2009 SENATE HUMAN SERVICES

SB 2063

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. SB 2063

Senate Human Services Committee

☐ Check here for Conference Committee

Hearing Date: 1-20-09

Recorder Job Number: 7310

Committee Clerk Signature Mary K Monson

Minutes:

Senator J. Lee opened the hearing on SB 2063 to provide an appropriation for defraying the expenses of the comprehensive tobacco control advisory committee. There is an appropriation listed at $18,600,000.

Laurie Laschkewitsch (Budget Analyst for Office of Management and Budget) said they introduced this bill in order to appropriate funding to the comprehensive committee on tobacco control. The money was put as a special line in the health department budget. The amount was based on what the CDC best practices was spending in the tobacco area.

Kathleen Mangskau ((Tobacco Prevention and Control Advisory Committee) provided testimony in favor of SB 2063 - Attachment #1.

Senator Erbele asked if there were any numbers relative to ND on where any numbers have changed in youth smoking.

Ms. Mangskau said the majority of past programs were directed at youth. There have been significant results. The youth rate was cut in half between 2001 and 2007. That is tapering in the last couple of years. Without additional resources those trends are not going to continue. That progress has not been seen in reducing adult usage. More efforts are needed to target all populations. The Native American rate is twice that of the smoking rate of non-native

Americans. Pregnant women are much higher than the national average. The 18 to about 30 year olds is also a very high group in terms of smoking and using other tobacco products at greater rate.

Senator Erbele asked if there was anything seen with helping public health with the results of smoking – heart and lung disease etc.

Ms. Mangskau responded that when you implement a best practices approach you really need an integrated approach. That means not only in the public health community but also with the private sector. As a result we should see reduction in chronic diseases.

Senator Heckaman didn't see third hand smoke mentioned.

Ms. Mangskau said third hand smoke is also a concern – especially for children.

Senator Marcellais asked how active Indian Health Service and the Native American Community programs are.

Ms. Mangskau replied that through the CDC grant and the Community Health Grant Program some funds were dedicated to tobacco control programs in the communities but were drastically underfunded.

Senator Marcellais asked if there was a Native American on the Advisory Committee.

Ms. Mangskau said no.

Senator Marcellais asked if it was possible to get someone on it.

Ms. Mangskau replied that at the present it is a nine member board and they go out and gather public input. The Native American communities were very active in supporting Measure 3 because they see that they are an area that really lacks resources to do what they need to do.

Senator Marcellais recommended they get a liaison on each reservation for the Advisory Committee. They need to get communications going between the Advisory Committee and the reservations.

Senator Dever asked (1) if she would provide the committee with a copy of the full text of Measure 3 and (2) is the existing programs are folded in the comprehensive plan.

Ms. Mangskau said they are working very closely with the health department to make sure they understand what the programs are and where they are being implemented. Her testimony included chart B & C on funding. They will be looking at the existing programs to see if they are truly best practice.

Senator Dever asked if the FTE's are reflected someplace.

Ms. Mangskau said the amendment they are proposing requests continuing appropriation which would allow them to hire needed staff.

Jodi Radke (Rocky Mountain/Great Plains Region for the Campaign for Tobacco Free Kids) presented testimony in favor of SB 2063 – Attachment #2.

Senator Dever asked how many states follow the CDC plan.

Ms. Radke replied they all have followed the CDC plan but have not done so at a sustained level.

Senator Marcellais asked if the Campaign for Tobacco Free Kids is connected to the drug free schools.

Ms. Radke said it is separate and they work in partnership with many organizations and that is one of them.

Senator Marcellais asked if there is more concentration with their program on reservations.

Ms. Radke said absolutely and they work very closely with the native communities.

Carol Russel provided testimony in support of SB 2063. Attachment #3.

Senator J. Lee asked if there was a breakdown of smokers on the reservations and off.

KaraleeHarper (Director of the Tobacco Prevention and Control Program/Department of Health) offered the information that they don't have current data because they didn't have the money to break down the specific population basis. She could get some of the numbers but don't have the numbers broken down for the refugees and Native Americans.

There was discussion on the need for funding to get specific numbers.

Senator Marcellais said he thought the information was out there on the reservations if they just asked for it.

Senator Dever wondered if there becomes a point of diminishing returns no matter what you do.

Ms. Russel said they haven't reached that point yet.

Vicki Voldal Rosenau (Valley City) testified in support of SB 2063 – Attachment #4.

Dr. Herbert J. Wilson (American Lung Association of ND) testified in favor of SB 2063 – Attachment #5.

Deborah Knuth (American Cancer Society Cancer Action Network in ND) testified in support of SB 2063 – Attachment #6.

There was no opposing testimony or neutral testimony.

Senator J. Lee asked if someone from the Cancer Society or Heart Association would talk about broadening the scope beyond just the tobacco cessation issues or lung cancer issues to other health conditions that would be affected by tobacco use.

Deborah Knuth (American Cancer Society) said they are always interested in seeing anything CDC based programs also addressed – chronic disease related to tobacco use.

Senator J. Lee asked if, in their opinion, it would be appropriate for the group to broaden the scope of the spending of the money to not just telling the people to stop smoking.

Mr. Knuth replied said she had not had a chance to work with the newly appointed committee in addressing that issue or seeing their plan.

