MICROFILM DIVIDER

OMB/RECORDS MANAGEMENT DIVISION
SFN 2053 (2/85) 5M

ROLL NUMBER

2401

DESCRIPTION

2001 SENATE FINANCE AND TAXATION

SB 2401

2001 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. 2401

Senate Finance and Taxation Committee

❑ Conference Committee

Hearing Date 2/6/01

Tape Number	Side A	Side B	Meter #
1		x	0-31.3
2/7/01 - 2	x		46.3-end
		x	0-15.5

Committee Clerk Signature Lynette M. Kraft

Minutes:

Senator Urlacher: Opened the hearing on SB 2401, relating to the rate of tax on the sale of cigarettes.

Senator Judy Lee: Co-sponsored the bill, testifies in support. Others can explain it.

Murray Sagsveen: Community Healthcare Assoc., testified in support. Written testimony attached.

Senator Kroeplin: Are you currently getting any of the 10% of the tobacco money?

Murray Sagsveen: Last session that 10% was allocated into an account but no money was appropriated out of that 10%. It's just accumulating. This bill would not take any money out of that 10%, but would add a little bit to it.

Senator Kroeplin: How much money is in the 10%?

Murray Sagsveen: 5-6 million per biennium.

Senator Wardner: According to OMB, it's about 5.3 million that's sitting in that fund.

Guy Tangedal: Family Physician, testified in support. Shared some experience of his practice. This bill is the step in the right direction of giving a break to some of the people that need it the most.

Tim Cox: President of Northland Healthcare Alliance, testified in support. There's been a number of things happening in recent years that have made access to health care for the uninsured and underinsured even more difficult and it's made it more difficult for us to provide service also. This bill will help to provide another avenue to help those people that don't have coverage.

Mary Muhlbradt: Fledgling Free Clinic in Minot, testified in support. The City & Country Health Clinic provides free service. 25% of our patients are from rural communities. We operate solely on a volunteer basis. People without health insurance often put off getting medical help. This bill would be wonderful for our state.

Sheralyn Dahl: ED of Family Health Care Center in Fargo, testified in support. Gives some statistics of uninsured patients that use their clinic. Explains sliding fee scale. The most important impact that this bill can have is to ease the burden of suffering & worry that people are facing today. It is an incremental effort, but it's one in the right direction.

Others signed the roster in support & opposition.

Henry Knoll: Frank McKone Cigar in Fargo, testified in opposition. If this passes, the state of ND may lose tax revenue to the state of MN because of the difference in price of cigarettes.

Bruce Kaiser: Testifying as a taxpayer, testified in opposition. It's for a wonderful cause but it's a targeted tax.

Alan O'Neil: Dept. Of Family Medicine, UND, testified in opposition. My feelings reflect those of Dr. William Mann, Chairman of the Dept. Of Family Medicine. The primary function of our residency program is education, not service to the uninsured.

Jeff Schwan: Schwan Wholesale, testified in opposition. I agree that it's a wonderful program, but my main concern is cigarette sales are already dropping and this would raise the tax even more.

Clayton Jensen: President of Community Health Center in Fargo, testified in support. The family practice centers are not required to accept this funding.

Senator Urlacher: Closed the hearing. Action delayed.

Discussion held 2/7/01. Meter number 46.3-end, Side A & 0-15.5, Side B.

Jenny Witham: Community Healthcare Assoc., appeared to clarify some things and to explain the similar bill in the House.

COMMITTEE ACTION: 2/7/01

Motion made by Senator Stenehjem for a DO NOT PASS, Seconded by Senator Kroeplin. Vote was 5 yeas, 1 nay, 0 absent and not voting. Bill carrier was Senator Nichols.

FISCAL NOTE

Requested by Legislative Council

01/30/2001

Bill/Resolution No.: SB 2401

Amendment to:

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	1999-2001 Biennium		2001-2003 Biennium		2003-2005 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues				$1,726,000		
Expenditures						
Appropriations						

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

1999-2001 Biennium			2001-2003 Biennium			2003-2005 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2. **Narrative:** *Identify the aspects of the measure which cause fiscal impact and include any comments relevant to your analysis.*

SB 2401 increases the tax on cigarettes by $.02 per package.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

SB 2401 is expected to generate $1,726,000 for the community health trust fund.

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, of the effect on the biennial appropriation for each agency and fund affected and any amounts included in the executive budget. Indicate the relationship between the amounts shown for expenditures and appropriations.*

Name:	Kathryn L. Strombeck	**Agency:**	Tax Department
Phone Number:	328-3402	**Date Prepared:**	02/05/2001

Date: 2/7/01
Roll Call Vote #: 1

2001 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2401

Senate Finance and Taxation Committee

☐ Subcommittee on _____
or
☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken DO NOT PASS

Motion Made By Stenehjem Seconded By Kroeplin

Senators	Yes	No	Senators	Yes	No
Senator Urlacher-Chairman	✓				
Senator Wardner-Vice Chairman		✓			
Senator Christmann	✓				
Senator Stenehjem	✓				
Senator Kroeplin	✓				
Senator Nichols	✓				

Total (Yes) 5 No 1

Absent 0

Floor Assignment Nichols

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE (410)
February 8, 2001 8:40 a.m.

Module No: SR-23-2663
Carrier: Nichols
Insert LC: . Title: .

REPORT OF STANDING COMMITTEE

SB 2401: Finance and Taxation Committee (Sen. Urlacher, Chairman) recommends **DO NOT PASS** (5 YEAS, 1 NAY, 0 ABSENT AND NOT VOTING). SB 2401 was placed on the Eleventh order on the calendar.

2001 TESTIMONY

SB 2401

Testimony – In Favor of S.B. 2401

Senate Finance and Tax Committee – February 6, 2001 – 9:45 AM

John R. Baird, MD

I am John Baird, a family physician from Fargo. I am Medical Director of the Family HealthCare Center and Program Director of the UND Family Practice Residency.

I grew up in Dickinson and have lived in North Dakota most of my life. I realize that the people of our state are hard working. We make due with what we have and only ask for help when absolutely necessary.

As a doctor I now understand the importance of routine, regular health care, including preventive care, which includes immunizations, and early detection of diseases such as cancer, diabetes, hypertension, and heart disease.

There are many people in our state that do not have health insurance. These include individuals and families who earn enough to live, eat, and have shelter, but not enough to pay the high cost of health insurance. They include young families starting out, people working several part time jobs with no benefits, self-employed individuals, and woman whose husbands have retired, but they are not old enough yet for Medicare. These people don't qualify for Medicaid and can't afford health insurance. So they make due and avoid medical care until they absolutely have to.

I have practiced in North Dakota for 22 years and have seen many individuals who could not afford to take care of their health. They don't have annual exams, don't get tests done for disease detection, and don't take needed medications. It has been frustrating for me to see patients, make recommendations they can't afford, and then to know that the patients are not able to do the best they should for their health.

In the last five years, practicing at the Family HealthCare Center, with a sliding fee scale available for patients, it has been more satisfying to be able to help people. One example of a medical condition we are working with is diabetes. There have been very good studies done that show early detection and vigorous treatment of diabetes are necessary to prevent serious complications such as peripheral vascular disease leading amputation, kidney problems leading to dialysis and transplantation, and heart disease.

At the Family HealthCare Center we are following over 350 individuals with diabetes. Over half of them are on our sliding fee scale. With frequent office visits, education, laboratory work, and vigorous treatment, we have been able to work with these patients to screen them for prevention of major complications, improve their treatment compliance, and their understanding of their disease. Without a sliding fee scale these patients would not have come to the office as frequently, would not have been able to afford their care, and could very likely develop more severe and costly complications.

I speak in support of this bill as an excellent opportunity for the state of North Dakota to care for our citizens in need. Thank you for your time and your thoughtful consideration of **S.B. 2401**. I ask that you vote for a **"do pass"** on this bill.

Testimony on SB 2401
Regarding a Tax on Tobacco Products to Fund a Primary Care Grant Program
before the
Senate Committee on Finance and Taxation
by
Darleen Bartz, Department of Health
February 6, 2001

Good Morning Chairman Urlacher and members of the Committee, I am Darleen Bartz, Chief of the Preventive Health Section of the state Department of Health. I am here to present testimony on SB 2401 which imposes an additional tax on cigarettes and provides that all revenue received from this additional tax of one mill per cigarette must be deposited in the Community Health Trust Fund. Because this tax and grant program is not included in the Governor's budget, this testimony is neither in support of nor in opposition to this bill.

Studies indicate that an increase in the price of tobacco products will lead to a decrease in the sale of those products. However, given the modest increase in the cigarette tax specified by SB 2401, one mill per cigarette, it is not possible to estimate with any specificity the effect of this legislation on tobacco consumption.

Section 2 of the bill provides an appropriation of $1 million from the Community Health Trust Fund to the State Department of Health for the purpose of providing "grants for primary health care to community clinics offering a sliding fee scale and demonstrating a commitment to serve a disproportionate share of low income uninsured and underserved populations in both rural and urban North Dakota." Previous surveys conducted by or on behalf of the Department of Health indicate that approximately 8.6 percent of the residents of North Dakota are not covered under any government or private health insurance plan. These surveys also indicate that some people with health insurance have large deductibles that do not provide coverage for ordinary primary care services. The goal of this legislation is to provide some measure of access to health care, primarily to low income working families and individuals whose income exceeds the eligibility limits for Medicaid, or in the case of children, the Healthy Steps program.

Turning to the specific provisions of section 2 regarding a grant program for community health clinics, the Department of Health believes it might be useful to define "primary health care," "community clinics," "sliding fee scale" (perhaps with specified income limits), and "uninsured and underinsured" individuals. Defining these terms, as well as indicating whether there is any limit on the amount of funding that may be provided to a single community clinic, would help to direct the Department's efforts, if this program is established.

Mr. Chairman this completes my testimony. I would be pleased to answer any questions you or your Committee members have regarding this legislation.

Testimony on Senate Bill 2401
before the
Senate Finance and Tax Committee
by
Murray G. Sagsveen
for the
Community HealthCare Association
February 6, 2001

1. Introduction

I am Murray G. Sagsveen. I represent the Community HealthCare Association and am submitting this testimony in support of Senate Bill 2401, which would provide funding to provide additional "safety net" healthcare to the uninsured and underinsured in North Dakota.

The Community HealthCare Association is a nonprofit corporation in North Dakota and South Dakota, established "to provide a network for advocacy and support services to member organizations whose purpose is to provide primary health care to the medically underserved residents of North and South Dakota."[1] The Association is primarily funded by grants from federal agencies and private foundations. The North Dakota Director is Jenny Witham, 311 North Washington, P.O. Box 1734, Bismarck, ND 58502-1734 (telephone 221-9824, fax 258-3161).

My testimony will explain that we should take additional steps to protect the health of North Dakotans, that approval of this bill would be a positive step in that direction, and this bill includes a method of funding the effort.

2. We should take additional steps to protect the health of our children.

Recent scientific studies have explained the adverse health consequences if children are uninsured. These consequences were eloquently summarized in a foreword by the president of the American College of Physicians – American Society of Internal Medicine to a recent study titled *No Health Insurance? It's Enough to Make you Sick*:[2]

> Uninsured Americans are far less likely to have a regular source of care or to have recently seen a physician. They are more likely to delay seeking care, even when ill or injured, and more likely to report unmet medical needs. They are more likely to forego even those services that many of us take for granted, such

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[1] Quoted from the mission statement of the Community HealthCare Association (see http://www.communityhealthcare.net).
[2] The study was completed by the American College of Physicians – American Society of Internal Medicine. See http://www.acponline.org/uninsured/lack-fore.htm.

as annual exams, well-child care visits, prescription drugs, eyeglasses, or dental care.

As a result of this reduced access to care, uninsured Americans are more vulnerable to adverse health outcomes. Because uninsured Americans do not have the same access to care, they are more often hospitalized for conditions, such as diabetes, hypertension, pneumonia, or ulcers, that the insured are able to manage as outpatients through physician care or medications. Uninsured Americans are more often diagnosed with cancer at a later stage and, as a result, suffer a lower survival rate.

Uninsured children are much less likely to receive medical care for normal childhood illnesses, such as a sore throat, an earache, or asthma. They are also less likely to receive recommended childhood immunizations. Even if an uninsured child suffers a serious illness or injury, such as appendicitis or a broken bone, they are often unable to seek medical care.

Evidence from these studies indicates that reduced access to care and poorer medical outcomes do not affect only the chronically uninsured. Even those with gaps in coverage – as short as one month or as long as a year or more – are less likely to seek care, pursue preventive care, or even to have prescriptions filled.

A lack of insurance is not simply an inconvenience. It is a real barrier to access and definitely contributes to poorer health. With 44 million Americans uninsured, and 100,000 more added to their ranks each month, their vulnerability to poorer health has reached epidemic proportions.

Lack of insurance is a public health risk that results in poorer health and earlier death. Ensuring that all Americans have health insurance can reduce the total burden of illness facing the United States.

Many North Dakota families do not have access to adequate healthcare for two basic reasons: they are uninsured or are underinsured.

There have been several recent estimates concerning the number of uninsured in North Dakota:[3]

- A 1994 survey funded by the Robert Wood Johnson Foundation indicated that approximately 9.9 percent of North Dakota's population was uninsured.
- A 1998 survey, also funded by the Robert Wood Johnson Foundation, concluded that 8.6 percent of the state's residents were uninsured.

[3] See the testimony of Alana Knudson-Buresh, Ph.D., before the Interim Budget Committee on Health Care at http://www.health.state.nd.us/testimony/interim/FarmHealthTestimony062700.pdf for additional information about the estimates of uninsured residents of North Dakota.

- Also in 1998, the U.S. Bureau of the Census estimated (using the Current Population Survey, a survey designed to provide national estimates) that 16 percent of the nation's population was uninsured.
- In early 2000, the Department of Health and the Community HealthCare Association contracted with the North Dakota Agricultural Statistics Services to conduct a random survey of 1,571 farm and ranch households to determine health insurance coverage in the agricultural community. When almost 90 percent of the farm and ranch operators responded, we learned that about six percent of the households have no health insurance.

Based on the 1998 RWJF survey, we may be able to assume that about 8.6% (642,200[4] residents x 8.6% = 55,200 uninsured) of North Dakota residents currently do not have health insurance coverage (approximately the population of Bismarck). The Healthy Steps and other similar programs may have reduced this number, but many North Dakotans still remain uninsured.

However, even families with health insurance may not have access to adequate medical care – the underinsurance issue. For example, a family with a high deductible, high co-payment requirements, and low co-insurance provisions may not be able to afford necessary health care.

There are several volunteer free clinics that provide limited safety net health care in this state, but these organizations do not have the funds to provide the necessary primary and preventive health care to the uninsured and underinsured in those cities.

There are also several government-funded organizations that do not have adequate funds to provide necessary preventive and primary health care to the uninsured and underinsured in North Dakota, including:

- the regional campuses of the University of North Dakota School of Medicine and Health Sciences; and
- the Fargo Family Health Care Center.

Private medical facilities also provide non-reimbursed care to the uninsured and underinsured.

However, is it realistic to expect volunteer clinics and private or public facilities to continue to provide uncompensated medical care to an estimated 64,000 North Dakotans year after year?

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[4] Preliminary 2000 census information. See http://www.census.gov/dmd/www/resapport/states/northdakota.pdf.

3. The initiatives in this bill will be positive steps toward protecting the health of our children.

No single approach will solve the challenge of improving the health of North Dakotans. However, this bill could have a significant positive impact.

The proposed legislation would appropriate $1,000,000 to the Department of Health to provide grants for additional medical care to uninsured and underinsured residents. Such an appropriation could provide $125,000 in each quarter of the state per year for necessary medical care.

The potential applicants for grants could include many existing organizations, such as:

- the volunteer free clinics;
- the non-profit or for-profit hospitals and clinics that make a commitment to provide safety net care;
- the UND School of Medicine and Health Science clinics located in the major cities; and
- the Fargo Family HealthCare Center.

It is important to point out that the healthcare would not be free. Instead, the grantees would adopt a sliding fee scale that would leverage the appropriated dollars and ensure that the fee would be based on an ability to pay. Sherlyn Dahl, administrator of the Fargo Family HealthCare Center, will testify about the sliding fee scale currently used in that clinic.

4. This bill includes a method of funding the proposed initiatives.

The bill would impose an additional 2¢ excise tax on each pack of cigarettes sold in North Dakota to pay for this program *and* the supplement the 10 percent of the tobacco settlement money allocated to the community health trust fund.

To put this 2¢ per pack increase in perspective, it is my understanding that the tobacco manufacturers increased the wholesale price of a pack of cigarettes by an additional 14¢ on December 15, 2000 – seven times more than the excise tax increase requested in this bill.

Information about the current federal and state excise taxes on cigarettes sold in North Dakota, along with information about the revenue to the state's general fund, is attached to this testimony.

We realize that cigarette sales have declined since the tax was increased from 29¢ to 44¢ per pack in 1993[5] and that cigarette sales for calendar years

[5] The attached chart, which is based on the table at page 87 in the Tax Department's "Red Book," illustrates an 11% decline in revenue over an 8 year period, or approximately 1.5% each year.

1999 and 2000 have decreased 8.9% (see the attached chart).[6] Therefore, a decrease in cigarette sales next biennium is likely.

We also realize that some interests may oppose increasing the state tax on cigarettes. However, scientific studies indicate an increased tax, even a very modest 2¢ per pack tax increase, may have a secondary beneficial impact of decreasing the number of cigarettes that are purchased and smoked in North Dakota.

5. Conclusion.

Enactment of this bill will have a positive effect on the health of North Dakotans. Therefore, the Community HealthCare Association urges this committee to vote a "do pass" to Senate Bill 2401.

Murray G. Sagsveen
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Lobbyist #309

[6] The number of cigarettes sold in ND declined 3.7% in 1999 and 5.4% in 2000; the average decline in sales during 1999-2000 was 8.9%.

Attachments

1. Federal excise tax

The current federal excise tax is 34¢ per pack, and will increase to 39¢ per pack in January 2002.

2. State excise tax

Information about the state excise tax is attached. The information is from two sources:

a. *State and Local Taxes: An Overview and Comparative Guide 2000* [The "Red Book"], North Dakota Tax Department.
b. Campaign for Tobacco-Free Kids, www.tobaccofreekids.org.

CAMPAIGN FOR TOBACCO FREE KIDS

U.S. CIGARETTE COMPANY PRICE INCREASES 1994-2000
(Compared to Federal Cigarette Tax & Retail Prices)

Date of Change	Price Per Pack (wholesale, pre-tax)	Federal Tax (per pack)	Average Retail Price (including federal & state taxes)
November , 1993	$0.88	$0.24	$1.69
November , 1994	$0.88	$0.24	$1.76
May 1995	$0.91	$0.24	NA
November , 1995	$0.91	$0.24	$1.80
May 1996	$0.95	$0.24	NA
November , 1996	$0.95	$0.24	$1.85
March 1997	$1.00	$0.24	NA
September 1997	$1.07	$0.24	NA
November , 1997	$1.07	$0.24	$1.95
January 1998	$1.09	$0.24	NA
April 1998	$1.14	$0.24	NA
May 1998	$1.19	$0.24	NA
August 1998	$1.25	$0.24	NA
November 1998	$1.25	$0.24	$2.18
November 23, 1998	$1.70	$0.24	NA
August 1999	$1.88	$0.24	NA
November 1999	$1.88	$0.24	$2.92
January 2000	$2.01	$0.34	NA
August 2000	$2.07	$0.34	NA
December 2000	$2.21	$0.34	NA

Sources: Economic Resource Service, U.S. Department of Agriculture, Tobacco Briefing Room, www.ers.usda.gov/Briefing/tobacco; and cigarette company press announcements. Average retail cigarette prices, including generic brands, from *The Tax Burden on Tobacco* (2000).

