF YES: "How many times have you tried to quit smoking?" (N = 50)



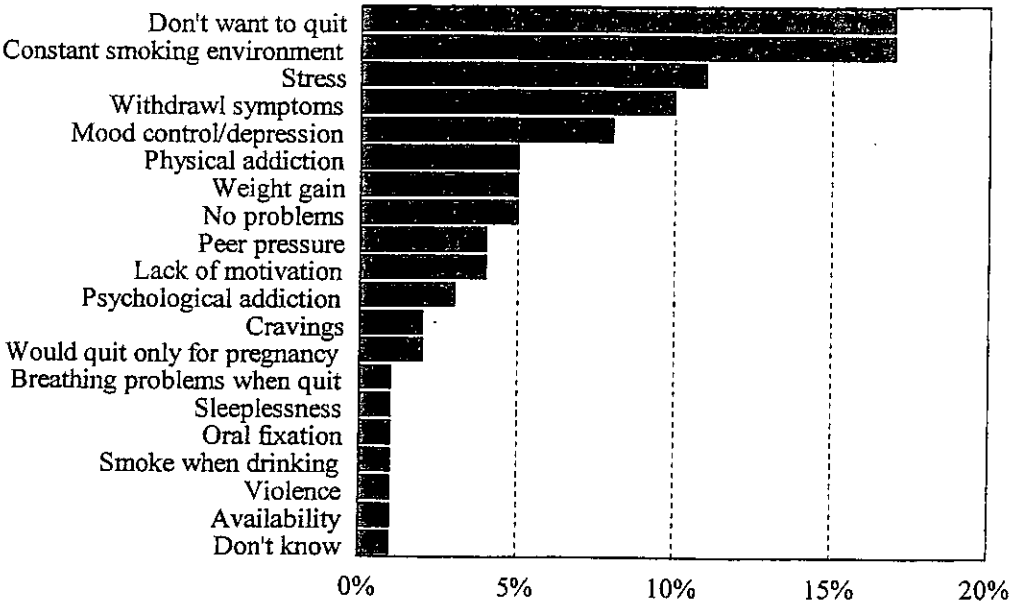


SB5: "What were the biggest problems you faced trying to quit smoking?" (N = 50)

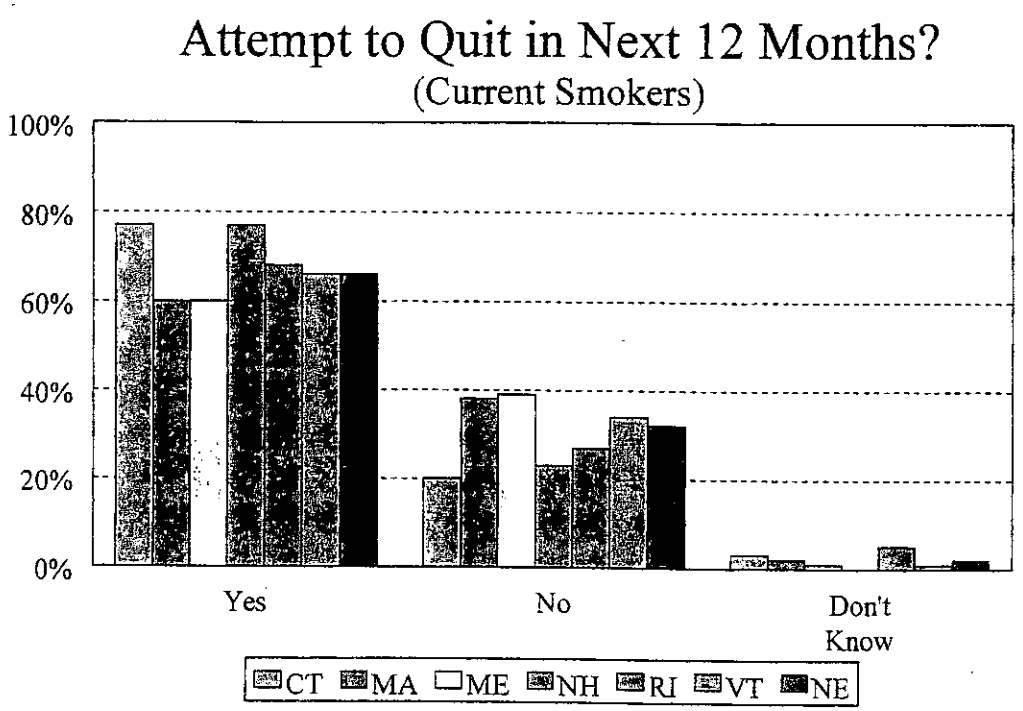
Most Important Difficulty When Trying to Quit Smoking
(All New England Smokers)

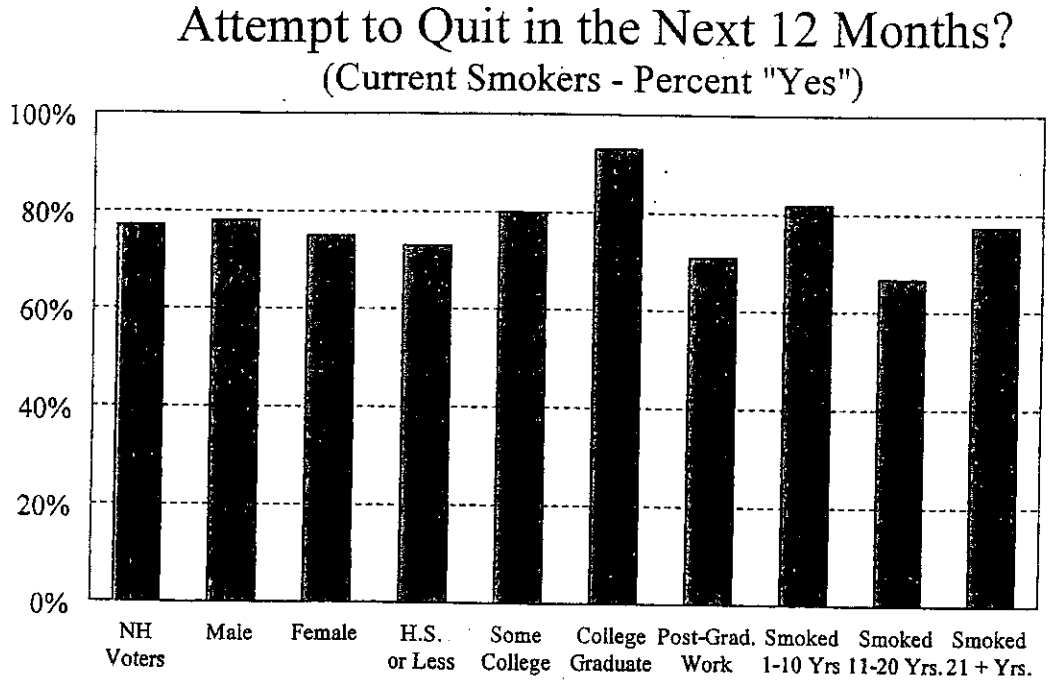


Most Important Difficulty When Trying to Quit Smoking
(NH Smokers)