Wholesale cigarette prices are the prices charged by the cigarette companies to wholesalers and distributors. Wholesale prices are for regular packs of the leading brands. A 3-percent discount to wholesalers is typically made for payment within 10 days or 2 percent within 14 days. Wholesale cigarette prices do not include federal taxes, which are levied when the cigarettes are sold by the manufacturers. Nor do they include wholesaler or retailer price mark ups, or state or local cigarette or sales taxes. The average retail prices are for all brands, including generics, and the prices include all taxes but do not include special discounts, coupons, and the like that may apply at the retail level (but are frequently financed by the manufacturers), and which reduce final prices to consumers. Wholesale cigarette price increases tend to produce slightly larger increases in retail cigarette prices. The federal cigarette tax is scheduled to increase by five cents per pack on January 1, 2002.

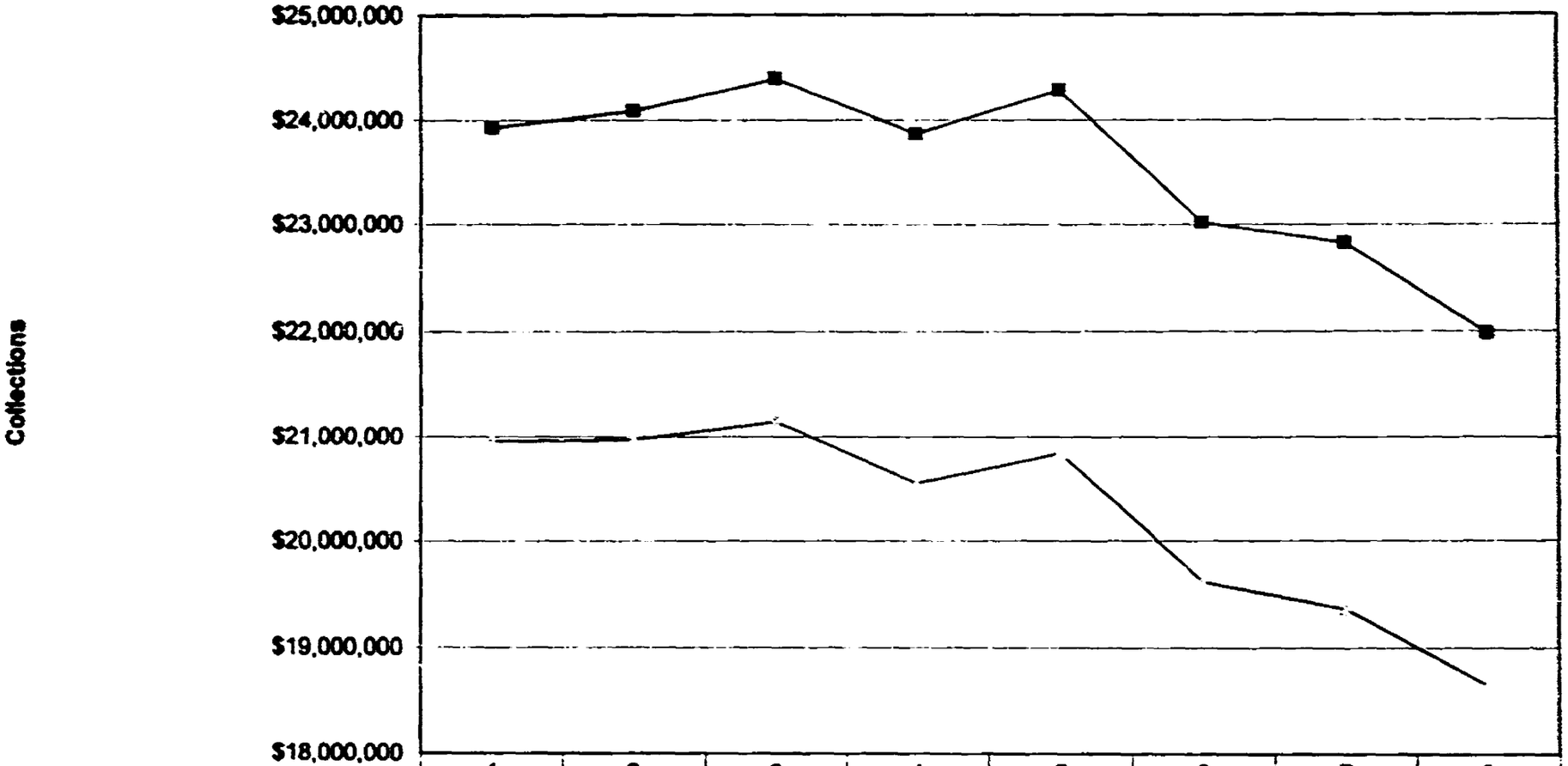
Related Campaign Fact Sheets (available at www.tobaccofreekids.org)

- *U.S. Cigarette Companies' Settlement-Related Price Hikes Are Excessive*
- *Increasing the Federal Cigarette Tax Reduces Smoking (and the Cigarette Companies Know It)*
- *State Cigarette Tax Rates*

The National Center for Tobacco-Free Kids, December 20, 2000

1707 L Street, NW Suite 800 Washington, DC 20036
Phone (202) 296-5469 Fax (202) 296-5427 www.tobaccofreekids.org

Tobacco-Related Tax Collections



	1	2	3	4	5	6	7	8
Year	1994	1995	1996	1997	1998	1999	2000	2001
Total Collections	$23,932,732	$24,093,508	$24,403,150	$23,872,859	$24,293,434	$23,026,300	$22,825,622	$21,987,000
Cigarette Tax (General Fund)	$20,958,608	$20,974,207	$21,149,970	$20,554,980	$20,846,708	$19,619,122	$19,359,086	$18,657,000

Years

Source:
ND Tax Department (Red Book, p. 87)
Aug)00

CIGARETTE AND TOBACCO TAXES

CURRENT LAW

Cigarette Tax

Imposition and Rates

The cigarette tax is levied at two different tax rates. Cigarettes weighing less than three pounds per thousand are taxed at 22 mills per cigarette or 44¢ for a common package of 20, and 55¢ for a package of 25. Cigarettes weighing more than three pounds per thousand are taxed at 22½ mills per cigarette. Gray market or repatriated cigarettes may not be sold or possessed in North Dakota. All cigarettes sold must be in packages of 20 or more cigarettes.

Roll your own cigarette tobacco is taxed at the cigarette rate. One cigarette equals .09 ounces of roll your own tobacco. Sales of bulk roll your own cigarette tobacco are converted to taxable cigarettes. Only tobacco advertised as roll your own is taxed at the cigarette rate.

, wholesalers and dealers must be licensed by the Attorney General. Wholesalers pay the tax with monthly reports filed with the State Tax Commissioner. For administrative compensation, wholesalers who file and pay on time may deduct 1½% of the tax due, up to a maximum of $100 per month.

Distribution of Revenue

Three cents of the 44¢ per package are distributed to the cities based on population and the remainder goes to the State General Fund. Of the 55¢ on the larger packages, 3¾¢ go to the cities with the remainder to the State General Fund.

Reference: North Dakota Century Code ch. 57-36.

Tobaccco Products Tax

Imposition and Rates

All tobacco products other than cigarettes and specific roll your own tobacco, such as pipe tobacco, chewing tobacco, cigars, cigarette papers and snuff, are subject to a tobacco products tax. The tax rate is twenty-eight percent of the wholesale purchase price. The tobacco products tax is administered in a manner similar to the cigarette tax.

Distribution of Revenue

Revenue from the tobacco products tax is placed in the State General Fund.

Reference: North Dakota Century Code ch. 57-36

Tribal Cigarette And Tobaccco Tax

The Standing Rock Sioux Tribe levies a cigarette and tobacco tax on all American Indian retailers operating in the Standing Rock Sioux Reservation. The tax rates are identical to the state tax rates. The State Tax Commissioner acts as the agent of the tribe to collect the tax. Seventy-five percent of collections, less a 3% administrative fee, is returned to the tribe. Twenty-five percent plus the administrative fee is deposited in the State General Fund.

HISTORICAL OVERVIEW

Significant Changes in Law

1983 Session. The legislature increased the cigarette tax from 6 mills to 9 mills per cigarette. This increased the cigarette tax from 12¢ to 18¢ per package of 20.

1987 Session. The cigarette tax was increased from 9 to 13½ mills per cigarette, or from 18¢ to 27¢ per package of 20. The tobacco products tax was increased from 11% to 20% of the wholesale purchase price.

1989 Session. The cigarette tax was increased from 13½ to 15 mills per cigarette, or from 27¢ to 30¢ per package of 20. The tobacco products tax was increased from 20% to 25% of the wholesale purchase price.

1991 Session. The cigarette tax was decreased from 15 mills to 14½ mills per cigarette, or from 30¢ to 29¢ per package of 20. The tobacco products tax was decreased from 25% to 22% of the wholesale purchase price. Cigarette stamp requirements were repealed and replaced with monthly reports and payments.

1993 Session. The cigarette tax was increased from 14½ to 22 mills per cigarette, or from 29¢ to 44¢ per package of 20. The tobacco products tax was increased from 22% to 28% of the wholesale purchase price.

1993 Agreement. The State Tax Commissioner and the Standing Rock Sioux Tribe signed a unique agreement to allow the commissioner to act as an agent of the tribe for the collection of a tribal cigarette and tobacco tax.

1999 Session. The sale of gray market cigarettes was prohibited, taxation of roll your own tobacco was moved from Other Tobacco Products to taxation as a cigarette and a minimum package size was established at 20 cigarettes per package. North Dakota Century Code 51-25 was passed and requires the State Tax Commissioner to accumulate information on purchases of cigarettes from non-participating manufacturers in the cigarette Master Settlement Agreement.

Comparison of State Tobacco Products Taxes

January 1, 2000

State	Tax Rate/Base [1]
Alabama	
Cigars [2]	1.5¢-20.25¢/10 cigars
Tobacco/Snuff	0.6¢-4.4¢/ounce
Alaska	75% Wholesale Price
Arizona	
Cigars [2]	6.5¢-64¢/10 cigars
Tobacco/Snuff	6.5¢/ounce
Arkansas	23% Manufactures Price
California [3]	66.50% Wholesale Price
Colorado	20% Manufactures Price
Connecticut	20% Wholesale Price
Delaware	15% Wholesale Price
Florida	
Tobacco/Snuff	25% Wholesale Price
Georgia	
Little Cigars	2¢/10 cigars
Other Cigars	13% Wholesale Price
Hawaii	40% Wholesale Price
Idaho	40% Wholesale Price
Illinois	18% Wholesale Price
Indiana	15% Wholesale Price
Iowa	22% Wholesale Price
Kansas	10% Manufactures Price
Louisiana	
Cigars	8%-20% Manufacture Price
Tobacco/Snuff	33% Manufactures Price
Maine	
Chewing Tob./Snuff	62% Wholesale Price
Smoking Tob./Cigars	16% Wholesale Price
Maryland	15% Wholesale Price
Massachusettes	25% Wholesale Price
Michigan	16% Wholesale Price
Minnesota	35% Wholesale Price
Mississippi	15% Manufactures Price
Missouri	10% Manufactures Price
Montana	12.5% Manufactures Price
Nebraska	15% Wholesale Price
Nevada	30% Wholesale Price
New Hampshire [3]	21.6% Wholesale Price
New Jersey	24% Wholesale Price
New Mexico	25% Product Value
New York	20% Wholesale Price
North Carolina	2% Manufacture Price
NORTH DAKOTA	28% Wholesale Price
Ohio	17% Wholesale Price
Oklahoma	
Cigars [2]	9¢-30¢/10 cigars
Tobacco/Snuff	30%-40% factory list price
Oregon	65% Wholesale Price
Rhode Island	20% Wholesale Price
South Carolina	
Cigars [2]	2.5¢-20¢/10 cigars
Tobacco/Snuff	5%-36% Manufacture Price
South Dakota	10% Wholesale Price
Tennessee	6% Wholesale Price
Texas	
Cigars [2]	1¢-15¢/10 cigars
Tobacco/Snuff	35.213% Manufactures Price
Utah	35% Manufactures Price
Vermont	41% Manufactures Price
Washington	74.9% Wholesale Price
Wisconsin	20% Wholesale Price
Wyoming [4]	20% Wholesale Price

SOURCE: Compiled by Federation of Tax Administrators from various sources.

[1] The volume based tax rates were converted to cents per 10 cigars or per ounce for consistency.
[2] Tax rate on cigars varies, based on the selling price.
[3] Tax rate is adjusted annually by the state, effective July 1st of each year or 10% of retail price.
[4] or 10% of the retail price.

Cigarette Tax and Tobacco Tax Collections

Fiscal Year	Total Collections	Tobacco Tax (General Fund)	Cigarette Tax (General Fund)	Cigarette Tax (Cities)	Cigarette and Tobacco Tax (Tribal)
1990	16,244,815	799,282	13,924,594	1,520,939	
1991	16,517,821	903,265	14,052,912	1,561,644	
1992	12,461,881	1,123,800	11,338,081	1,307,730	
1993	16,658,763	1,259,362	13,806,364	1,593,037	
1994	23,932,732	1,419,381	20,958,608	1,497,925	56,818
1995	24,093,508	1,512,791	20,974,207	1,532,674	73,835
1996	24,403,150	1,634,213	21,149,970	1,545,546	73,421
1997	23,872,859	1,746,105	20,554,980	1,502,113	69,661
1998	24,293,434	1,847,905	20,846,708	1,523,488	75,534
1999	23,026,300	1,891,262	19,619,122	1,440,232	75,684
2000	22,825,622	1,983,222	19,359,086	1,414,712	68,602
2000 est.*	21,987,000	1,900,000	18,657,000	1,365,000	65,000

SOURCE: North Dakota Office of State Tax Commissioner and estimates prepared with the Office of Management and Budget.

Comparison of State Cigarette Taxes

January 1, 2000

State	Cents Per Pack	State	Cents Per Pack	State	Cents Per Pack
Alaska	100	Utah	51.5	Oklahoma	23
Hawaii	100	Connecticut	50	New Mexico	21
California	87	Minnesota	48	Colorado	20
Washington	82.5	NORTH DAKOTA	44	Louisiana	20
New Jersey	80	Vermont	44	Mississippi	18
Massachusetts	76	Texas	41	Montana	18
Michigan	75	Iowa	36	Missouri [1]	17
Maine	74	Nevada	35	West Virginia	17
Rhode Island	71	Nebraska	34	Alabama [1]	16.5
Oregon	68	Florida	33.9	Indiana	15.5
Maryland	66	South Dakota	33	Tennessee [1] [2]	13
Dist. of Columbia	65	Arkansas [2]	31.5	Georgia	12
Wisconsin	59	Pennsylvania	31	Wyoming	12
Arizona	58	Idaho	28	South Carolina	7
Illinois [1]	58	Delaware	24	North Carolina	5
New York [1] [3]	56	Kansas	24	Kentucky [2]	3
New Hampshire	52	Ohio	24	Virginia [1]	2.5
				U.S. (median)	34.0

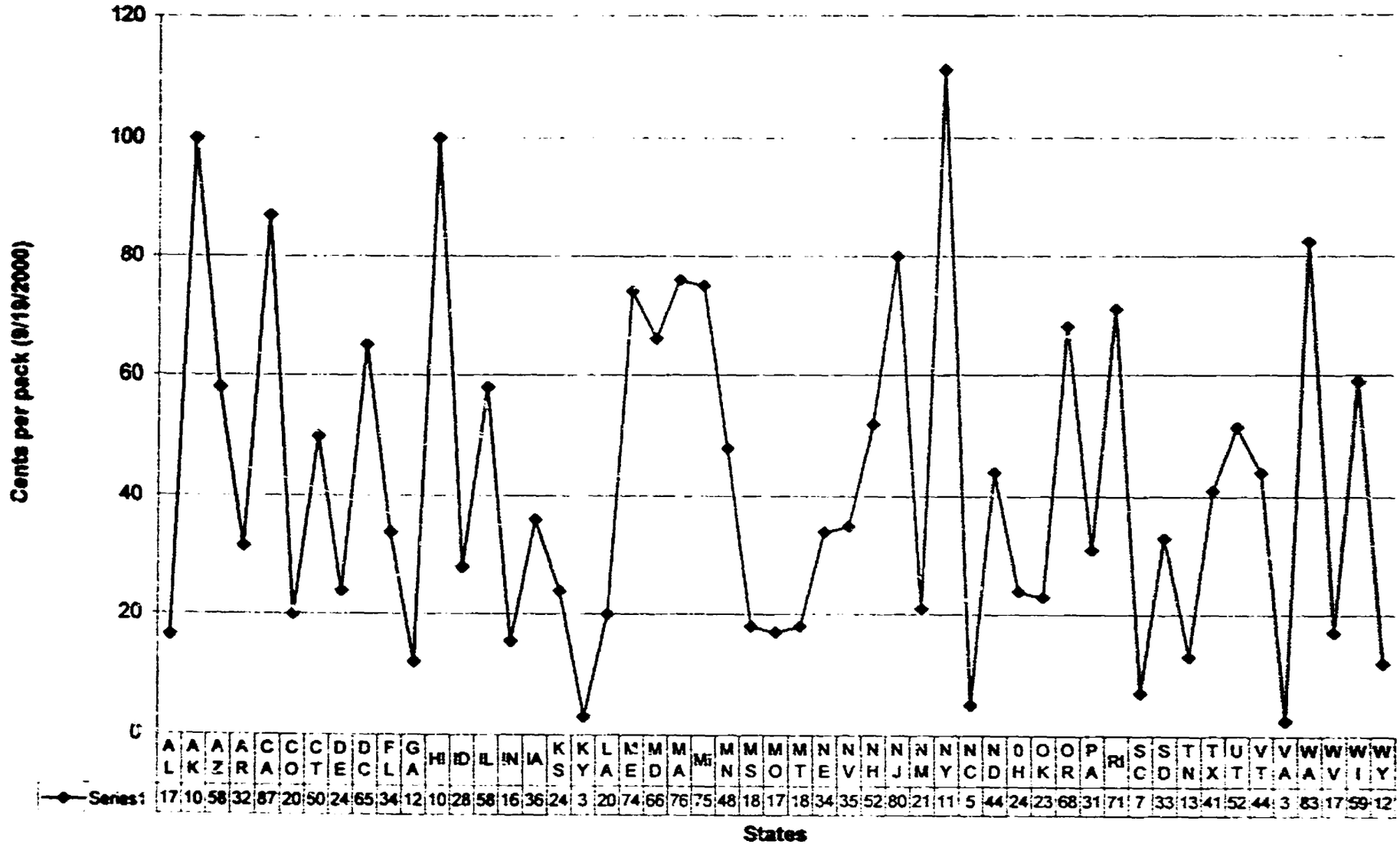
SOURCE: Compiled by Federation of Tax Administrators from various sources.