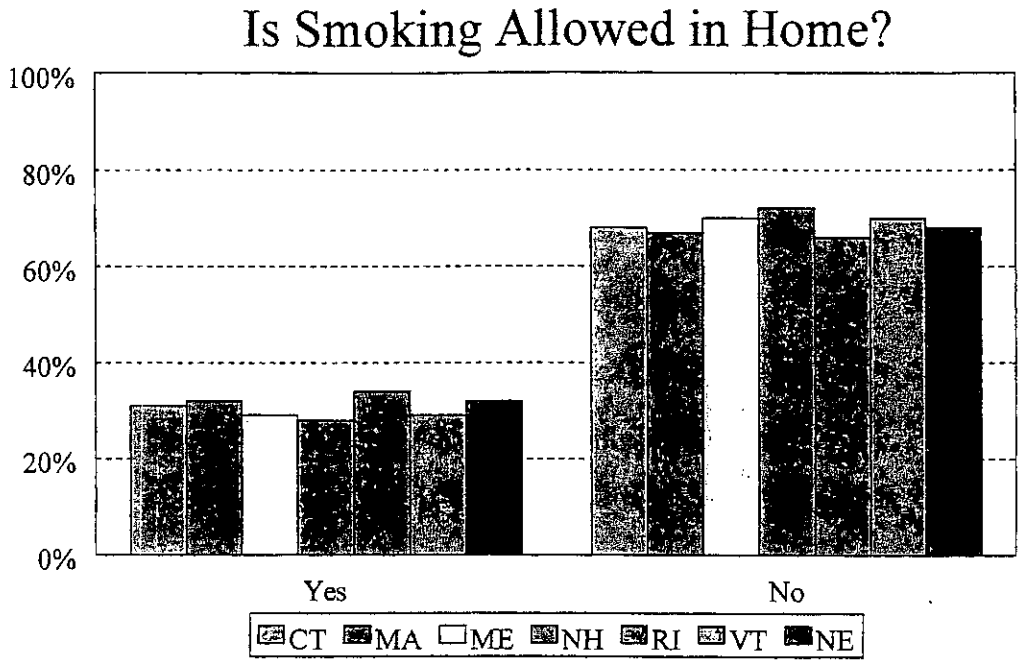


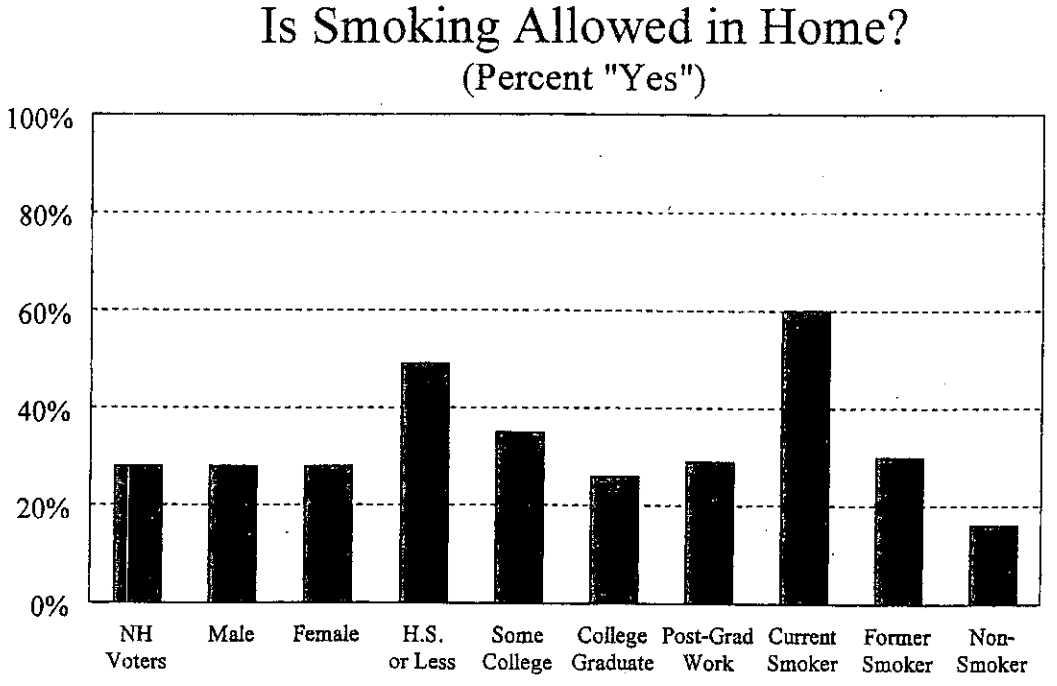
SB6: "Do you think that you will make a serious attempt to quit smoking in the next 12 months?" (N = 52)