[1] Counties and cities may impose an additional tax on a pack of cigarettes in AL, 1¢ to 6¢; IL, 10¢ to 15¢; MO, 4¢ to 7¢; TN, 1¢; and VA, 2¢ to 15¢.

[2] Dealers pay an additional enforcement and administrative fee of 0.1¢ per pack in KY and 0.05¢

[3] HI, cigarette tax will increase to $1.00 per pack on 6/30/98.

State Cigarette Excise Tax Rates



Source: Campaign for Tobacco-Free Kids
www.tobaccofreekids.org

STATE CIGARETTE TAX RATES AND DATE OF LAST INCREASE

36 states have not increased their cigarette tax rate for at least five years. Of these, 17 have not increased th en years. And six states have not increased their taxes in at least twenty years. Virginia and Tennessee hav cigarette taxes since the 1960s.

State	Current Cigarette Tax (per pack)	National Rank	Date of Last State Tax Increase	Cig. Tax Revenue in FY 1999 (millions)	Cig. Pack Sales FY 1999 (millions)	Adult Smoki Rate (percent
State Average	*0.42*	///	///	*$150.8*	*422.3*	*23.2*
Alabama	0.165	43	7/1/84	$65.4	435.1	24.6
Alaska	1.00	2	10/1/97	$42.9	42.9	26.0
Arizona	0.58	15	11/29/94	$163.1	281.1	21.9
Arkansas	0.315	29	7/1/93	$81.5	264.5	26.0
California	0.87	4	1/1/99	$841.9	1523	19.2
Colorado	0.20	37	7/1/86	$59.6	309.9	22.8
Connecticut	0.50	19	7/1/94	$118.8	240	21.1
Delaware	0.24	32	1/1/91	$24.3	102.2	24.5
Washington, DC	0.65	13	7/1/93	$17.4	26.9	21.6
Florida	0.339	27	7/1/90	$428.5	1292.7	22.0
Georgia	0.12	46	4/1/71	$85.7	726.6	23.7
Hawaii	1.00	2	7/1/98	$38.9	38.6	19.5
Idaho	0.28	31	7/1/94	$24.2	90.9	20.3
Illinois	0.58	15	12/16/97	$486.6	858.8	23.1
Indiana	0.155	44	7/1/87	$116.3	781.8	26.0
Iowa	0.36	24	6/1/91	$92.3	261.6	23.4
Kansas	0.24	32	10/1/85	$51.0	216.2	21.2
Kentucky	0.03	50	7/1/70	$17.6	646.2	30.8
Louisiana	0.20	37	8/1/90	$82.8	439.6	25.5
Maine	0.74	9	11/1/97	$76.9	106.2	22.4
Maryland	0.66	12	7/1/99	$129.6	383.5	22.4
Massachusetts	0.76	7	10/1/96	$279.6	369.4	20.9
Michigan	0.75	8	5/1/94	$597.2	798.5	27.4
Minnesota	0.48	20	7/1/92	$177.3	378.3	18.0
Mississippi	0.18	39	6/1/85	$47.2	263.8	24.1
Missouri	0.17	41	10/1/93	$105.0	637.5	26.3

State	Current Cigarette Tax (per pack)	National Rank	Date of Last State Tax Increase	Cig. Tax Revenue in FY 1999 (millions)	Cig. Pack Sales FY 1999 (millions)	Adult Smoki Rate (percent
Montana	0.18	39	8/15/93	$12.7	72.6	21.5
Nebraska	0.34	26	7/1/93	$47.3	143.5	22.1
Nevada	0.35	25	7/1/89	$59.1	174.2	30.4
New Hampshire	0.52	17	7/1/99	$72.0	201.4	23.3
New Jersey	0.80	6	1/1/98	$409.7	511.8	19.2
New Mexico	0.21	36	7/1/93	$21.1	103.3	22.6
New York	1.11	1	3/1/00	$637.0	1140.8	24.3
North Carolina	0.05	49	8/1/91	$41.8	839.8	24.7
North Dakota	0.44	21	7/1/93	$21.0	47.9	20.0
Ohio	0.24	32	1/1/93	$269.3	1163.8	26.2
Oklahoma	0.23	35	6/1/87	$64.2	369.7	23.8
Oregon	0.68	11	2/1/97	$173.4	259.1	21.1
Pennsylvania	0.31	30	8/19/91	$333.3	1095.1	23.8
Rhode Island	0.71	10	7/1/97	$60.2	85.8	22.7
South Carolina	0.07	48	7/1/77	$27.6	411.2	24.7
South Dakota	0.33	28	7/1/95	$19.4	61.6	27.3
Tennessee	0.13	45	6/1/69	$78.7	620.7	26.1
Texas	0.41	23	7/1/90	$524.2	1314.7	22.0
Utah	0.515	18	7/1/97	$46.6	90.4	14.2
Vermont	0.44	21	7/1/95	$23.7	55.4	22.3
Virginia	0.025	51	9/1/66	$15.5	687.8	22.9
Washington	0.825	5	7/1/96	$252.2	309.1	21.4
West Virginia	0.17	41	8/1/78	$33.3	204.1	27.9
Wisconsin	0.59	14	11/1/97	$257.4	443.4	23.4
Wyoming	0.12	46	7/1/89	$5.7	50.3	22.8
State Average	*0.42*	///	///	*$150.8*	*422.3*	*23.2*

Sources: Tax data from *Tax Burden on Tobacco* (2000). Adult smoking data from the U.S. Centers for Disease Prevention (CDC), *1998 Behavioral Risk Factor Surveillance System* (1999). Youth smoking rates from CDC, *Surveillance -- United States, 1999* (2000) and from the most comparable data available from those states not YRBS.

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.

BlueCross BlueShield of North Dakota

Fall 2000
Volume 3, Number 3

Health Care Discussions

Information for physicians, administrators and other health care professionals

North Dakota's uninsured -- Who are they and where do they live?

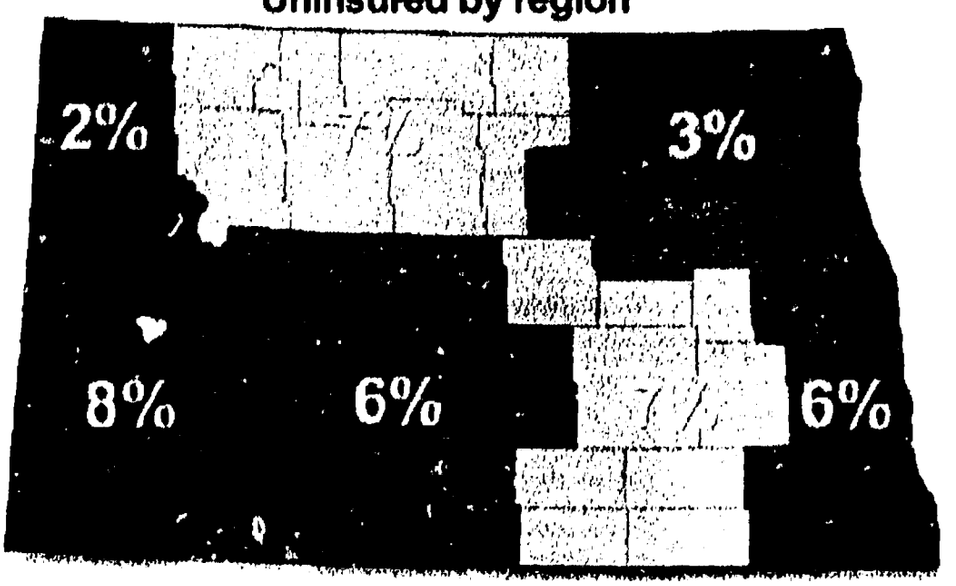
By Mary Schieve

He is a young man who works three part-time jobs to support his wife and two children. None provides benefits, and he can't afford to pay for health coverage on his own. There are more immediate needs such as paying the rent and buying food and clothes.

She is a single parent and works full time. She's eligible for benefits through her employer, but her wages aren't adequate to allow her to purchase family insurance coverage.

He is a farmer who has seen his income drastically reduced by low commodity prices and the rising cost of doing business. He doesn't want to drop his family's health coverage, but he may not have a choice if he wants to keep the farm.

Uninsured by region



Source: North Dakota Department of Health

Contrary to common belief, the uninsured in North Dakota are more likely to fit profiles such as those above than stereotypical images of the homeless. A high percentage are the "working poor." Quite often, they are young adults who either are not offered health insurance through their employers or cannot afford to pay for it.

It's a trend that tracks with other state and national surveys. According to a 1999 report issued by the Center on Budget and Policy Priorities, children in low-income working families receive assistance through Medicaid and, in some states, through newly established child health programs, but the parents who head these families remain at a high risk of being uninsured. The same report revealed that working poor parents are twice as likely to be uninsured as their unemployed counterparts.

Dr. Alana Knudson-Buresh, until recently data director for the North Dakota Department of Health, explained that while Medicaid exists primarily for children and caretakers, and Medicare is designed for the elderly, few government

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North Dakota's uninsured

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? Did You Know...

In 1998 the number of uninsured in North Dakota was 8.6 percent, or an estimated 55,000 out of a total population of 638,244. That figure is lower than the national average of 16 percent and lower than that of other states.
— ND Department of Health

Discussion Point

The uninsured in North Dakota do not include only those with minimal education. Forty percent of uninsured adults have a high school diploma or GED, 30.8 percent have some college or an associate degree, 9.4 percent have a bachelor's degree and 1.5 percent have a graduate degree.
— ND Department of Health

programs provide a safety net for low-income working adults. These people are making a contribution to our state, she said, yet in many cases, it is difficult for them to pay the cost of health insurance.


Sherlyn Dahl

A longtime advocate for those who have access barriers to health care, Sherlyn Dahl believes this is an issue people need to start discussing. "There is a great deal of concern about access to health care in rural communities in North Dakota," she said, "but I would like to push the dialogue further and talk about the issue of the uninsured. We need to recognize that this is a problem."

Dahl is executive director of the Family HealthCare Center in Fargo, a federally funded community health center whose mission is to deliver primary health care to anyone regardless of ability to pay. One of 700 such facilities across the country, it is the only one of its kind in North Dakota and has been in operation since 1993.

"I feel strongly about our role," she said, "but I don't think we're the answer to the problem. We need to support programs like ours, but we also have to look at the larger issues of insurance and affordability. How can we make insurance more affordable for low-income families? We need to engage employers and small businesses, legislators, insurance companies and all the different providers in the discussion. The answers will be found when people start to talk about the problems."

A closer look at North Dakota's uninsured

In North Dakota, quite a bit is known about the uninsured and why they lack health coverage.

While many states rely on national surveys to gather information about their uninsured, North Dakota is able to draw extensive data from two comprehensive statewide health insurance surveys completed in the last six years, one in 1994 and another in 1998. Conducted for the North Dakota Department of Health and funded by the Robert Wood Johnson Foundation, both surveys assess the percentage of uninsured in the state and access to health care.

In 1994, an estimated 9.9 percent of North Dakotans were uninsured. By 1998 that number had actually declined to 8.6 percent, or an estimated 55,000 uninsured out of a total population of 638,244. That figure is lower than the national average of 16 percent and lower than that of other states.


Dr. Alana Knudson-Buresh

Knudson-Buresh noted several factors that may have contributed to the decrease, among them a strong economy in North Dakota between 1994 and 1998. "Our unemployment rate is so low," she said, "that many employers have had to offer insurance to be competitive in the market." Also, she pointed out, some health insurance reforms seem to have had a positive impact on reducing the number of unemployed in the state.

What else do we know about uninsured adults in North Dakota from the 1998 survey? We know this:

- The highest percentage of the state's uninsured are 25 to 34. In 1998, 51 percent of the people in this age group reported they were uninsured.
- There is very little difference in terms of gender – 8.2 percent of women are uninsured compared to 9 percent of men.

- Of uninsured adults, half live alone, and one in five is married.
- The uninsured in North Dakota do not include only those with minimal education. Forty percent of uninsured adults have a high school diploma or GED, 30.8 percent have some college or an associate degree, 9.4 percent have a bachelor's degree and 1.5 percent have a graduate degree.
- Of the uninsured adults, 4 percent are full-time students; 3 out of 4 are employed. Two-thirds of the 3 out of 4 work for a private company, while 15 percent are self-employed.
- Sixty percent of the uninsured said they worked at firms that offered health insurance, but only 50 percent of them were eligible to apply. Their ineligibility, said Knudson-Buresh, is mostly due to their part-time status.
- One out of 10 work at more than one job.
- Uninsured adults in North Dakota are more likely to be employed in construction, farming, retail, restaurants and nursing homes.
- Of the adults with insurance who responded to the survey, 31.6 percent felt they had excellent health compared to 25.4 percent of the uninsured. Typically, the uninsured rate their personal health as slightly less than their insured counterparts. There are many theories that account for this, said Knudson-Buresh. "One is that insured people, by virtue of being healthy, have an easier time getting health insurance, while the uninsured may have had some pre-existing condition that precluded them from being eligible," she said. Also, she notes, no matter where you live, a person's socio-economic status has a great impact on health. People on the lower end are often the most challenged with their health and have poorer health outcomes.

Working parents

The following information on working parents was taken from "Employed But Not Insured: A State-by-State Analysis of the Number of Low-Income Working Parents Who Lack Health Insurance," 1999, Center on Budget and Policy Priorities:

- Nationwide, more than one out of three working parents with income below 200 percent of the poverty level ($27,300 a year for a family of three in 1998) are uninsured.
- The uninsured rate among working parents with income below 100 percent of the federal poverty level is even higher. Nationwide, close to half of all poor working parents are uninsured.
- In 1997, some 23 percent of poor parents who had no earnings throughout the year were uninsured compared to 46 percent of poor parents who worked for 13 weeks or more during the year.

Focus on children

According to the 1998 Robert Wood Johnson survey, 14,663 of North Dakota's 175,822 children are uninsured. That number may improve with the latest federal effort to insure more of America's children.

An effort proposed by President Clinton and launched in 1997 to provide coverage to more uninsured children, the State Children's Health Insurance Program (SCHIP) is the largest single expansion of health insurance coverage for children in more than 30 years and is already having an effect, not only in North Dakota, but also across the country.

continued

Discussion Point

A high percentage of North Dakota's uninsured are the "working poor," and very few government programs provide a safety net for low-income working adults.
— ND Department of Health

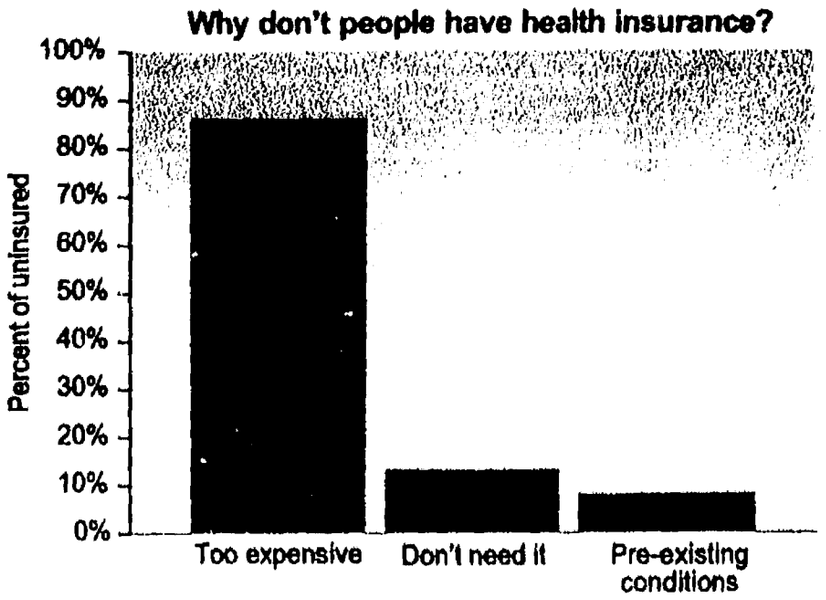
North Dakota's uninsured

continued from page 25

Discussion Point

More than 80 percent of the uninsured in North Dakota say they don't have insurance because it is too expensive.
— ND Department of Health

Just one month after North Dakota launched its version of the program, Healthy Steps, the governor announced that 620 previously uninsured children had health coverage through the plan. As was intended by federal legislation, the Healthy Steps plan is projected to meet the needs of working families who cannot afford health insurance coverage for their children, yet earn too much to qualify for Medicaid. The 1999 Legislature budgeted funds to cover an average of 2,000 children per month during the biennium, and Blue Cross Blue Shield of North Dakota (BCBSND) was chosen to administer the program. Healthy Steps is expected to reach its goal by the end of the year. As of September 30, 2000, there were already 2,022 children enrolled, according to Camille Eisenmann, Healthy Steps outreach coordinator.



Source: North Dakota Department of Health

? Did You Know...

Six percent of North Dakota farm and ranch operators are uninsured.
— ND Department of Health

Applicants who do not meet the income guidelines are referred to BCBSND's Caring Program for Children, an older program also designed to reach children who fall between the cracks and are uninsured.

Focus on farmers and ranchers

A downturn in the agricultural economy prompted a more recent survey on North Dakota's uninsured, this time with a focus on the state's farmers and ranchers. Concerned about anecdotal information that indicated farm and ranch families were having a difficult time maintaining their health insurance coverage due to low crop and cattle prices, legislators wanted to know more about the situation. The Health Department and Community HealthCare Association partnered with the North Dakota Agricultural Statistics Service to examine coverage of the group and released the findings of their work last June. Surprisingly, only six percent of households surveyed reported having no health insurance—a relatively low number.

Knudson-Buresh cautioned, however, that rural health coverage problems have not lessened. "We found that the six percent reflects the number of uninsured, but it doesn't tell us the number of underinsured," she said. She suspects that many farmers and ranchers buy coverage at the catastrophic level, which is less expensive but carries a higher deductible. It is really more of a safety net for the operators who believe their ability to farm is dependent upon their health in an occupation that carries a high risk of injury. These farm families who can't afford more coverage may not be receiving regular or preventive care, she said.

Also, she noted, many farmers have received significant disaster payments over the last couple of years that may have helped them maintain their health insurance. "If we have another bad year and don't receive the level of disaster payments we've had in the past, that six percent could change dramatically," she added.

Clearly, she said, farm and ranch operators are concerned about health insurance based on the volume of the comments and the 90 percent response rate to the survey. Other survey findings include the following:

- Forty-two percent of the respondents were at least 55. Twenty percent lived in households where the head of the household was over 64 – a percentage consistent with other studies that estimate 21 percent of North Dakota's farm and ranch operators are over 64.
- Younger farmers and ranchers were more likely to go without health insurance. Of the farmers younger than 34, about 10 percent did not have coverage – a figure consistent with other state and national surveys that show younger workers are more likely to be uninsured than older workers.
- "Too expensive" or "cannot afford it" were listed by 86 percent as the primary reasons for not having health insurance. Nearly half who responded offered comments related to financial issues, such as the cost of premiums, high deductibles and the need to seek off-farm employment to secure health insurance coverage.

Dr. Deb Walker, left, with a patient at the Fargo Family HealthCare Center

What difference does health insurance make?

Literature on the uninsured suggests that there are negative consequences to living without health insurance. The Kaiser Commission on Medicaid and the Uninsured, a program of the Henry J. Kaiser Family Foundation, reported that nationally:

- More than half of uninsured adults and one in five uninsured children do not have a usual source of health care.
- Preventive services are less commonly used by the uninsured. Thirty-five percent reported a routine check-up in the past year compared to 61 percent of the insured. Uninsured children are less likely to be up-to-date with the accepted standard for well-child visits.

Dr. Deb Walker, a family physician at the Fargo Family HealthCare Center, understands the dilemmas faced by her uninsured patients. "We have family practitioners here," she said. "If someone comes in and needs a general surgeon, computerized tomography (CT) scan or magnetic resonance imaging (MRI), it can cost $1,200. That's pretty prohibitive for people who don't have money. Uninsured people are very careful about costs. They don't want to run up bills they can't pay. They're very reluctant to have workups they can't afford."

continued

? Did You Know...

More than 44 million Americans currently lack health insurance coverage.
— Health Insurance Association of America

North Dakota's uninsured

continued from page 27

Fargo's Family HealthCare Center

Designed to meet the health care needs of anyone in the community, regardless of ability to pay, Fargo's Family HealthCare Center served 9,884 people with more than 32,000 visits in 1999. Thirty-two percent of its patients are uninsured. Seventy-five percent are low income. Sherlyn Dahl, the center's executive director, noted a 60 percent increase in the number of uninsured patients from 1995 to 1999, and pointed out that most of that growth occurred from 1998 to 1999, mostly among uninsured racial and ethnic minority groups.

While the center has not yet analyzed its data to determine where the growth is coming from, Dahl said, "My sense is that the uninsured we see tend to be a little more weighted to those who are Caucasian and working in jobs where employers don't provide health insurance. They are the working poor."

By far, the majority of the uninsured who apply to participate on the center's sliding fee scale are young people, according to the center's eligibility worker. They are young families, with one or two parents and a couple of kids. They're working part-time jobs or full-time jobs where there is no provision for health insurance, or if there is, they don't make enough money to afford it. They are also young single people just entering the work world, who often work at one or two part-time jobs where no insurance is provided.

While the center serves a large number of minorities, they are often insured primarily through medical assistance.

The center has about 140 requests for applications to its sliding scale each month, but center staff are quick to point out that "some may think people take advantage of our sliding fee scale, but that is not the case. Most of these families are working hard and really need the help."

Therefore, the center's physicians try to obtain discounts for their patients. "I've become really good at begging," said Walker, who often asks specialists to donate or discount their services. But even then, she says, people may elect to go without treatment. Some people can't afford half the cost of a $1,200 MRI.

Dahl agrees that both adults and children who are uninsured are less likely than those who are insured to receive preventive care and more likely to require emergency services for conditions that may have been avoided.

"The difference in treatment occurs," she said, "before they show up at our door. The uninsured have a tendency to take care of a problem themselves or to ignore it, so we see people seeking care late in an illness. They use the emergency room to access care, which is probably the most expensive way to do it."

With that in mind, the center takes a preventive approach to health care, integrating it into the system. "If we have a child in for an ear infection, we check on immunizations. We ask if the child has had a well-child exam. We try to address the full spectrum of health care, not just deal with the sickness," Dahl said. She explained that the center is currently involved in an effort to help its patients better manage diabetes, making sure their feet are checked and their blood sugars are maintained appropriately.

"Having a provider like us that focuses on this population is a way of saying, 'We understand that you're concerned about the cost. It's OK for you to come in. We can help you. We can take care of your illness before you get really sick,'" she said.

"We're paying for that care, anyway – the providers, the insurance companies, the businesses who buy health insurance, the taxpayers – so we might as well deal with it," said Dahl.

She noted that while it is primarily federal dollars now that pay for the uninsured, more states are beginning to look at their role and developing grant programs for providers serving higher percentages of low income people.

Monitoring the Uninsured: A North Dakota Perspective

Alana Knudson-Buresh, Ph.D.
North Dakota Department of Health
June 8, 2000

1994 RWJF Household Survey

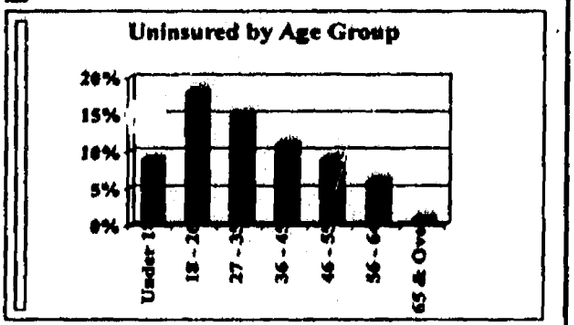
- Funded by RWJF State Initiative Project
  - ND Health Task Force
  - $250,000
- 2,756 Households interviewed
  - 6,116 people
  - 83% response rate
- Mathematica Policy Research, Inc.
- Same survey conducted in nine other states

1994 RWJF Household Survey

Age	Males	Percent of Age Group	Females	Percent of Age Group	Total	Percent of Age Group
Under 18	6,861	11%	6,652	7%	13,513	9%
18 - 26	6,431	22%	8,017	14%	14,048	18%
27 - 35	7,536	17%	5,362	13%	13,098	15%
36 - 45	5,015	12%	4,856	10%	9,871	11%
46 - 55	3,272	9%	2,757	6%	6,029	8%
56 - 64	1,387	6%	1,627	7%	3,014	6%
65 & Over	0	0%	244	1%	244	1%
Total	34,694	12%	36,966	9%	61,866	9.9%

9.9% Uninsured

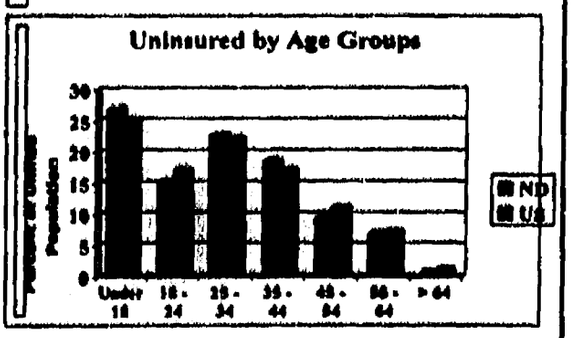
1994 RWJF Household Survey



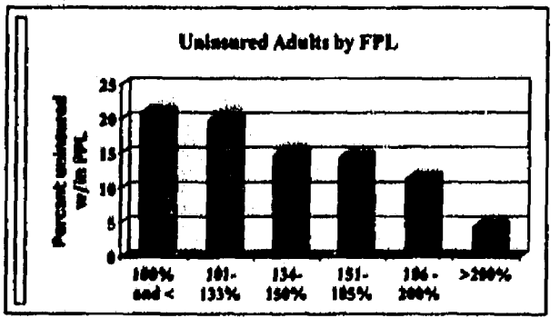
1998 RWJF Household Survey

- Grant to determine if 1997 flood impacted health insurance rates
  - $175,000
- Random telephone survey
- 5,027 households
  - 76.2% response rate
- Mathematica Policy Research, Inc.

1998 RWJF Household Survey



1998 RWJF Household Survey



1998 RWJF Household Survey

- 4% are full-time students
- 3 out of 4 are employed
  - 2/3 work for a private company
  - 15% are self-employed
  - 60% are offered health insurance through employer
    - 50% eligible
- 1 out of 10 work at more than one job
- Types of employment
  Construction, Farming, Retail
  Restaurants and Nursing Homes

2000 Farm and Ranch Operator Survey

- Partners
  - North Dakota Department of Health
  - Community HealthCare Association
  - ND Agricultural Statistic Services
- Surveyed farm and ranch operators
  - 1,374 households (about 90% response rate)
  - 4,080 people
- Release findings in late June, 2000

1998 Insured and Uninsured North Dakota Children by Poverty Level, Age, and Race/Ethicity

Demographic Subgroups	Population Distribution	Number of Insured Children*	Number of Uninsured Children	Number of Children with Unknown Status	Number Insured by Medicaid	Number Insured by Private Plans	Number Covered by IHS, Military and Other
1998 North Dakota Population	175,822	160,448	14,663	710	14,833	134,791	24,131
Household Poverty Level							
Unknown	16,004	13,951	1,754	299	1,186	11,435	2,031
<100%	17,689	14,448	2,975	266	7,694	5,253	4,664
100% - 133%	16,011	12,920	3,091	0	3,122	7,250	4,701
134% - 150%	9,270	7,945	1,325	0	640	7,135	1,168
151-200%	23,598	21,364	2,233	0	1,241	18,399	3,846
Overall 200%	93,250	89,820	3,285	145	950	85,319	7,721
Total Children <=18	175,822	160,448	14,663	710	14,833	134,791	24,131
Age Group							
Less than 1 year	7,265	6,905	231	129	1,029	5,467	818
1 to 5 years	38,992	35,673	3,203	115	4,791	28,501	5,408
6 to 12 years	66,971	59,976	6,818	177	6,271	50,189	8,567
13 to 18 years	62,594	57,894	4,411	289	2,742	50,634	9,338
Total Children <=18	175,822	160,448	14,663	710	14,833	134,791	24,131
Race/Ethnicity							
Unknown	838	607	199	32	30	295	314
White	158,462	144,641	13,200	620	9,995	128,532	13,545
Black	1,742	1,684	58	0	475	856	759
Native American	11,832	11,157	675	0	3,904	3,751	8,831
Asian/Pacific Islander	832	832	0	0	90	599	190
Other	2,116	1,527	531	58	339	758	492
Total Children <=18	175,822	160,448	14,663	710	14,833	134,791	24,131

Source: The Robert Wood Johnson Foundation Family Survey, 1998

**Children covered by Medicare are included.*

NO DEP[illegible]NT OF HEALTH, OFFICE OF HEALTH DATA

[illegible] 7, 1999

Health Insurance on the Farm

2000 Health Insurance Survey of North Dakota Farm and Ranch Operators

What is the current health insurance situation for North Dakota's farmers and ranchers? How do farm families compare with the general population in terms of health insurance?

A recently completed survey on health insurance coverage for North Dakota's farm population attempts to answer these and other important questions. The 2000 Health Insurance Survey of North Dakota Farm and Ranch Operators was a cooperative effort by the North Dakota Department of Health, the Community HealthCare Association and USDA's North Dakota Agricultural Statistics Service (NDASS).

The response and volume of respondent comments on the survey was extraordinary. This brochure provides a summary of comments as well as the results of the survey and details on how the survey was conducted.

HEALTH INSURANCE SURVEY, NORTH DAKOTA, MAY 2000

Health Insurance Coverage

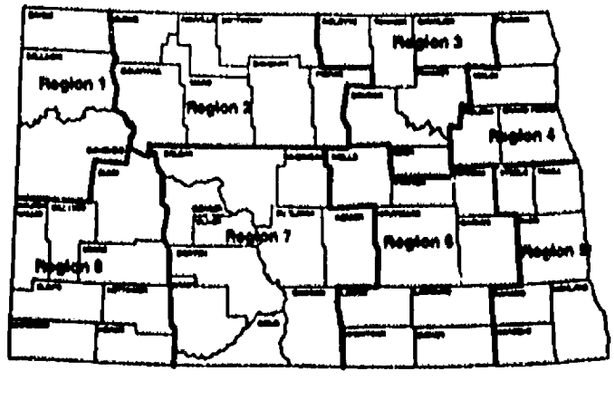
Item	Total	Regions							
		1	2	3	4	5	6	7	8
Households (Number)	1,374	87	239	145	116	170	239	245	133
Households With No Health Insurance	78	2	16	4	4	10	17	14	11
	6%	2%	7%	3%	3%	6%	7%	6%	8%
Households With Health Insurance [1]	1,296	85	223	141	112	160	222	231	122
	94%	98%	93%	97%	97%	94%	93%	94%	92%
Private Health Insurance Coverage [1]	1,240	80	214	136	109	158	215	219	109
	90%	92%	90%	94%	94%	93%	90%	89%	82%
Public Health Insurance Coverage [1]	357	29	67	38	30	31	54	67	41
	26%	33%	28%	26%	26%	18%	23%	27%	31%
Individuals (Number)	4,080	228	715	426	349	546	708	729	379
Uninsured	246	8	47	15	15	23	53	48	37
	6%	4%	7%	4%	4%	4%	7%	7%	10%
Insured	3,834	220	668	411	334	523	655	681	342
	94%	96%	93%	96%	96%	96%	93%	93%	90%

[1] *Coverage may not extend to all household members.*

Findings

Findings indicate that 6 percent of the state's farm households had no health insurance. This number is slightly below the 8.6 percent for the state's 1998 general population study. Twenty-six percent of all farm households with insurance had some form of public health insurance, and 90 percent had private health insurance. Only 6 percent of households declined to answer and 6.6 percent were not accessible. On a regional basis, there tended to be more households in the southwestern region (region 8) of the state without health insurance (8 percent).

Regions



N.D. Agricultural Statistics Service, USDA • P.O. Box 3166, Fargo, ND 58108-3166 • 701-239-5306

Of all households with private insurance, 69 percent were self-insured and 41 percent were insured through an employer or union (group) membership.

Of those in the latter group, 87 percent had insurance policies that covered all household members. Of these, 76 percent paid some or all of the cost of premiums and almost half of these paid 50 percent or more of premium costs. Twenty-four percent paid no insurance premiums. Medicare was by far the leading form of public health insurance, providing coverage in 22 percent of surveyed households.

Totals often do not add to 100 because multiple coverages exist in many households.

HEALTH INSURANCE SURVEY, NORTH DAKOTA, MAY 2000
Households With Private Health Insurance

Item	Total	Regions							
		1	2	3	4	5	6	7	8
Self Insured	858	59	140	98	77	106	150	148	80
	69%	74%	65%	72%	71%	67%	70%	68%	73%
Insured Through Employer/Union	506	30	96	53	43	64	89	87	43
	41%	38%	45%	39%	39%	41%	41%	40%	39%
All Household Members Covered	441	24	83	46	41	57	76	77	37
	87%	80%	86%	87%	95%	89%	85%	89%	86%
Some Household Members Covered	34	3	7	5	1	5	5	6	2
	7%	10%	7%	9%	2%	8%	6%	7%	5%
Single Household Member Covered	30	3	6	2	1	2	8	4	4
	6%	10%	6%	4%	2%	3%	9%	5%	9%
Pay 1 - 49% of Premium	200	11	42	26	19	22	35	28	18
	40%	37%	45%	47%	44%	34%	39%	33%	43%
Pay ≥ 50% of Premium	180	13	33	13	13	27	35	30	16
	36%	43%	35%	25%	30%	42%	39%	36%	38%
No Premium Contribution	119	6	19	15	11	15	19	26	8
	24%	20%	20%	28%	26%	23%	21%	31%	19%
Households with Private Health Insurance	1,240	80	214	136	109	158	215	219	109

HEALTH INSURANCE SURVEY, NORTH DAKOTA, MAY 2000
Households With Public Health Insurance

Item	Total	Regions							
		1	2	3	4	5	6	7	8
Medicare	306	27	61	30	26	26	47	56	33
	22%	31%	26%	21%	22%	15%	20%	23%	25%
Medicaid	57	4	7	8	8	4	7	10	8
	4%	5%	3%	6%	7%	2%	3%	4%	6%
CHAMPUS	3	-	-	1	-	-	1	1	-
	-	-	-	1%	-	-	-	-	-
Healthy Step	13	-	2	-	-	3	-	4	4
	1%	-	1%	-	-	2%	-	2%	3%
VA	21	1	1	4	-	1	5	6	3
	2%	1%	-	3%	-	1%	2%	2%	2%
IHS	4	-	1	3	-	-	-	-	-
	-	-	-	2%	-	-	-	-	-
Other	14	1	3	1	3	1	-	4	1
	1%	1%	1%	1%	3%	1%	-	2%	1%
Households in Survey	1,374	87	239	145	116	170	239	245	133

HEALTH INSURANCE SURVEY, NORTH DAKOTA, MAY 2000
In the Last 12 Months, Did Any Household Member Not Receive Medical Care or Delay Medical Care Because of No Health Insurance or Inadequate Health Insurance?

Item	Total	Regions							
		1	2	3	4	5	6	7	8
Yes	87	2	10	11	4	8	18	24	10
	6%	2%	4%	8%	3%	5%	8%	10%	8%
No	1,287	85	229	134	112	162	221	221	123
	94%	98%	96%	92%	97%	95%	92%	90%	92%
Number of Households	1,374	87	239	145	116	170	239	245	133

HEALTH INSURANCE SURVEY, NORTH DAKOTA, MAY 2000
Households With One or More Members Without Health Insurance

	Total	Regions							
		1	2	3	4	5	6	7	8
1 Household Member not Covered	60	4	15	6	2	4	10	12	7
	4%	5%	6%	4%	2%	2%	4%	5%	5%
2 Household Members not Covered	29	2	3	3	-	3	7	6	5
	2%	2%	1%	2%	-	2%	3%	2%	4%
3 Household Members not Covered	10	-	2	1	1	1	2	1	2
	1%	-	1%	1%	1%	1%	1%	-	2%
4+ Household Members not Covered	18	-	3	-	2	2	4	4	3
	1%	-	1%	-	2%	1%	2%	2%	2%
Households in Survey	1,374	87	239	145	116	170	239	245	133

HEALTH INSURANCE SURVEY, NORTH DAKOTA, MAY 2000
Reasons Given for Not Having Health Insurance

Item	Total	Regions							
		1	2	3	4	5	6	7	8
Too Expensive/Can't Afford	101	5	19	8	3	8	21	20	17
	86%	83%	83%	80%	60%	80%	91%	87%	100%
Don't Need It/Healthy	15	-	2	2	-	1	4	3	3
	13%	-	9%	20%	-	10%	17%	13%	18%
Medical Problems/Preexisting Conditions	9	1	3	-	-	-	1	2	2
	8%	17%	13%	-	-	-	4%	9%	12%
Don't Believe in Insurance	4	-	-	-	1	1	2	-	-
	3%	-	-	-	20%	10%	9%	-	-
[illegible]us Convictions	1	-	1	-	-	-	-	-	-
	1%	-	4%	-	-	-	-	-	-
Free or Inexpensive Care Available	1	-	-	-	1	-	-	-	-
	1%	-	-	-	20%	-	-	-	-
Other	4	-	1	-	-	-	1	2	-
	3%	-	4%	-	-	-	4%	9%	-
Households With at Least One or More Uninsured Members	117	6	23	10	5	10	23	23	17

Methods

This survey was conducted by North Dakota Agricultural Statistics Service (NDASS) at the request of the North Dakota Department of Health. Response to this inquiry was voluntary. A random sample of 1571 farm and ranch operators were selected from the universe of active producers maintained by the NDASS. All individual responses are protected from disclosure by statute.

Instructions to the respondent said, "Please report for all members of the household of the farm operator identified . . . Do not include other households which may be associated with the operation." In this manner the reporting unit was restricted to the household of active farm operators. The questionnaire was mailed on March 20. Included was a cover letter from the State Health Office requesting cooperation, and postage paid return envelopes. A total of 523 questionnaires, or 33 percent, were returned by mail and only 9 questionnaires were returned with an undeliverable or unknown address.

Telephone follow-up began on April 3 and continued through April 13. A total of 843 (54 percent) questionnaires were completed by telephone, using computer-assisted data collection techniques.