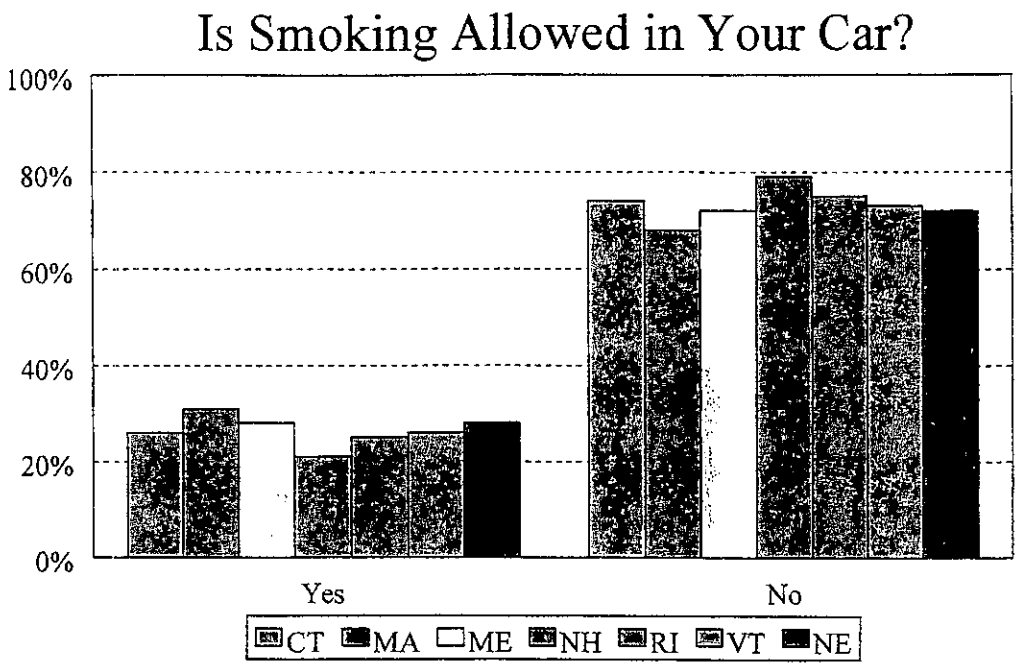


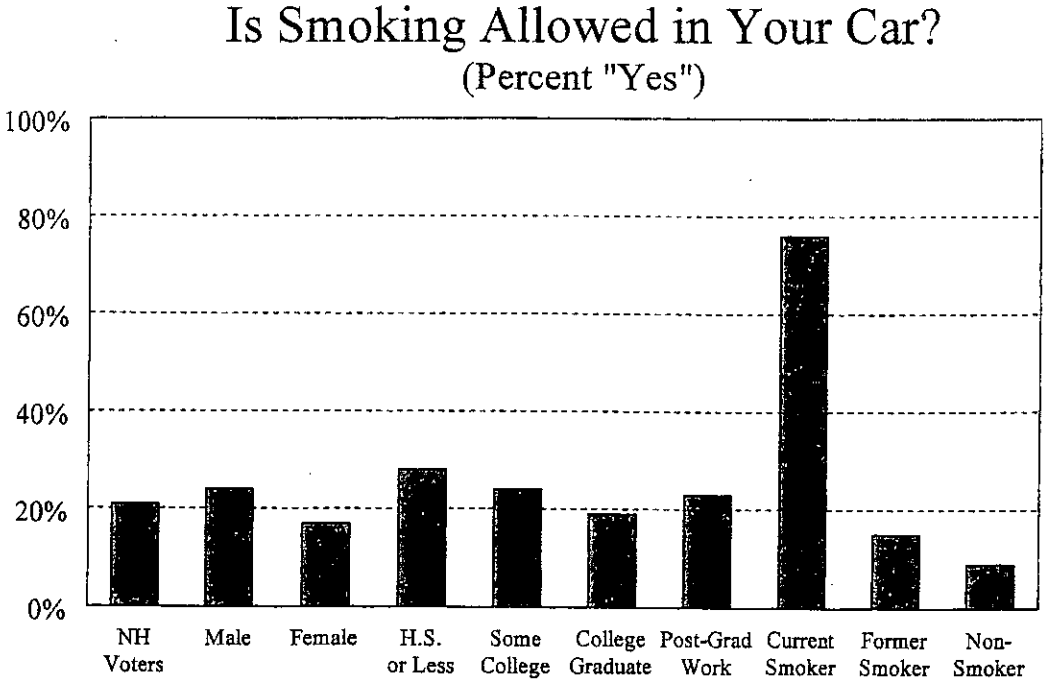
SB10: "Some households have rules about when and where people may smoke. Are people allowed to smoke inside your home?" (N = 398)