Combining mail and telephone response, only 88 (6 percent) respondents refused to complete an interview. This is a remarkably low refusal rate for a voluntary survey. The residual 117 respondents not tabulated as complete or refusal include operators who have left farming, and those that were inaccessible by phone during the data collection period.

Respondents were given the opportunity to comment on survey content. Comments were prompted with the statement "such as availability, affordability, coverage of your current health insurance." Comments were tabulated by the subject they addressed.

Respondent Comments

The volume of respondent comments on the 2000 Health Insurance Survey of Farm and Ranch Operators was extraordinary, far exceeding the volume of comments received on typical NDASS surveys. A total of 619 comments was recorded from 1,374 interviews.

A tabulation of significant comment categories was made.

The following representative comments from each category are paraphrased:

HIGH PREMIUMS: *55 percent of all comments (most frequent)*

Very concerned about high monthly premiums. Can't afford not to carry it, we could lose the farm.

With low farm prices, we will have to cancel our insurance due to the cost.

I have a $1,000 deductible and pay 20 percent of the next $5,000; this costs $500 a month.

We are old and just can't afford to keep up the premium for the medicare supplement, we don't know what we're going to do.

Monthly premiums have more than doubled in two years. There is no prescription program. Have to pay $2,000 before insurance pays 80 percent. Monthly premiums are too high.

HIGH DEDUCTIBLES: *13 percent of comments*

All we have is major medical...can't afford better coverage. Our deductible is still $5,000, this is ridiculous.

It's a problem, with high deductibles we can't go in for our eyes and ears, or annual checkups. Can't pay the premium and the clinic bill both.

$5,000 deductible and premium is still 3 times the cost of food.

Health insurance never covers anything. I don't remember ever reaching our deductible so we always pay out of pocket.

OFF-FARM EMPLOYMENT: *11 percent*

A farm wife: the only reason I'm working is the insurance and retirement benefits. It is not for the take home pay.

My husband works off the farm to get us insurance. He works around the clock between his job and the farm. What will we do when he wants to retire?

We're OK because of wife's position, but if I had to do this solely from the farm, we would have dropped it. Neighbors have dropped because they could not afford it and they have kids.

PLEASED WITH COVERAGE: *5 Percent*

Happy with insurance we have.

Just me in the household, I'm pleased with the coverage.

PRESCRIPTION COVERAGE: *4 Percent*

Wish Medicare would cover pills.

It takes almost all of my Social Security check to pay for medicine.

NEED FULLY DEDUCTIBLE PREMIUMS: *4 percent*

Premiums are too high for the self-employed. We should be able to deduct her health insurance premiums from taxes.

SAFETY NET ONLY: *3 Percent*

I have nursing home insurance. Health insurance is too expensive.

I have cancer coverage only...

Insurance for major medical only. Routine physicals and tests for preventative care are not covered.

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New Federalism

THE URBAN INSTITUTE

Series B, No. B-22, July 2000

Public Health Coverage for Adults: How States Compare

Brenda C. Spillman

Recent policy debate about the uninsured has focused mostly on the need to expand public coverage of children. However, about three-quarters of Americans without health insurance are nonelderly adults. These adults are 40 percent more likely than children to be uninsured and less than half as likely to have public coverage. Their chances of obtaining public coverage vary widely, however, depending on where they live. States differ in both the degree to which they cover the nonelderly adult population without private insurance and the likelihood of public coverage for different groups *within* that population: women versus men, parents versus nonparents, healthy versus sick, and poor versus nonpoor.

Nonelderly adults are 40 percent more likely than children to be uninsured and less than half as likely to have public coverage.

This brief uses data from the 1997 National Survey of America's Families (NSAF)[1] to compare the types of medical assistance eligibility a state may provide—Medicaid with little or no expansion beyond federal minimums (limited programs), more generous state options using Medicaid (moderate programs), or even more generous state options using Medicaid and state-only coverage (comprehensive programs)—and that state's relative success in covering its otherwise uninsured adult residents. As expected, states with more comprehensive approaches to medical assistance cover more otherwise uninsured adults than do states with more limited approaches. For example, states with comprehensive approaches are twice as likely as states with limited approaches to cover otherwise uninsured adults, regardless of income. They also reach the largest proportions of low-income adults—whether or not they are in groups that Medicaid traditionally has covered (single parents and disabled adults).

Severing the link between cash welfare and Medicaid, as the 1996 Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) did, could significantly increase states' willingness to provide public health coverage. However, many states have not taken advantage of federally matched expansion options Medicaid has provided since its inception.[2] This suggests that major expansion of adult coverage is unlikely without further federal support.

State Differences in Insurance Status and Coverage Gaps

The NSAF, in addition to being nationally representative, contains representative subsamples for 13 states. These focal states are shown in table 1, grouped by the relative comprehensiveness of their policy approaches to providing public coverage for adults in 1997.[3] For apparently close cases, such as Massachusetts and New Jersey, which both covered between 2 and 10 percent of their uninsured through state programs beyond Medicaid, the final designation was made by looking at other dimensions—in this case, income eligibility limits and eligibility rates for poor adults, both of which were considerably higher in Massachusetts.

The Coverage Picture

The insurance status of the nonelderly adult population in the United States and in each of the focal states is shown in

TABLE 1: Dimensions of the Medical Assistance Approaches of the 13 Focal States

	Medicaid Program Characteristics				
	Income Eligibility Limits				
	Welfare Related[a] (% of national average)	Pregnant Women (% of national minimum)	Medically Needy Program?	Poor Adult Eligibility Rate[b] (% of national average)	Percentage of Uninsured in State-Only Programs[c]
Limited					
Alabama	37	100	No	55	—
Colorado	96	100	No	61	—
Florida	69	139	Yes	88	—
Mississippi	84	139	No	80	—
Texas	42	139	Yes	64	—
Moderate					
California	138	150	Yes	124	—
Michigan	126	139	Yes	125	<2%
New Jersey	101	139	Yes	95	2%–10%
Wisconsin	118	139	Yes	99	<2%
Comprehensive					
Massachusetts	132	139	Yes	113	2%–10%
Minnesota	121	207	Yes	81	over 10%
New York	131	139	Yes	119	over 10%
Washington	124	150	Yes	112	over 10%

Source: Urban Institute tabulations from the 1997 National Survey of America's Families. *See Spillman (2000) for details.

Notes:
a. AFDC income limit.
b. Adult eligibility rate is the estimated number of nonelderly poor adults eligible for Medicaid divided by the poor adult population in a given state.
c. Caseload as a percentage of the state's adult uninsured.

table 2. The primary determinant of the percentage uninsured is the percentage privately insured, which is mostly employment-related coverage. The four states with the highest percentages of adults uninsured in 1997 (Florida, Mississippi, Texas, and California) had the lowest levels of private coverage, ranging from about 66 percent in Texas to about 70 percent in Florida. The five states with the lowest percentages uninsured (Michigan, New Jersey, Wisconsin, Massachusetts, and Minnesota) all had more than 80 percent of their population privately insured.

This foundation of private insurance largely defines the magnitude of the health coverage problem states confront. Military-related and Medicare coverage, which together covered about 4 percent of nonelderly adults nationwide, slightly ameliorated the impact of low private coverage because they tended to be higher in states where private coverage was lower.

Bridging the Coverage Gap

Assessing a state's success in covering its otherwise uninsured population requires a measure of the insurance gap it faces. A state's insurance gap is measured here as the share of its adult residents who would be uninsured *in the absence of state-provided medical assistance* (that is, without Medicaid and any state-funded programs).[4] The last column of table 2 shows this coverage gap for the United States and for each of the 13 focal states.

Nationwide in 1997, the coverage gap comprised 21 percent of nonelderly adults. The limited approach states exhibited the largest coverage gaps—averaging 26 percent, compared with 22 percent for the moderate states and 20 percent for the

TABLE 2: Insurance Status and Coverage Gaps in the 13 Focal States (Percentage of Nonelderly Adult Population)

	Non-Medical Assistance Coverage			Coverage Gap		
	Private	Other[a]	Total	Uninsured	Medical Assistance	Total Gap
U.S.	74.8	3.9	78.7	17.0	4.3	21.3
Limited	68.6	4.8	73.5	22.9	3.5	26.4
Alabama	73.4	5.0	78.4	17.9	3.8	21.7
Colorado	76.7	4.7	81.4	16.2	2.4	18.6
Florida	69.7	5.8	75.5	21.1	3.3	24.5
Mississippi	67.5	6.5	74.0	20.3	5.6	25.9
Texas	65.6	3.9	69.5	26.9	3.5	30.4
Moderate	74.2[b]	3.3[b]	77.5[b]	17.4[b]	5.0[b]	22.4[b]
California	68.2	4.3	72.5	21.6	6.0	27.6
Michigan	82.5	1.8	84.3	11.1	4.6	15.7
New Jersey	81.3	2.3	83.6	13.1	3.3	16.4
Wisconsin	85.7	2.0	87.7	9.9	2.4	12.2
Comprehensive	76.8[c]	3.0[b]	79.8[c]	14.1[c]	6.1[c]	20.2[c]
Massachusetts	81.8	2.7	84.5	11.5	4.0	15.5
Minnesota	83.7	1.8	85.5	8.8	5.7	14.5
New York	74.2	2.5	76.7	16.3	7.0	23.4
Washington	74.4	5.7	80.1	14.2	5.6	19.8

Source: Urban Institute tabulations from the 1997 National Survey of America's Families.

Notes:
a. Medicare, dual Medicare/Medicaid, and military coverage.
b. Statistically different from group mean for limited states.
c. Statistically different from group mean for limited and moderate states.

comprehensive states. At the extremes were Texas, with a gap of 30 percent, and Wisconsin, with a gap of slightly over 12 percent.

Table 3 shows the extent to which public coverage filled these gaps. The limited states—by and large those with the largest gaps—tended to cover lower proportions of their gaps than did the moderate states, which, in turn, covered lower proportions of their gaps than did the comprehensive states. In all states, the size of the coverage gap and the percentage of the gap bridged fell as income rose (not shown). In every income group, the moderate states as a group covered larger percentages than the limited states, and the comprehensive states covered even more—twice the percentage for limited states.

Texas, California, and New York provide a straightforward comparison of the implications of the three public coverage approaches for the poor. They were similar with respect to percentage of adult population in poverty (14 to 16 percent) and percentage of poor adults otherwise uninsured (about 70 percent). However, Texas reached only about one in five of its otherwise uninsured poorest adults, compared with 35 percent for California and 51 percent for New York.

Coverage Differences within the Low-IncomePopulation

Family Structure

Low-income unmarried parents (income below 200 percent of the federal poverty level) face substantially larger coverage gaps than married parents or adults without children in the home. Nationwide in 1997, for example, 67 percent of unmarried parents lacked private coverage, compared with 46 percent of both married parents and adults with no children in the home.

TABLE 3: Percentage of Coverage Gap Filled in the 13 Focal States (Nonelderly Adult Population)

	Of Overall Gap	Of Low-Income Gaps	
		Poor	Near Poor[a]
U.S.	20.2	36.1	14.5
Limited	13.3	24.2	10.1
Alabama	17.5	26.1	15.2
Colorado	13.0	23.9	8.9
Florida	13.6	26.9	10.0
Mississippi	21.8	31.1	15.4
Texas	11.5	21.6	9.0
Moderate	22.2[b]	37.8[b]	14.7[b]
California	21.6	35.2	14.2
Michigan	29.2	50.6	18.9
New Jersey	20.0	40.6	14.6
Wisconsin	19.3	37.3	13.6
Comprehensive	30.2[c]	50.4[c]	21.0[c]
Massachusetts	25.7	47.5	23.5
Minnesota	39.3	61.8	40.2
New York	30.2	51.4	15.2
Washington	28.5	42.6	28.0

Source: Urban Institute tabulations from the 1997 National Survey of America's Families.

Notes:
a. Between 100 percent and 200 percent of the federal poverty level.
b. Statistically different from group mean for limited states.
c. Statistically different from group mean for limited and moderate states.

With respect to bridging their insurance gaps, all states do much better for low-income unmarried parents than for other low-income adults.

Even in Wisconsin, which has the smallest coverage gap for unmarried parents, more than half of low-income unmarried parents lacked private coverage. In California, the gap for this group was nearly 80 percent. Married parents generally were no more likely to have private coverage than adults without children in this low-income population.

With respect to bridging their insurance gaps, all states do much better for low-income unmarried parents than for other low-income adults (table 4). Nationally in 1997, about half of all low-income unmarried parents without private insurance obtained public coverage, relative to just under 20 percent of both married parents and adults with no children in the home. The limited states on average covered 41 percent of their low-income unmarried parents who lacked other coverage, compared with 58 percent and 67 percent, respectively, in the moderate and comprehensive states. Thus, state disparities in public coverage of low-income unmarried parents, though still large, are not as extreme as disparities for the low-income adult population as a whole.

Low-income adults with no children in the home are twice as likely to obtain public coverage in comprehensive as in limited states. However, their chances of obtaining public coverage are not significantly higher in moderate than in limited states. Thus, on average, only states with state-funded public programs in addition to Medicaid do better in covering this group.

Gender, Health, and Work Status

Gender does not make a large difference in the size of the coverage gap facing low-income adults, but health and work status do. For the country as a whole, the coverage gap for both men and women is about 50 percent, for those in fair or poor health about 60 percent (versus 47 percent for those in excellent or good health), and for

TABLE 4: Percentage of Low-Income[a] Coverage Gap Filled, by Family Structure (Nonelderly Adult Population)

	Unmarried Parents	Married Parents	No Children in Household
U.S.	51.1	19.4	17.8
State Approach			
Limited	40.6	10.8	12.6
Moderate	58.2[b]	20.4[b]	15.7
Comprehensive	66.6[c]	33.3[c]	25.9[c]

Source: Urban Institute tabulations from the 1997 National Survey of America's Families.

Notes:
a. Income below 200 percent of the federal poverty level.
b. Statistically different from group mean for limited states.
c. Statistically different from group mean for limited and moderate states.

those in families with no full-time worker about 58 percent (versus 44 percent for those with at least one full-time worker). These gaps do *not* vary systematically with the public coverage approach a state chooses.

Whatever their coverage approach, most states bridge larger percentages of their coverage gaps for the groups most closely associated with Medicaid eligibility—women, those in poorer health, and nonworkers. The coverage approach a state chooses, however, does have a major effect on the likelihood of coverage by gender, health, and work status (table 5). Residing in a comprehensive state rather than a limited one nearly doubles the likelihood that a person in only fair or poor health will obtain public coverage—an advantage that is almost as great for women and for nonworkers. However, comprehensive states also bridge the largest percentages of their coverage gaps for the groups *less* associated with Medicaid eligibility—men, those in better health, and full-time workers and spouses. Indeed, the *relative advantage* of living in a comprehensive state is greater for these groups than for the Medicaid-favored groups.

Notably, the fact that a state has a medically needy component in its Medicaid program does not increase the likelihood that its nonelderly adult residents obtain Medicaid coverage. Of the five limited states, for example, two (Texas and Florida) have medically needy programs. Yet neither bridges a larger proportion of the coverage gap for its less healthy low-income population than do the other three limited states. All four moderate states have medically needy programs, but they do not, as a group, cover a significantly larger percentage of their low-income, less healthy adults without private coverage than do the limited states as a group.

Implications for the Future

By removing the link between cash welfare and Medicaid, PRWORA has significant potential to increase states' willingness to provide health coverage. This legislation provides options for covering additional adults by allowing states to disregard higher levels of earned income and other resources, establish higher limits on hours of work, and provide transitional coverage. In theory, these new opportunities also give states with supplemental programs the ability to shift some additional groups to Medicaid (with its subsidizing federal match) and thus cover more persons with the same level of state funding. As of 1996, however, adult Medicaid enrollment was down in all but five states, with decreases in cash assistance–related enrollment not generally offset by increases in noncash enrollment (Holahan, Bruen, and Liska 1998). This trend appears to be continuing (Ku and Bruen 1999).

The findings reported here make clear that state approaches do matter in

The coverage approach a state chooses has a major effect on the likelihood of coverage by gender, health, and work status.

TABLE 5: Percentage of Low-Income[a] Coverage Gap Filled, by Gender, Health, and Work Status (Nonelderly Adult Population)

	Gender		Health		Full-Time Worker in Home	
	Women	Men	Fair or Poor	Excellent or Good	None	At Least One
U.S.	**34.3**	**14.4**	**31.4**	**23.6**	**42.4**	**12.4**
State Approach						
Limited	26.0	7.1	23.9	15.1	31.3	6.9
Moderate	36.6[b]	13.6[b]	27.0	27.6[b]	44.5[b]	14.1[b]
Comprehensive	47.5[c]	23.3[c]	47.3[c]	34.6[c]	55.6[c]	20.5[c]

Source: Urban Institute tabulations from the 1997 National Survey of America's Families.

Notes:
a. Income below 200 percent of the federal poverty level.
b. Statistically different from group mean for limited states.
c. Statistically different from group mean for limited and moderate states.

whether and which low-income adults obtain public health coverage. Moderate and comprehensive programs reach substantially larger proportions of those with traditional Medicaid characteristics than limited programs do. In addition, comprehensive programs reach larger proportions of other groups. However, even the most expansive programs still fail to reach substantial proportions of low-income adults who lack other coverage.

The findings here make clear that state approaches do matter in whether and which low-income adults obtain public health coverage.

Medicaid participation rates are one contributing factor. Eligible persons may perceive Medicaid as a stigma or see little value to coverage in states with shallow benefit packages—a factor that may become more important now that coverage is no longer linked to cash benefits. More recent concerns in the context of welfare reform are burdensome application procedures, lack of information, and rules that vary from group to group. Evidence for children reveals that 22 percent of Medicaid-eligible children remain uninsured and that participation is lower among those in groups newly eligible through the Medicaid expansions (Selden, Banthin, and Cohen 1998).

Even more important than low participation are the income and categorical limits that restrict adult Medicaid eligibility. Among the focal states, the highest income limit for welfare-related eligibility is only about 60 percent of the federal poverty level, and even the poorest of those who do not meet categorical eligibility criteria remain ineligible. Under the current Medicaid structure, expansions of coverage for these groups will remain largely under the purview of state programs. Of the 50 states, 8 have comprehensive programs and 15 have moderate programs. Given that the other 27 states have not taken advantage of the flexibility that has always characterized Medicaid—and only 8 have expanded significantly beyond Medicaid—even the post-welfare reform enhancements to flexibility and fiscal incentives will not reduce the substantial state variations in adult access to public health coverage. Barring a federal initiative to set and perhaps underwrite a higher income floor for the Medicaid program, expand or remove categorical requirements, or establish an adult counterpart to the Children's Health Insurance Program, state efforts alone are unlikely to significantly expand health insurance coverage for adults.

Endnotes

This brief is drawn from results in Spillman (2000).

1. The first wave of the NSAF collected economic, health, and social information on 44,000 households between February and November 1997. The survey oversamples households with incomes under 200 percent of the federal poverty level and households in each of 13 targeted states. The NSAF provides

information on a nationally representative sample of the civilian, noninstitutionalized population under age 65 and their families. A second wave of this survey was fielded in 1999. For more information and the survey methods and data reliability, see Kenney, Scheuren, and Wang (1999).

2. The federal matching rate is related to state per capita income. In the richest states, the federal share of Medicaid spending is 50 percent. In Mississippi, the poorest state, the federal share is 77 percent.

3. This typology is modified from one developed by Rajan (1998). The modification excluded factors applying only to children.

4. The impact is net of any substitution of public insurance for private, known as "crowd out." This analysis cannot address crowd out. Large programs tend to be associated here with small gaps, but the counterfactual— "What would the gaps be if the programs were less expansive?"— is not observed.

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About the Author

Brenda Spillman is a senior research associate in the Urban Institute's Health Policy Center. Her research focuses on access to and utilization of health services for nonelderly adults, including the role of the health care "safety net," as well as projects examining disability trends and long-term care use and financing among the elderly. Dr. Spillman recently published a study projecting service use and cost for the Medicare elderly, and a study of changes over time in the role of informal caregivers for the disabled elderly is forthcoming this fall.

Public Health Coverage for Adults: How States Compare

Brenda C. Spillman

Recent policy debate about the uninsured has focused mostly on the need to expand public coverage of children. However, about three-quarters of Americans without health insurance are nonelderly adults. These adults are 40 percent more likely than children to be uninsured and less than half as likely to have public coverage. Their chances of obtaining public coverage vary widely, however, depending on where they live. States differ in both the degree to which they cover the nonelderly adult population without private insurance and the likelihood of public coverage for different groups *within* that population: women versus men, parents versus nonparents, healthy versus sick, and poor versus nonpoor.

Nonelderly adults are 40 percent more likely than children to be uninsured and less than half as likely to have public coverage.

This brief uses data from the 1997 National Survey of America's Families (NSAF)[1] to compare the types of medical assistance eligibility a state may provide—Medicaid with little or no expansion beyond federal minimums (limited programs), more generous state options using Medicaid (moderate programs), or even more generous state options using Medicaid and state-only coverage (comprehensive programs)—and that state's relative success in covering its otherwise uninsured adult residents. As expected, states with more comprehensive approaches to medical assistance cover more otherwise uninsured adults than do states with more limited approaches. For example, states with comprehensive approaches are twice as likely as states with limited approaches to cover otherwise uninsured adults, regardless of income. They also reach the largest proportions of low-income adults—whether or not they are in groups that Medicaid traditionally has covered (single parents and disabled adults).

Severing the link between cash welfare and Medicaid, as the 1996 Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) did, could significantly increase states' willingness to provide public health coverage. However, many states have not taken advantage of federally matched expansion options Medicaid has provided since its inception.[2] This suggests that major expansion of adult coverage is unlikely without further federal support.

State Differences in Insurance Status and Coverage Gaps

The NSAF, in addition to being nationally representative, contains representative subsamples for 13 states. These focal states are shown in table 1, grouped by the relative comprehensiveness of their policy approaches to providing public coverage for adults in 1997.[3] For apparently close cases, such as Massachusetts and New Jersey, which both covered between 2 and 10 percent of their uninsured through state programs beyond Medicaid, the final designation was made by looking at other dimensions—in this case, income eligibility limits and eligibility rates for poor adults, both of which were considerably higher in Massachusetts.

The Coverage Picture

The insurance status of the nonelderly adult population in the United States and in each of the focal states is shown in

Healthy Kids
A Healthy Future

A Study of North Dakota's Uninsured Children

Table of Contents

Introduction

In September 1999, The Robert Wood Johnson Foundation approved a three-year grant of $669,963 to the State of North Dakota's Children's Services Coordinating Committee in support of its participation in the Foundation's program, Covering Kids: A National Health Access Initiative for Low-Income, Uninsured Children. The goals of the initiative are three-fold:

- design and conduct outreach programs that identify and enroll eligible children into Medicaid and other coverage programs,
- simplify enrollment processes, and
- coordinate existing coverage programs for low-income children.

The purpose of this study is to evaluate the current enrollment processes and identify opportunities for simplification and increased coordination between Medicaid for children and families and the State's Children's Health Insurance Program, Healthy Steps. Program simplification and increased coordination will not only increase the enrollment of eligible children, but also reduce the administrative costs associated with program implementation. This study makes several recommendations that can be low cost and sometimes no cost to the State of North Dakota.

"The test of our progress is not whether we add more to the abundance of those who have much; it is whether we provide enough for those who have too little."

Franklin Delano Roosevelt

A top priority for our state's leadership has always been improving the quality of life for all North Dakotans. An integral component to achieving this goal is the promotion of better health and strong, self-sufficient families. However, to realize the vision of a healthy workforce and a healthy future for North Dakota, it is fundamental that we set a high priority on the health of our children.

Executive Summary

The purpose of this study is to evaluate the current enrollment processes and identify opportunities for simplification and increased coordination between Medicaid for children and families and the State's Children's Health Insurance Program, Healthy Steps. Specifically we were interested in answering the following questions:

1. What are the attitudes, perceptions, issues and/or barriers associated with increasing the number of low-income children receiving medical assistance?
2. What recommendations should be considered to enroll and cover more uninsured children?
3. What authority and/or latitude does a county or the state have in changing policies or procedures which impact the number of low-income children receiving healthcare coverage?
4. What can we learn from secondary research to impact the objectives of the study?

"Every child needs medical attention and early care saves everyone time and money."
Social Service Board member

In July 2000, the Community HealthCare Association engaged Boyd & Company, Inc., a local business development, planning and marketing firm, to conduct the study's focus groups, administer the written surveys and compile the findings. Throughout October and November, focus groups were conducted with parents and caregivers, county social service board directors, and eligibility workers. The parent focus groups included 147 participants and were held in Bismarck, Dickinson, Fargo, Grand Forks, Minot, and the two reservation communities of St. Michael (Spirit Lake Reservation) and New Town (Fort Berthold Reservation).

Additionally, information was gathered from a parent survey of all registered focus group participants and state-wide surveys of county social service eligibility workers, directors and board members.

This study found the primary issue that affects Medicaid enrollment is not the stigma assumed to be associated with applying for public assistance, but rather a basic lack of knowledge and awareness regarding the programs themselves.

It also was clear that no one organization has embraced a public awareness program as their primary responsibility. An opportunity exists to create partnerships with organizations and agencies that have a special interest in reducing the number of uninsured children in their respective communities. A detailed and concise strategy can be implemented to build commitment and assist in education and outreach to low-income parents and guardians. The strategy should be a multi-faceted campaign involving the stakeholders, employers, health care providers and agencies, schools and advocates such as the parents themselves.

A limited coordination between the Medicaid and Healthy Steps application processes compounds the difficulties a parent encounters when navigating the enrollment process. It is the recommendation of this study to create a joint application and more closely align the application processes and eligibility criteria for Medicaid and Healthy Steps. Although low-income families in North Dakota highly value access to health care coverage for their children, the process of obtaining that coverage is extremely frustrating.

"While the goal is healthier children, the challenge is creating a program that fills the coverage gap, isn't too cumbersome for county eligibility workers and parents, and is offered in such a way that parents feel comfortable applying for it and using it."

Carol Olson, Executive Director, Department of Human Services

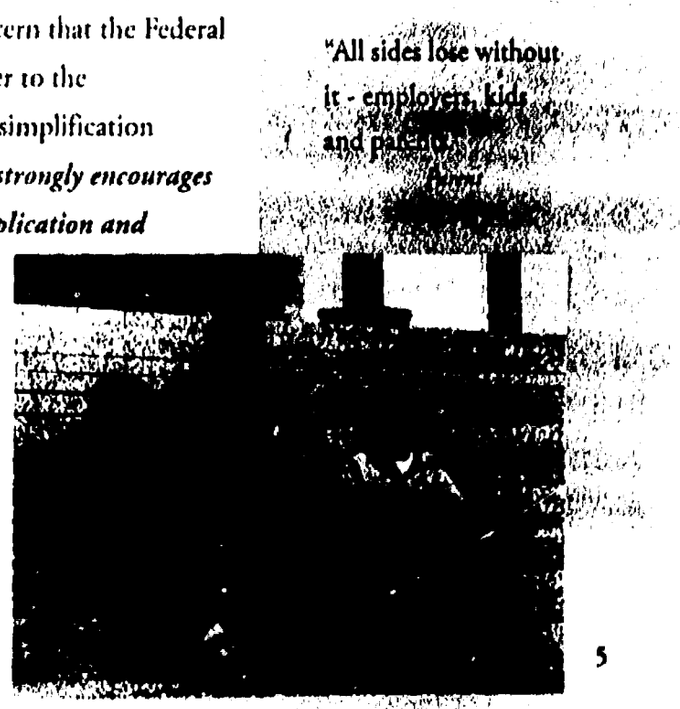
Barriers to Medicaid enrollment, both actual and perceived, that were most often identified by parents in this study were as follows:

- Confusion about the programs
- Lengthy and intrusive enrollment process
- Complicated, burdensome and redundant process to maintain eligibility
- Over-burdened county social service system
- Access and transportation to county social service offices, particularly in rural areas and Native American communities

North Dakota designed a simple application and enrollment system for the healthy Steps program in 1999. Although there is considerable flexibility under current law to take similar steps to simplify and streamline the Medicaid application and enrollment procedures, the state is not taking advantage of these opportunities.(Center on Budget and Policy Priorities, December 1999.)

Recently the Health Care Financing Administration (HCFA), the federal agency charged with administering the Medicaid program, has encouraged states to simplify their application process. In letters to state health officials issued on January 23, 1998, and on September 10, 1999, HCFA promoted a range of strategies including elimination of the test for assets, allowing applications to be submitted by mail without requiring an interview at a welfare office, adopting presumptive eligibility procedures, and reducing verification requirements. (The Kaiser Commission on Medicaid and the Uninsured, October 2000.)

On September 12, 2000, HCFA issued another letter to state officials assuring them that simplification measures can be implemented without compromising program integrity. According to the letter, "...some states have voiced concern that the Federal Medicaid Eligibility Quality Control (MEQC) program is a barrier to the simplification efforts. However, there is no indication that states' simplification procedures have contributed to an increase in errors." ***This study strongly encourages North Dakota to explore its options for simplifying the existing application and enrollment processes.***

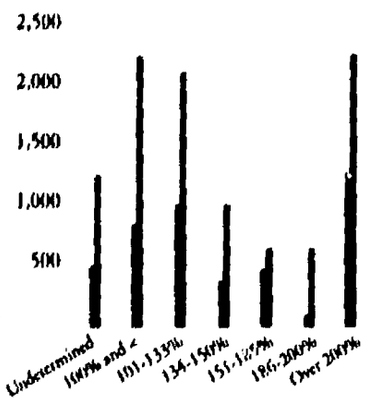


North Dakota's Uninsured

According to a 1998 Robert Wood Johnson Foundation Family Survey, 8.3 percent of North Dakota's 175,822 children are uninsured–approximately 14,593 children. This is lower than the national figure of 13.9 percent, however, the Current Population Survey from 1996 to 1998 averaged North Dakota's uninsured as high as 13.1%.[1]

The highest percentage of the state's uninsured is found between the ages of 25 and 34. In 1998, 51 percent of the people in this age group reported they were uninsured. This age group is of particular significance due to the fact that they represent North Dakota's young parents. This compares nationally with only 23.2 percent of this age group being uninsured. ***Three out of four uninsured are employed, and one out of ten work at more than one job.*** Sixty percent of the uninsured said they worked at firms that offered health insurance, but only 50 percent of them were eligible to apply. Their eligibility is mostly due to their part-time status. Uninsured persons in North Dakota are more likely to be employed in construction, farming, retail, restaurants, and nursing homes.[2]

North Dakota's uninsured children by poverty level



Many of the parents surveyed in this study have personal insurance for themselves, but have uninsured children because the proportion of their take-home pay required for premiums for their children's coverage can be as much as 30 to 50 percent or more. Due to the level of income these parents make, the premium cost to them means that, if they pay the premiums, they go without food or shelter.

Nationally, the number of uninsured Americans is estimated at 42.5 million people, or 15.5 percent of the population, down from 44.2 million or 16.3 percent, in 1998.[3] Within the last decade, however, the number of uninsured has grown over 10 million, or approximately 1 million per year. The decline in the last year is the first since the Census Bureau began collecting data in 1987.

"A high percentage of North Dakota's uninsured are the 'working poor.' Quite often they are young adults who either are not offered health insurance through their employers or cannot afford to pay for it."

Mary Schieve,
Health Care Discussions Fall 2000

Why Health Coverage is Important

Recent research has documented that uninsured children are more likely to be hospitalized for conditions that could have been treated through primary care. Uninsured children are less likely to be up-to-date with well-child care and all recommended immunizations. Not only are uninsured children less likely to receive treatment for common childhood illnesses, but also they are less likely to receive treatment even for a serious injury, a chronic illness, or a special need. Additionally, uninsured children, when compared with insured, are: [4]

- Up to 6 times more likely to have gone without needed medical, dental or other health care.
- Twice as likely not to have seen a physician during the previous year.
- Up to four times as likely to delay seeking care.
- Up to ten times less likely to have a regular source of care.

The scope of this study did not include determination of the financial impacts of the costs or benefits to enrolling more uninsured children. However, throughout the study, respondents shared their thoughts about the impact to society when children do not have healthcare coverage, when parents do not utilize medical services because of concern over the cost of services, when parents miss days at work due to sick children, and when children miss or cannot participate in school because of health problems and lack of preventive health care.

Uninsured persons in North Dakota are more likely to be employed in construction, farming, retail, restaurants and nursing homes.

RWJF Family Survey

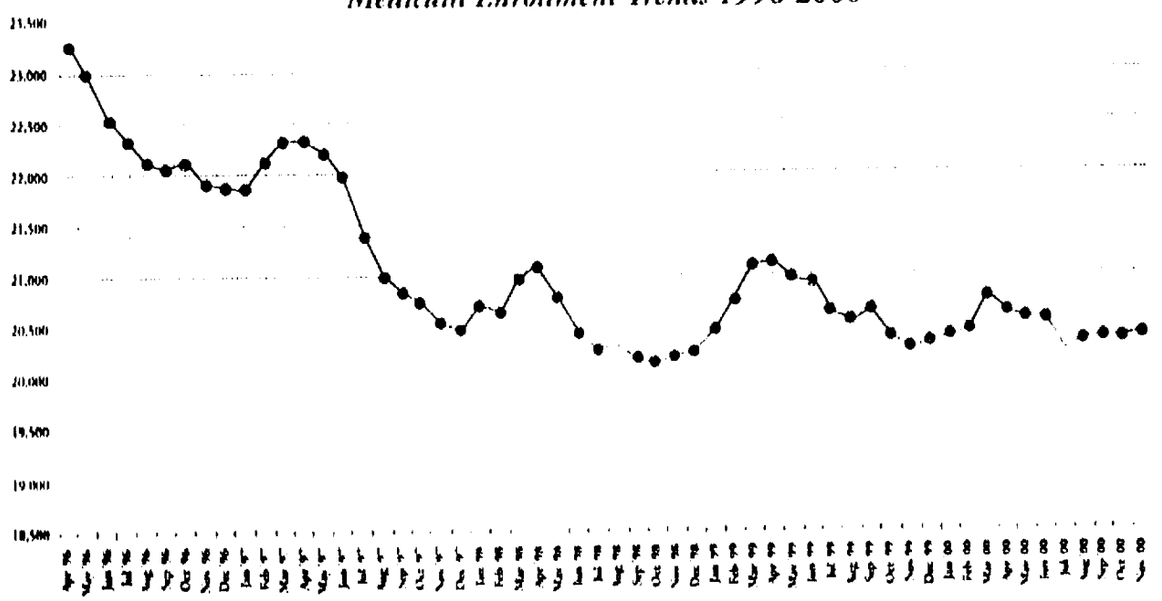
Enrollment Trends

In this era of post welfare reform, there is continued concern nationally regarding the affect of welfare policy changes has had on the number of eligible children enrolled in Medicaid.[5] Between 1996 and 1998 North Dakota experienced a dramatic downward trend in enrollment of children and adult caretakers, but in the past two years the numbers have somewhat stabilized.

It was anticipated that the implementation of the Healthy Steps' program in October 1999 would provide for increased enrollment in the children's Medicaid program due to the requirement that Healthy Steps' applicants first be screened for Medicaid eligibility. The impact, however, has not been as great as initially anticipated. In fact, the overall increase in Medicaid enrollment since the inception of Healthy Steps has been about 1%.[6] With approximately one-third of all Healthy Steps' applicants referred to Medicaid over the past fourteen months, it appears applicants are falling through the gap created by the lack of coordination between the administration of these two programs.

Detailed information regarding income eligibility limits for these programs is outlined in Appendix A.

Medicaid Enrollment Trends 1996-2000



Medicaid

Medicaid is a jointly funded, Federal-State health insurance program for certain low-income and needy people. It covers approximately 36 million individuals including children, the aged, blind, and/or disabled, and people who are eligible to receive federally assisted income maintenance payments. Medicaid, or Title XIX of the Social Security Act, was enacted by Congress in 1965 and began in North Dakota on January 1, 1966. The program is supervised by the Department of Human Services and administered by the 51 county social service boards.

State Children's Health Insurance Program , "Healthy Steps"

With overwhelming bipartisan support, Congress created the State Children's Health Insurance Program (SCHIP) in 1997, allocating $48 billion over the next 10 years to expand health care coverage to uninsured children. This new program, together with Medicaid, provides meaningful health care coverage to millions of previously uninsured children. Today, every state has implemented SCHIP, providing health coverage to over 3.3 million children nationwide since the beginning of the program.

This program is also a jointly funded, Federal-State health insurance program and is the most significant funding increase for children's health since 1965. North Dakota SCHIP, "Healthy Steps", is administered at the state level through the Department of Human Services. Established by the 1999 Legislative Assembly and authorized by Section 12 of the 1999 Senate Bill No. 2012, Healthy Steps began providing coverage for uninsured children in October 1999. With an income eligibility limit of 140 percent of the federal poverty level, Healthy Steps currently provides medical, vision, and dental coverage for approximately 50 percent of the estimated 4,000 eligible children at the income level.

Indian Health Services

Indian Health Services is often mistaken for health insurance. It is in fact a trust responsibility of the U.S. government based on treaty obligations and federal statues to provide health care to members of federally recognized tribes - a responsibility that the Indian Health Service (IHS) has partially fulfilled since 1955. However, because these services are predominately available through reservations, in 1997 only 20% of Native Americans reported having access to IHS. (Kaiser Commission on Medicaid and the Uninsured: Health Insurance Coverage and Access to Care Among American Indians and Alaska Natives, June 2000) In North Dakota, IHS outpatient facilities exist on the Fort Berthold, Standing Rock, Turtle Mountain and Fort Totten reservations. Inpatient IHS facilities are located on both the Standing Rock and Turtle Mountain reservations.

"This is one case where we should help get the facts about the program out to the public either personally or as a board."

Social Service Board member

Study Purpose and Scope

Purpose

The purpose of this study is to evaluate the current enrollment processes and identify opportunities for simplification and increased coordination between Medicaid for children and families and the State's Children's Health Insurance Program, Healthy Steps. Specifically, the study was interested in answering the following questions:

1. What are the attitudes, perceptions, issues and/or barriers associated with increasing the number of low-income children receiving medical assistance?
2. What recommendations should be considered to enroll and cover more uninsured children?
3. What authority and/or latitude does a county or the state have in changing policies or procedures which impact the number of low-income children receiving healthcare coverage?
4. What can we learn from secondary research to impact the objectives of the study?