SB11: "Are people allowed to smoke inside your car?" (N = 397)





Voting Sheets

HOUSE COMMITTEE ON WAYS AND MEANS

EXECUTIVE SESSION on HB 762-FN-A

BILL TITLE: **increasing the tobacco tax to allow for a healthy families trust fund and for increased funding for the tobacco use prevention fund.**

DATE: 4/2/01

LOB ROOM: 202

Amendments:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Motions: OTP, OTP/A, ITL, ~~Interim Study~~ Retain (Please circle one.)

Moved by Rep. Lasky

Seconded by Rep. Dickenson

Vote: 16-0 (Please attach record of roll call vote.)

Motions: OTP, OTP/A, ITL, Interim Study (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote: (Please attach record of roll call vote.)

CONSENT CALENDAR VOTE:

(Vote to place on Consent Calendar must be unanimous.)

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep. Vivian R. Clark, Clerk

OFFICE OF THE HOUSE CLERK

2001 SESSION

WAYS AND MEANS

Bill #: HB 762-FN-A Title: _____

PH Date: ___/___/___ Exec Session Date: 4/12/01

Motion: retain Amendment #: _____

MEMBER	YEAS	NAYS
Alukonis, David J, Chairman	16	
Major, Norman L, V Chairman	1	
Clark, Vivian R	2	
Dickinson, Howard C	3	
McRae, Karen K	4	
Eaton, Stephanie	5	
Hess, David W		
Langone, John S	6	
Pappas, Marc P	7	
Sapareto, Frank V		
Camm, Kevin L		
Gilbert, Jeffrey D	8	
Giuda, Robert J	9	
Konys, Christine M	10	
Cote, David E	11	
Almy, Susan W	12	
Bradley, Paula E		
Downing, Michael W	13	
Lasky, Bette R	14	
McGuirk, Paul A	15	
TOTAL VOTE:	16 – 0	

Printed: 12/27/2000

HOUSE COMMITTEE ON WAYS AND MEANS

EXECUTIVE SESSION on

BILL TITLE: HB 762

DATE: 12/11/01

LOB ROOM: 202

Amendments:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Motions: OTP, OTP/A, ITL, Interim Study (Please circle one.)

Moved by Rep. Camm

Seconded by Rep. Alukonis

Vote: 11-7 (Please attach record of roll call vote.)

Motions: OTP, OTP/A, ITL, Interim Study (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote: (Please attach record of roll call vote.)

CONSENT CALENDAR VOTE:

(Vote to place on Consent Calendar must be unanimous.)

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep. Vivian R. Clark, Clerk

OFFICE OF THE HOUSE CLERK

2001 SESSION

WAYS AND MEANS

Bill #: HB762 Title: _____

PH Date: ____/____/____ Exec Session Date: 12/11/01

Motion: ITL Amendment #: _____

MEMBER	YEAS	NAYS
Alukonis, David J, Chairman	11	
Major, Norman L, V Chairman	1	
Clark, Vivian R	2	
Dickinson, Howard C	3	
McRae, Karen K	4	
Eaton, Stephanie		
Hess, David W	5	
Langone, John S		1
Pappas, Marc P		
Sapareto, Frank V	6	
Camm, Kevin L	7	
Gilbert, Jeffrey D	8	
Giuda, Robert J	9	
Konys, Christine M		2
Cote, David E		3
Almy, Susan W		4
Bradley, Paula E		5
Downing, Michael W		6
Lasky, Bette R		7
McGuirk, Paul A	10	
	11-7	
TOTAL VOTE:		

Printed: 12/27/2000

Committee Report

COMMITTEE REPORT

COMMITTEE: **Ways and Means**

BILL NUMBER: **HB 762-FN-A**

TITLE: increasing the tobacco tax to allow for a healthy families trust fund and for increased funding for the tobacco use prevention fund.