Scope

In July 2000, Boyd & Company, Inc., a local business development, planning, and marketing firm, was contracted with to conduct the focus groups, compile the findings, and to assist the staff of the Community HealthCare Association in the planning process. In August, input regarding the study process and potential participant, was gathered from the North Dakota Department of Human Services, the North Dakota Department of Health, and County Social Service Directors. In addition, Ami Nagel, a consultant involved in a similar study in the state of Arizona, attended the August meeting to provide feedback and guidance. The following scope of the study was established:

- Listen to low-income parents from across North Dakota and discuss their experiences, perceptions, and knowledge of the current Medicaid application and eligibility process.
- Seek input from local county social service eligibility workers, directors, board members, and the Department of Human Services regarding the Medicaid process.
- Review secondary research that applies to the objectives of the study.

Seven parent focus groups were conducted during October 2000 in various locations throughout North Dakota as a method to gain perceptions regarding the current Medicaid application and eligibility process and outreach efforts. Significant thought was given to conducting focus groups in large and small communities, urban and rural communities, communities with a farm/ranch audience and Native American communities. The seven communities were:

- Fargo
- St. Michael, located on Spirit Lake Reservation
- Bismarck
- Minot
- New Town, located on the Fort Berthold Reservation
- Dickinson
- Grand Forks

A total of 147 parents participated in the seven focus groups. In each focus group, a combination of parents with Medicaid insured or uninsured children were present. Appendix B outlines the demographics of the focus group participants.

In each region of the state where a focus group was to be held, community partners were contacted about assisting in the outreach for focus group attendance. Packets of invitations and posters were made available for each group willing to assist in recruiting focus group participants. In addition, the North Dakota Department of Human Services assisted in the distribution of invitations to families with special needs children. Samples of the participant Recruitment Material are included in Appendix B.

Each respondent for the parent focus groups was pre-qualified and pre-registered by calling a toll-free number at the Community HealthCare Association. The participants were advised they would be attending a "Children's Insurance Meeting" and were not made aware of the specifics or scope of the study.

"Remember that every issue is a human issue, and human implications come before everything else."

former Governor Sinner "Advise for the Next Governor" Bismarck Tribune, 6/4/2000

Parents included in the focus group and parent survey had to meet the following criteria:

- Have children 18 or younger
- Monthly income at or below:

Family size	Income
1	$975
2	$1,313
3	$1,651
4	$1,990
5	$2,328
6	$2,666
7	$ 3,005
8	$3,343
9	$ 3681

Meetings were held in various buildings such as community health centers, public libraries, Community Action Agencies, community centers, and banks in order to ensure the widest possible audience with no fears of attending based on location. At each meeting, parents were provided with pizza or appropriate refreshments, as well as nominal compensation for participating in the meeting. Focus group meetings were two hours in length. A parent discussion guide was utilized to provide consistency to the questions asked. Comments made at the focus groups were recorded by a computer-aided transcriber and audio taped.

A written parent survey was presented to the participants prior to the focus group discussion. There were 20 questions on the survey that was developed by Boyd & Company, Inc. with the assistance of county and state professionals. All 147 participants complete the survey.

"I think I need to always be aware of children in my county and town. Children are the most important assets we have."
Social Service Board Member

A statewide e-mail survey of county eligibility workers to ascertain their opinions about the process was conducted in October 2000. The e-mail survey was distributed through the efforts of the North Dakota Department of Human Services Medicaid Eligibility Policy. Boyd & Company, Inc. developed a thirty-five question survey with the assistance of county and state professionals. It was sent to approximately 280 county eligibility workers located in 53 counties throughout the state of North Dakota. There was a total of 72 survey respondents with a 26 percent response rate.

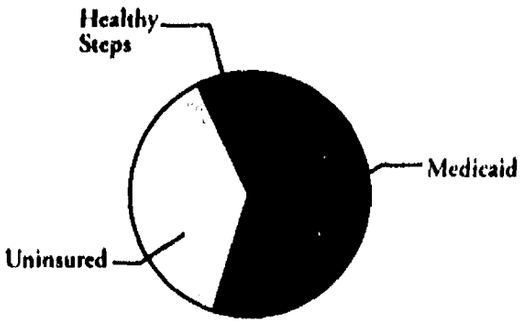
A statewide e-mail survey of county social service directors was conducted in October 2000 to ascertain their opinions about the Medicaid process. The e-mail survey was distributed through the efforts of Michon Sax, current president of the North Dakota

County Social Service Directors Association. Boyd & Company, Inc. developed a thirty-three question survey with the assistance of county and state professionals. The survey was sent to approximately 33 social service directors statewide. A total of 17 Social Service Directors responded with a 51 percent response rate.

An Eligibility Worker Focus Group was conducted in October 2000 with the statewide Eligibility Workers Technical Task Force. The focus group was held in conjunction with their regularly scheduled quarterly meeting. Since the participants were not screened as in a traditional focus group, the feedback from this group is perhaps skewed to the positive since the Eligibility Workers Technical Task Force's purpose is to seek quality and improvement in the eligibility process. The Task Force Chairman, Larry Bernhardt of Stark County, distributed e-mail invitations to the meeting. A total of 13 eligibility workers participated in the meeting. A discussion guide was utilized to provide consistency to the questions as well as to ask questions that provided for cross tabulation with parents and social service directors.

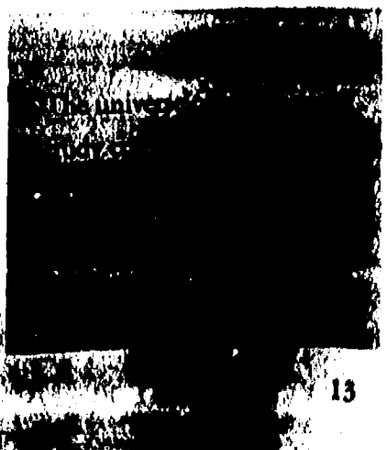
A Social Service Director Focus Group was conducted in November 2000. All Social Service Directors were invited to participate in this focus group which was scheduled during their regular monthly statewide meeting. The North Dakota County Social Service Directors Association President Michon Sax distributed e-mail invitations to the meeting. Twenty-four social service directors participated. A discussion guide was utilized to provide consistency to the questions as well as to ask questions that provided for cross tabulation with parents and social service directors.

Insurance Status of North Dakota's Uninsured Children



A mail survey was distributed to approximately 280 Social Service Boards and/or County Commissioners who served that function in November. Social Service Directors were asked to distribute the envelopes at their meeting in November and a follow-up mailing was made to counties where responses had not yet been received by the closing date of the survey. Boyd & Company, Inc. developed a sixteen question survey with the assistance of county and state professionals.

All written survey instruments utilized in this study contain specific questions for cross tabulation with parents, eligibility workers, social service directors, and to test against secondary research such as the national George Washington University Children's Medicaid study dated July 2000. A complete list of the secondary research materials utilized by this study is provided in the *References* section of this report.



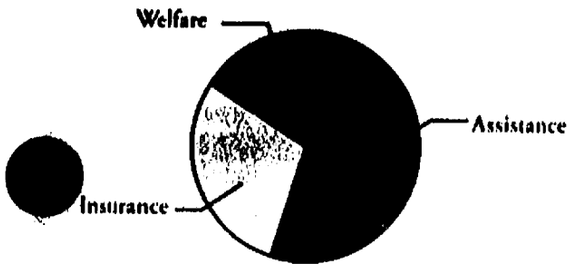
Key Findings and Recommendations

Stigma Was Not Found to be a Barrier

This study found that the primary issue affecting Medicaid enrollment is not the stigma assumed to be associated with applying for public assistance, but rather a basic lack of knowledge and awareness regarding the programs themselves.

A July 2000 George Washington University Issue Brief: Beyond Stigma: What Barriers Actually Affect the Decisions of Low-Income Families to Enroll in Medicaid? found that, to the extent that stigma is a barrier to applying for and enrolling in Medicaid, the stigma is more about how people are treated in the process rather than the stigma of being associated with the program. This study found the same result. Only 30 percent of each study group stated that Medicaid's association with public assistance is a negative stigma affecting parents' decisions to apply for Medicaid.

How Parent's Perceive Medicaid



In fact, this study found parents do not think of Medicaid for children and families as welfare. When parents were asked which of the following best describes Medicaid for children, over half of the parents described Medicaid as assistance, almost one-third indicated insurance and only 15 percent selected welfare.

Although many parents did not describe Medicaid as welfare, they do perceive that the front office staffs of health care providers treat them differently because they have Medicaid coverage. About one third of parents responded that when compared to all patients, people receiving Medicaid benefits are treated in an inferior manner when making appointments and registering at health facilities.

Although the parents that participated in the focus groups came from diverse communities, their responses were very consistent. Low-income families in North Dakota highly value access to health care coverage for their children, but find the process of obtaining that coverage is extremely frustrating. Barriers to Medicaid enrollment, both actual and perceived, most often identified by parents in this study were as follows:

- Confusion about the programs
- Lengthy and intrusive enrollment process
- Complicated, burdensome and redundant process to maintain eligibility
- Over-burdened county social services system
- Access and transportation to county social service offices, particularly in rural areas and Native American communities

Finding: Confusion about the programs

One of the primary findings of this study is the lack of awareness parents have about Medicaid and Healthy Steps. The study found 86 percent of the parents and 83 percent of county social service directors state parents with children eligible to receive benefits are less aware of available programs to assist them.

Many North Dakota parents are still unaware of the availability of reduced cost or free child health insurance programs available within the state. Parent outreach and education ranked in the top three recommendations from parents, eligibility workers and social service directors. Parent focus groups indicated only 11 percent were familiar with the Healthy Steps' program. Parents also indicated their willingness to attend additional meetings for no compensation in order to learn more about their options.

Recommendation: Increase awareness through outreach partnerships and parent education

No one organization has embraced public awareness as their primary responsibility. An opportunity exists to create partnerships with organizations and agencies that have a special interest in reducing the number of uninsured children in their respective communities. A detailed and concise strategy can be implemented to build commitment and assist in education and outreach to parents and guardians of low-income children. The strategy should be a multi-faceted campaign involving the stakeholders, employers, health care providers and agencies, schools, and advocates such as the parents themselves.

People cannot access what they do not know exists. Therefore, the importance of implementing strategies to educate and inform parents and guardians of the health care options available to them is an important element in ensuring North Dakota's children remain healthy. Social marketing requires understanding what motivates the person and requires more than a brochure to detail the information. We need to determine how to motivate parents to seek help for their children prior to a health care crisis.

In addition to education about health coverage assistance options, education needs to be directed towards quality of care issues outlined in the findings section of this report. For instance, public forums could be held across the state to address benefits and restrictions of Medicaid and Healthy Steps. Making additional information available to North Dakota parents concerning the importance of preventative health care, and appropriate follow-up, would also be beneficial.

"This is one case where we should help get the facts about the program out to the public either personally or as a board."
Social Service Board member

Finding: Lengthy and intrusive enrollment process

The application form for Medicaid is currently incorporated within a sixteen page multi-program form used also for Temporary Assistance for Needy Families (TANF), Food Stamps, and Child Care Assistance. The first four pages are instructions and ten of the remaining twelve pages must be completed when applying for Medicaid. In comparison, the application for the Healthy Steps program is only two pages in length, with two additional pages of instructions.

As the table below shows, the Medicaid program has the heaviest burden of proof for the applicant. How valid is the requirement that Medicaid applicants provide this information when it is not required of Healthy Steps applicants? Is the assets test a viable means of determining a family's ability to otherwise pay health premiums or expenses themselves? The Department of Human Services recently conducted a study that may help answer these questions.

For the sixteen-month period of January 1999 to April 2000 a report was generated identifying all children and family cases that were denied or closed due to the household having excess assets. Of the 21,158 applications that this report identified, 20,886 (98.7%) of the applications were approved. Only 272 applications were denied due to excess assets, and of those, nearly half would have been denied due to excess income regardless of their asset status. Therefore, in a sixteen-month period, approximately 0.6 percent (136 out of 21,158) of all applications were denied due to excess assets. Although these figures do not include applicants that did not complete an application, the asset test does not appear to be a necessary tool in determining eligibility.

	Medicaid	Healthy Steps
Mode of application	Mail, In-person interview	Mail
Period of eligibility	Monthly if income fluctuates	12 Steps
Assets Test	Yes	No
Documentation	Citizenships status; records that show the current value of all your assets (checking and savings account balances, certificates of deposit, stock/bonds, IRA, 401K keogh plans life insurance, burial plan, trust documents, and real property); records that show expenses for child/dependent care, medical expenses, health insurance premiums, court ordered payments, rent/mortgage, telephone bill, lease agreement, home owner's insurance, heating and cooling costs, housing assistance contract, property taxes; identity/age of all household members; income;residence;social security numbers; and if applicable, verification of pregnancy.	Income

**The data for this table is taken from the "Things You Will Need To Provide" section of the Application for Medicaid, Temporary Assistance for Needy Families (TANF), Food Stamps, and Child Care Assistance.*

Like other national studies, intrusive personal questions asked during the enrollment process were a frequent complaint of parents in the focus groups. (Center for Public Policy Priorities, September 2000).

Parents and eligibility workers see the information required for the Medicaid application differently. Parents were about three times as likely as eligibility workers to state that having to answer unfair and personally imposing questions is a significant barrier affecting parents applying for medical assistance. Parents state there is little privacy and their life is an "open book" to the eligibility worker. Eligibility workers state they are just asking for the information they are required to collect.

"It's too complicated and they can't understand. We overwhelm them with information and paperwork."
Eligibility Worker

From the family's perspective, verification is often a major barrier to enrollment because it involves obtaining documentation from third parties, such as employers, banks and noncustodial parents, who may not be cooperative. In addition, the intrusive nature of the verification process adds considerably to the stigma associated with applying for Medicaid (Southern Institute, December 1998).

Because of the perception of intrusiveness, the relationship between eligibility workers and parents is strained. Parents express frustration over having to share personal information with someone they know by first name only, and in some cases, with people they know personally. This is compounded when parents live in small communities where there is less anonymity.

Recommendation: Simplify the process by removing the asset test and align the application processes for Medicaid and Healthy Steps

To better align the programs, it is the recommendation of this study to remove the asset test requirement for medicaid eligibility for children and families.
By streamlining the documentation and verification requirements that apply to both programs, the paperwork burdens for both families and administrating agencies would be greatly reduced. The projected cost of removing the asset test is outlined in the Conclusions and Policy Implications section of this report.

North Dakota is one of only nine remaining states to utilize an assets test when determining eligibility for Medicaid families and children. See Appendix D for comparative state data. If this requirement were removed, North Dakota would be able to greatly reduce Medicaid's documentation requirements and create a streamlined, single application for both Healthy Steps and Medicaid. This action alone would allow for increased coordination and a less burdensome process for both

families and eligibility workers. Additionally, a single application process would provide opportunities for more effective outreach, marketing, and parent education.

Within the past few years, the federal agency that regulates Medicaid, the Health Care Financing Administration (HCFA), has encouraged states to simplify their application process. In letters to state health officials issued on January 23, 1998 and on September 10, 1999, HCFA promoted a range of strategies including elimination of the test for assets, allowing applications to be submitted by mail without requiring an interview at a welfare office, adopting presumptive eligibility procedures, and reducing verification requirements. (The Kaiser Commission on Medicaid and the Uninsured, October 2000.)

More recently, on September 12, 2000, HCFA issued another letter to state officials assuring them that simplification measures can be implemented without compromising program integrity. According to the letter, "Some states have voiced concern that the Federal Medicaid Eligibility Quality Control (MEQC) program is a barrier to the simplification effort. However, there is no indication that states' simplification procedures have contributed to an increase in errors."

Key federal requirements for Medicaid include:

- Signed application;
- Social Security numbers for applicant children;
- Documentation of immigration status of children who are qualified aliens;
- Recertification is required at least every 12 months, but need not be face-to-face.

States are NOT required:

- To conduct a face-to-face interview;
- To collect documentary proof of eligibility related questions other than immigration status;
- To impose any resource or asset limit on children's Medicaid;
- To terminate children's eligibility immediately when family income increases;
- Verify income.

"The North Dakota Medicaid program rules are complicated to the extreme. Think the rules the eligibility workers must follow should be less complicated. It makes it difficult to explain all the different budgeting methodology to the households."

Eligibility Worker

The above outlines the federal government's increased flexibility to allow states to determine the Medicaid eligibility and enrollment of uninsured children. As can be seen in Appendix D, North Dakota has taken advantage of very few of the opportunities provided to streamline the enrollment process.

Parents unanimously agreed that they want choices when it comes to applying for Medicaid. Parents that were familiar with Healthy Steps appreciated the anonymity applying by mail afforded them. Not only does a mail in application provide anonymity, it allows working parents more flexibility to apply at their convenience. For instance, parents expressed frustration with having to take time-off from work and make transportation arrangements to attend a face-to-face meeting at county social service offices. In addition, parents would like available to them a toll-free number they can access for application assistance, eligibility criteria, and information regarding program benefits.

By providing choices for parent to enroll and gain information either through face-to-face, phone, mail or fax methods, you increase the likelihood that more parents with uninsured children will apply for Medicaid.

Finding: Limited Coordination Between Medicaid and Healthy Steps

A limited coordination between the Medicaid and Healthy Steps application processes compounds the difficulties a parent encounters when navigating the enrollment process. Although it is a requirement that Healthy Steps applicants first be screened for Medicaid eligibility, only a moderate increase in Medicaid enrollment has occurred since the inception of Healthy Steps in October 1999.[6] With approximately one-third of all Healthy Steps applicants referred to Medicaid over the past fourteen months, it appears applicants are falling through the gap created by the lack of coordination between the administration of these two programs.

Of the Eligibility Workers surveyed, twenty-eight percent indicated they rarely to never assist parents in applying for Healthy Steps.

The Medicaid program is supervised by the Economic Assistance Division of the Department of Human Services and administered by the 51 individual county social service boards with county eligibility staff determining eligibility for the program. The administration and eligibility determination for Healthy Steps is centralized in the Medical Services Division within the Department of Human Services.

Of additional concern is the misunderstanding of parents regarding the options available to them when they no longer qualify for Medicaid. Participants in the parent focus group expressed that they believed their only option is to be considered for the Medically Needy program in which they must first incur a large recipient liability before qualifying for assistance with their medical expenses. It appears they are not aware of the Healthy Steps program as a more affordable option.

Recommendation: Create a joint application Medicaid and Healthy Steps. Of the 32 states with CHIP-funded separate programs, 28 states allow families to apply for health coverage for their children using a single application. See state comparisons in Appendix D.

According to the Health Care Financing Administration (HCFA) in their November 1998 program guidance: "The simplest way to meet the 'screen and enroll' requirement is to use a joint application form. A state would review the joint application and determine Medicaid or SCHIP eligibility consecutively, without requiring the family to submit additional information. Medicaid enrollment can be accomplished without referring the family to another office or completing another application."

"Keep it as simple as possible. The fewer people involved the better."
Social Service Board member

As discussed in previous recommendations, the removal of the asset test for children and families will simplify the enrollment process and open the door for creating a joint application with Healthy Steps. A joint application would allow for a closer alignment of the programs and provide for many "no cost" improvements. Awareness campaigns and parent education could be coordinated under the theme of "health insurance for children" with a single application and a shared toll-free number. Eligibility determination could also be better coordinated and the current need to refer parents from one program to the next could be eliminated and enrollment streamlined. Prospective enrollees could be screened and enrolled in the program for which their income qualifies without the additional confusion of navigating two programs.

Finding: Complicated, burdensome, and redundant process to maintain eligibility

Families enrolled in Medicaid whose income is derived from hourly pay or self-employment are required to submit pay stubs on a monthly basis for recertification. In addition, if a family's income fluctuates, parents must report these changes to their county social service office within 10 days.

The redundancy in gathering the same information month after month is perceived as a paperwork nightmare by parents. If the appropriate documentation is not submitted within the timeframe allowed, the Medicaid case is closed and a family must re-apply. The process for re-applying requires the parent(s) to resubmit all information and complete a full application. Parents voiced frustration over the fact that the social service office has this data on file, such as names, birth dates, social security numbers, etc., but parents are still required to complete a full application.

Parents commented on the high pressure, unrealistic workloads, and sometimes poor working conditions of the county eligibility workers. These comments are not unique to North Dakota as demonstrated by other national studies (Center for Public Policy Priorities, September 2000). It is interesting to note that parents have a very empathetic attitude towards their eligibility worker. Parents stated that eligibility workers are generally professional people working in a burdensome or tedious system.

Over 40 percent of county social service directors would characterize the resources their county appropriates to conduct eligibility work and assistance to families with uninsured children as less than sufficient.

Over half of the county social service directors believe a case can be made for their board to support added administrative expense to increase the number of children enrolled in Medicaid.

Over two-thirds of the social service board members that were surveyed indicated that they would support finding ways to increase the number of enrollments in Medicaid from families with uninsured children.

Parents also expressed concern their eligibility worker is not an advocate on their behalf. Many parents view their eligibility worker as a gatekeeper and voiced frustration that they are not forthcoming about their case and may withhold information they view as critical to their eligibility status. Not only do they feel that information is withheld, in general parents believe eligibility workers construct unnecessary barriers that limit the number of parents eligible for Medicaid.

When asked, how would parents describe their interaction with social services, less than 10 percent of parents and social service board members indicated very good to excellent. In contrast, over half of the eligibility workers and directors indicated parent's interaction with social services as very good to excellent.

"You have to go from month-to-month and give them all your paperwork. I do more paperwork in a month than most people do in a year."

Recommendation: Allow for Continuous Coverage

Continuous coverage is a provision that allows children eligible for Medicaid or SCHIP to remain eligible for a specific period of time regardless of any change in family income or family structure (Mathematica Policy Research, June 2000). Currently Healthy Steps has continuous eligibility for 12 months, while children's Medicaid eligibility is determined on a month-to-month basis.

Advocates of continuous coverage believe this policy will:

1. Simplify the enrollment and eligibility process for both the state and for families. For example, a national study found that adopting a policy of "continuous coverage would simplify administration for eligibility staff, [however] the simplification would be more significant for families. Continuous coverage reduces the number of redeterminations eligibility workers have to process. It may also reduce the general workload of eligibility workers." (Mathematica Policy Research, June 2000).

2. Reduce or eliminate the "cycling" of children on and off Medicaid due to temporary changes in income. In low-income families, income can be unpredictable and can fluctuate from month to month. Unless a state has continuous enrollment policies for families, children may be required to drop and re-apply for coverage according to the family's current circumstances, even when income differences are relatively small amounts.

3. Enable eligible children to obtain care for an uninterrupted period, thus increasing their opportunities for obtaining preventative health care and early intervention.

Recommendations

1. Simplify the enrollment process
2. Reduce the "cycling" of children on and off Medicaid
3. Enable eligible children to obtain care for an uninterrupted period

Finding: Access and Transportation Issues

Transportation and access to county social service agencies, particularly in rural areas and American Indian communities, poses a challenge and is a barrier to Medicaid enrollment.

In addition, more than a third of parents and a quarter of eligibility workers indicate that convenience issues such as time, place or transportation is a significant barrier affecting parents applying for medical assistance.

Recommendation: Outstationed Eligibility Services

Twenty- three percent of parents indicated that their lack of access to enrollment assistance is a significant barrier affecting parents applying for Medicaid. Parents stated they would like out-stationed enrollment in clinics, hospitals and other alternate locations such as schools and child-care centers (George Washington University, July 2000). Forty-five percent of the parents indicate off-site application opportunities would increase the number of children covered by medical assistance.

"If a case closes, it cannot be reverted open. The line workers hate it when a case closes and they have to reopen. It's the ultimate terror. Maybe we should call it a dormant case make the process simpler."

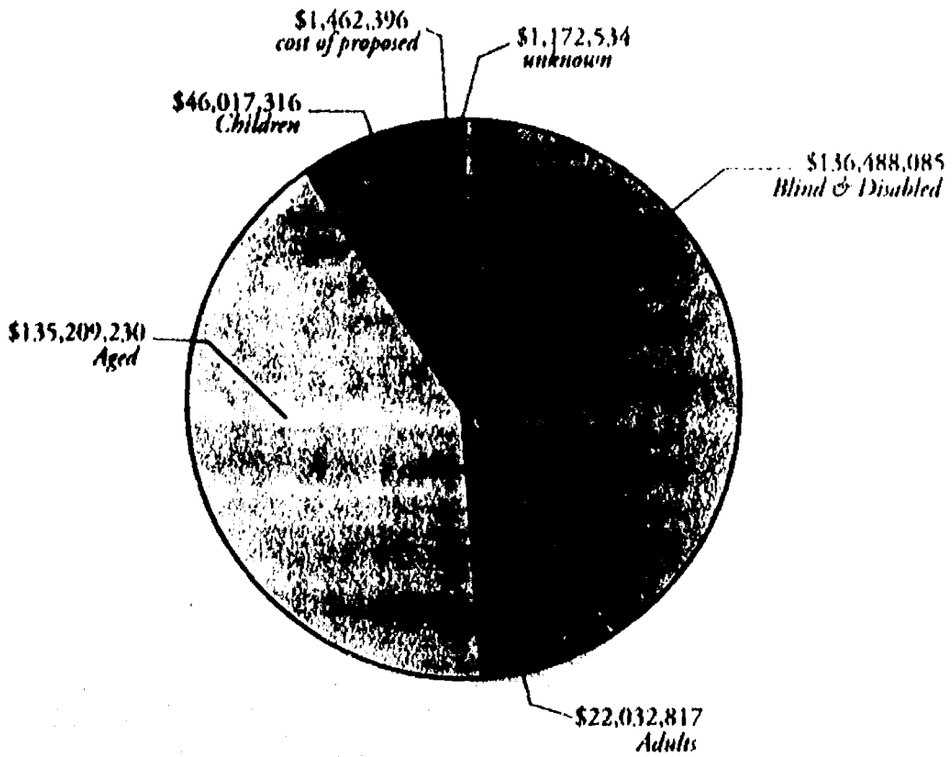
Social Service Director

Conclusion and Policy Implications

The purpose of this study was to evaluate the current enrollment processes and identify opportunities for simplification and increased coordination between Medicaid and the State's Children's Health Insurance Program, Healthy Steps. Several low-cost and sometimes no cost recommendations have been made that would not only streamline the enrollment process, but also build a greater awareness of the program's benefits for uninsured, low-income families. As identified earlier in the study, the opportunities that would have the greatest impact are:

- A joint application for Medicaid and Healthy Steps eligibility
- Removal of the asset test for Medicaid
- Align the application processes of Medicaid and Healthy Steps
- Allow for continuous coverage within the Medicaid program
- Increase awareness and knowledge of the program(s) through outreach partnerships and parent education
- Explore the outstationing of eligibility workers

In almost all cases, the implementation of a recommendation provides a significant decrease in administrative complexity and the associated cost represents no more than the inherent cost of enrolling additional currently income-eligible uninsured children. The graph below identifies the financial impact of those costs over the next biennium and their relationship to the entire Medicaid program budget:



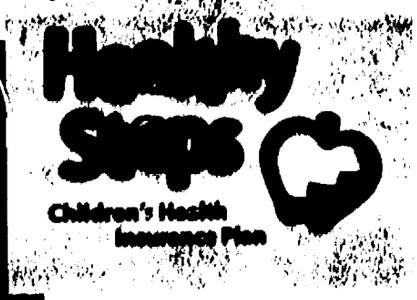
As the graph illustrates, the estimated increase of $2,924,792 ($1,852,256 to remove the asset test and $1,072,536 to provide for 3 month continuous eligibility) is minimal when compared to the overall cost of the Medicaid program, $681,839,964. The state contribution to this total cost is only $877,730 that leverages the additional $2,047,062 in federal matching funds.

The data for this chart was taken from the following North Dakota Department of Human Services testimony: 1) the cost of removing the asset test was addressed in the August 1, 2000 testimony to the Interim Committee on Health Budget and represents the enrollment of an additional 1,367 children; 2) the cost of all Medicaid programs was addressed in the January 4, 2001 testimony to the House Appropriations Committee concerning HB 1012; and 3) the cost of extending continuous eligibility from monthly to quarterly was addressed in the January 15, 2001 testimony to the House Human Services Committee concerning HB 1036.

The removal of the asset test for children and families will simplify the enrollment process and open the door for creating a joint application with Healthy Steps. A joint application would allow for a closer alignment of the programs and provide for many "no cost" improvements. Awareness campaigns and parent education could be coordinated under the theme of "health insurance for children" with a single application and a shared toll-free number. Eligibility determination could also be better coordinated and the current need to refer parents from one program to the next could be eliminated and enrollment streamlined. Prospective enrollees could be screened and enrolled in the program for which their income qualifies without the additional confusion of navigating two programs.

To increase recognition, consideration should also be given to branding the program under the single name of "Healthy Steps". As income increases and parents move toward greater self-sufficiency, they would likewise progress through the "steps" in the program. If the income eligibility for Healthy Steps were to be raised from 140% to 150% of the federal poverty level, North Dakota could allow parents to cost-share at income levels above 150%. This potentially new "next step" would help fill the gap for parents willing and able to pay a portion of their child's health coverage, but have no affordable alternative.

Brand children's Medicaid and the State Children's Health Insurance Program under the single name of



Endnotes

[1] Dr. Alana Knundson. Presentation to the Covering Kids Advisory Board: Monitoring the Uninsured: A North Dakota Perspective. June 8, 2000. The Current Population Survey (CPS) is a monthly national labor force survey. The March supplement of the CPS includes extensive questioning about income and health insurance status, however, uninsured status is measured as a residual, i.e. not having coverage from a named source at anytime during the prior year. A direct follow-up question to confirm that the individual surveyed is uninsured was added in March 2000. The sample size is 50,000 households with Primary Sample Units (PSUS) in each state. North Dakota's has one PSU which is Fargo. Sampling error is unavoidable for state-level data, and the US Census Bureau uses a 3-year average. The 1998 Robert Wood Johnson Foundation Family Survey is also a random telephone survey conducted throughout the state of North Dakota. The sample size was 5,027 households and Mathematica Policy Research, Inc designed the survey instrument.

[2] Dr. Alana Knudson-Buresh. *Health Care Discussions.* Fall 2000: 24-29.

[3] On the Net: Census report:
(www.census.gov/Press-Release/www/2000/cb00-160.html.)

[4] American College of Physicians - American Society of Internal Medicine. *No Health Insurance? It's Enough to Make You Sick - Scientific Research Linking the Lack of Health Coverage to Poor Health.* August 2000. www.acponline.org/uninsured

[5] Jocelyn Guyer. *Health Care After Welfare: An Update of the Findings From State-Level Leaver Studies.* August 16, 2000.
During the debate over the 1996 federal welfare law, a bipartisan consensus emerged that low-income families with children should not lose health care coverage as a result of changes in welfare policies. Congress therefore included a provision in the welfare law that "delinked" Medicaid and welfare eligibility, creating the opportunity for families to qualify for Medicaid regardless of their welfare status. Nevertheless, a growing body of evidence suggests that welfare policy changes in recent years have caused a loss of Medicaid among eligible low-income families with children.

[6] David Zentner. *Testimony before the Interim Budget Committee on Health Care.* June 28, 2000.

References

Children's Action Alliance. *Children Without Health Insurance: Listening to Arizona's Parents.* June 1999. The Children's Action Alliance (CAA) held 11 focus groups with low-income parents from across Arizona to discus their experiences and perceptions of the Arizona Health Care Cost Containment System (AHCCCS) application and eligibility process. The study found that while participating parents came from different kinds of communities and households, they consistently and repeatedly described three perceptions of the AHCCCS enrollment process that discouraged them from enrolling their children: excessive, intrusive and complicated paperwork, time-consuming and burdensome appointment procedures and demeaning interactions with eligibility staff.

National Conference of State Legislatures. *Keeping Kids Enrolled: Continuity of Coverage under SCHIP and Medicaid.* January 2000. This paper provides information about how states can keep kids enrolled once outreach and enrollment have succeeded, and examines some early data on the effectiveness of retention mechanisms.

George Washington University Center for Health Services Research and Policy Issue Brief. *Beyond Stigma: What Barriers Actually Affect the Decisions of Low-Income Families to Enroll in Medicaid?* July 2000. This Issue Brief reports on the Medicaid-related findings from one of the largest studies ever undertaken on the subject of public benefits and stigma. The study consisted of nationwide in-person interviews with 1400 low-income families who receive health care at community health centers. The study identified the ways in which stigma, as well as other problems, actually affects families' decisions about enrolling in Medicaid programs.

Kaiser Commission on Medicaid and the Uninsured. *Making it Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures.* October 2000. This study of enrollment procedures incorporated the thirty-two states that have opted to create a separate SCHIP program (verses a Medicaid expansion) with their Title XXI funding. The study was comprised of a nationwide telephone survey of the state Medicaid and CHIP officials, a review of the state CHIP plans, and interviews with state child health advocates. The survey focused on income eligibility guidelines as well as simplified application, enrollment and redetermination procedures for children in the state Medicaid and separate state CHIP programs, implemented as of July 2000.

Kaiser Commission on Medicaid and the Uninsured. *Medicaid and Children: Overcoming Barriers to Enrollment.* January 2000. This study is comprised of a nation wide telephone survey of 1,335 low-income parents and six focus groups and represents a major effort to better understand the barriers to Medicaid enrollment. Two groups of parents participated in this research: 1) parents of children currently enrolled in Medicaid ("Medicaid enrolled") and, 2) parents of children who are uninsured but who appear to be eligible for Medicaid ("eligible uninsured").

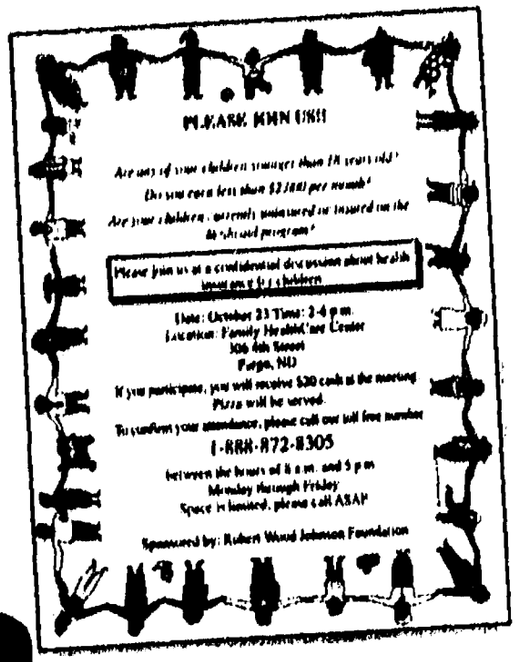
Kaiser Commission on Medicaid and the Uninsured. *Putting Express Lane Eligibility Into Practice. A Briefing Book and Guide for Enrolling Uninsured Children Who Receive Other Public Benefits into Medicaid and CHIP.* November 2000. This publication describes one method for expediting health insurance enrollment for uninsured children by establishing connections with programs that have similar income eligibility rules to Medicaid and CHIP - such as Food Stamps, and Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and the National School Lunch Program.

Mathematica Policy Research, Inc. Status Report: *The Policy of 12-Month Continuous Coverage in Children's Public Insurance Programs in Four States.* June 2000. Under contract with the Health Resources and Services Administration (HRSA), this study analyzes the implications of 12-month continuous coverage for children in public health insurance programs in four states — California, Michigan, Missouri, and New Jersey.

Southern Institute on Children and Families. *The Burden of Proof: How Much is Too Much for Child Health Coverage?* December 1998. This study examines the Medicaid application procedures and verification requirements that evolved from welfare rules and their relevance to a health insurance program for children.

University of Southern Florida. Florida *Covering Kids: Social Marketing Communication Plan.* December 2000.

Appendix B: Participant Recruitment Material



Call Steps to Securing Community Partners

1. Identify and call one key Community Partner who can act as community liaison.

2. Call other community partners to get their involvement.

3. Determine if there are others in that community/region that should be contacted.

4. After each call, mail invitation package to Community Partner. Package should contain: a Community Partner Letter, Overview Sheet, Invitation, and Screener Information.

5. Maintain a list of community partners and contacts.

6. Follow-up with Community Partner five days later to ensure they got package and to remind them how important their assistance is.

7. Reconfirm with them right before the focus group meeting in their community for any updates.

8. Send thank you following the focus group to all community partners.

Appendix C: Survey Demographics

Parent Survey Demographics

	Parents (N=147)
Gender:	
Female	83%
Male	17%
Age:	
Under 25	27%
25 to 30	26%
31 to 35	14%
36 to 40	12%
Over 40	15%
No Response	6%
Insurance Status:	
Medicaid	61%
Healthy Steps	3%
Uninsured	36%

This universe of parents has a total of 301 children.

"Self-sufficiency is achieved in small steps, with no small number of missteps. But self-sufficiency is never achieved by those who never take that first step."

Blaine Nordwall, Economic Assistance, Policy Director, Letter to the Editor, May 2000

Appendix D: State Program Comparisons

States that have not adopted key simplification strategies in Medicaid for children.

No joint application for Medicaid and CHIP	Face-to-face interview required	Asset test required	Frequent redetermination (more than once a year)
Nevada	**Alabama**	Arkansas	Alaska
[redacted]	**Georgia**	**Colorado**	Florida
Texas	**Montana**	Idaho	**Georgia**
Utah	New Mexico	**Montana**	Maine
	New York	**Nevada**	**Minnesota**
	Tennessee	**North Dakota**	**New Jersey**
	Texas	Oregon	**North Dakota**
	Utah	**Texas**	Oklahoma
	West Virginia	**Utah**	Oregon
	Wisconsin		**Tennessee**
	Wyoming		**Texas**
			Vermont
			Wyoming

**States in bold print have adopted simpler enrollment procedures (no face-to-face interview, no asset test and 12 month redetermination periods) for their separate CHIP programs but not for their Medicaid program.*

**Kaiser Commission on Medicaid and the Uninsured. Medicaid and Children: Overcoming Barriers to Enrollment. January 2000.*

*States with Medicaid for Children or CHIP income eligibility set below 200 percent of the federal poverty line**

Colorado	185%
Idaho	150%
[redacted]	185%
Louisiana	150%
[redacted]	150%
Nebraska	185%
North Dakota	140%
Oklahoma	185%
Oregon	170%
South Carolina	150%
South Dakota	140%
Virginia	185%
West Virginia	150%
Wisconsin	185%
Wyoming	133%

***The other 36 states have set income eligibility levels at or above 200 percent of the federal poverty line.**

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