DATE: December 11, 2001 CONSENT CALENDAR YES ☐ NO ☒

☐ OUGHT TO PASS

☐ OUGHT TO PASS WITH AMENDMENT

☒ INEXPEDIENT TO LEGISLATE

☐ REFER TO COMMITTEE FOR INTERIM STUDY
(Available only in second year of biennium.)

STATEMENT OF INTENT
(Include Committee Vote)

A majority of the committee felt that the objectives of this bill relative to teen smoking were certainly worthwhile. However, for the following reasons regarding the funding (a 50 cent increase to the cigarette tax), we voted ITL. Our cigarette sales are very high (per capita) due to the impact of cross border sales. Collateral damage primarily to border community businesses, and resulting state tax revenues, where not convincingly addressed. Damage such as lost business profits, rooms & meals, gasoline, beer and wine, and not to mention employment. Should Health and Human Services determine this program is a priority, they should first offer to incorporate the program and its associated costs in the department's budget with their other requests. This tax increase (96%) hits our low and moderate-income smokers the hardest. Those that can least afford it. In reality, this program will not reduce their reliance on smoking but will certainly lower their disposable income. And finally this bill will establish another dedicated fund.

Vote 11-7.

Rep. Kevin L. Camm
FOR THE COMMITTEE

Original: House Clerk
cc: Committee Bill file

USE ANOTHER REPORT FOR MINORITY REPORT

Ways and Means

HB 762-FN-A, increasing the tobacco tax to allow for a healthy families trust fund and for increased funding for the tobacco use prevention fund. **INEXPEDIENT TO LEGISLATE**

Rep. Kevin L. Camm for Ways and Means: A majority of the committee felt that the objectives of this bill relative to teen smoking were certainly worthwhile. However, for the following reasons regarding the funding (a 50 cent increase to the cigarette tax), we voted ITL. Our cigarette sales are very high (per capita) due to the impact of cross border sales. Collateral damage primarily to border community businesses, and resulting state tax revenues, where not convincingly addressed. Damage such as lost business profits, rooms & meals, gasoline, beer and wine, and not to mention employment. Should Health and Human Services determine this program is a priority, they should first offer to incorporate the program and its associated costs in the department's budget with their other requests. This tax increase (96%) hits our low and moderate-income smokers the hardest. Those that can least afford it. In reality, this program will not reduce their reliance on smoking but will certainly lower their disposable income. And finally this bill will establish another dedicated fund. **Vote 11-7.**

HB 644-FN-A-L

This bill was retained by the committee as a gambling bill vehicle. There are at least 5 new bills coming forth that we feel deserve consideration. The sponsor's concerns were that expanded gambling (should that occur) should not be an exclusive license to a chosen few and that there should be fair opportunity for the distribution of licenses to those that want to participate. These concerns can be addressed at the appropriate time with the upcoming bills.

Kevin L. Camm

HB 762-FN-A

A majority of the committee felt that the objectives of this bill relative to teen smoking were certainly worthwhile. However, for the following reasons regarding the funding (a 50 cent increase to the cigarette tax), we voted ITL: Our cigarette sales are very high (per capita) due to the impact of cross border sales. Collateral damage primarily to border community businesses, and resulting state tax revenues, where not convincingly addressed. Damage such as lost business profits, rooms & meals, gasoline, beer & wine, and not to mention unemployment. Should Health and Human Services determine this program is a priority, they should first offer to incorporate the program and its associated costs within the department's budget with their other requests. This tax increase (96%) hits our low and moderate income smokers the hardest. Those that can least afford it. In reality, this program will not reduce their reliance on smoking but will certainly lower their disposable income. And finally this bill will establish another dedicated fund.

Kevin L. Camm

HB 762, increasing the tobacco tax to allow for a healthy families trust fund and for increased funding for the tobacco use prevention fund.

This bill would increase the tobacco tax to raise monies to establish a healthy families trust fund and to increase funding of the tobacco use prevention fund. The committee voted unanimously to retain this bill in committee. This is a complex bill which deserves further study to address a number of critical health issues before us today and to further investigate the tobacco tax increases our neighboring states will enact.

VOTE 16-0.

Rep. Bette Lasky