Senator J. Lee distributed information to the committee on the money that has been appropriated in this biennium 2007-2009 for tobacco, alcohol, substance abuse and other risky behavior addiction and cessation programs-Attachment #7.

The hearing on SB 2063 was closed.

Attachment #8 – Testimony in support of SB 2063 from Bruce Levi (ND Medical Association).

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. SB 2063

Senate Human Services Committee

☐ Check here for Conference Committee

Hearing Date: 2-04-09

Recorder Job Number: 8610, 8613

Committee Clerk Signature Mary K Monson

Minutes:

Senator J. Lee opened SB 2063 for committee work.

Senator Dever said this bill comes to them simply as an appropriation. He had concerns about insuring that there are proper controls in place and that they have proper understanding of what the situation is with the committee that is going to deal with this program. He proposed amendments that would address that – Attachment #9. He went on to explain the amendments.

Kathleen Mangskau (Tobacco Prevention and Control Advisory Committee) said the amendments clarifies that they are a state agency and puts it into the intent language. She addressed the funding and provided the committee with information – Attachment #10.

KaraleeHarper (Director of the Tobacco Program, Department of Health) explained the North Dakota Department of Health Tobacco Program Sheet – Attachment #11.

Senator J. Lee asked her to clarify if some of the tobacco money should be used to continue some of the programs that have to do with tobacco related illness.

Ms. Harper said what they have done in the past with the heart disease and stroke prevention program is that they pool some of their money together to media pieces. They worked collaboratively with other health department programs and each funds a portion.

Senator J. Lee asked if they will be able to continue to do that.

Ms. Harper said they would but not to the extent of what they would like.

Senator Heckaman asked if the appropriation in this bill stays.

Discussion that the number would change to 12.8.

FTE's were discussed. The thought was that they might need 4 but they don't know exactly what types of positions they will need until the plan is developed. Three of the positions would be an executive director, administrative assistant, and an accountant.

Senator Dever explained that there might be further evolution of this bill as it finds its way through the process but he thought they were putting in place a framework that they could work from.

Senator Dever moved to **adopt the amendment** to include the change in appropriation to $12, 882,000 and 4 FTE's.

Seconded by **Senator Heckaman**.

Roll call vote 5-0-1. Amendment adopted.

Senator Dever moved a **Do Pass as Amended on SB 2063 with a rereferral to Appropriations.**

Seconded by **Senator Pomeroy**.

Roll call vote. 5-0-1. Motion carried.

Senator Dever is the carrier.

Additional information – Attachment #12.

Job #8613

Senator Dever moved to reconsider their Do Pass actions on SB 2063.

Seconded by **Senator Heckaman**.

Carried on a voice vote.

Senator Dever moved to further amend SB 2063 to provide for a report to a committee of the Legislative Council prior to Sept. 1, 2010.

Seconded by **Senator Heckaman**.

Roll call vote 5-0-1. (Vote left open for Senator Erbele) Final vote 6-0-0.

Senator Dever moved a **Do Pass as twice Amended on SB 2063 with rereferral to Appropriations.**

Seconded by **Senator Heckaman**.

Roll call vote 5-0-1 (Vote left open for Senator Erbele) Final vote 6-0-0. Motion carried.

Carrier is **Senator Dever**.

Date: 2-4-09

Roll Call Vote #: 1

2009 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. SB 2063

Senate Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number Dever Amendments and add'l

Action Taken ☐ Do Pass ☐ Do Not Pass ☒ Amended ☐ Rerefer to Appropriations

☐ Adopt Amendment ☐ Reconsider

Motion Made By Sen. Dever Seconded By Sen. Heckaman

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee, Chairman	✓		Senator Joan Heckaman	✓	
Senator Robert Erbele, V.Chair			Senator Richard Marcellais	✓	
Senator Dick Dever	✓		Senator Jim Pomeroy	✓	

Total (Yes) 5 No 0

Absent 1

Floor Assignment

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

Date: 2-4-09

Roll Call Vote #: 2

2009 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. SB 2063

Senate Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken ☒ Do Pass ☐ Do Not Pass ☒ Amended ☐ Rerefer to Appropriations

☐ Adopt Amendment ☐ Reconsider

Motion Made By Sen. Dever Seconded By Sen. Pomeroy

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee, Chairman	✓		Senator Joan Heckaman	✓	
Senator Robert Erbele, V.Chair			Senator Richard Marcellais	✓	
Senator Dick Dever	✓		Senator Jim Pomeroy	✓	

Total (Yes) 5 No 0

Absent 1

Floor Assignment Senator Dever

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

Date: 2-4-09

Roll Call Vote #: 3

2009 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. SB 2063

Senate Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken ☐ Do Pass ☐ Do Not Pass ☐ Amended ☐ Rerefer to Appropriations

☐ Adopt Amendment ☒ Reconsider

Motion Made By Sen. Dever Seconded By Sen. Heckaman

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee, Chairman			Senator Joan Heckaman		
Senator Robert Erbele, V.Chair			Senator Richard Marcellais		
Senator Dick Dever			Senator Jim Pomeroy		

Passed on a voice vote.

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

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

Adopted by the Human Services Committee
February 4, 2009

2-5-9

PROPOSED AMENDMENTS TO SENATE BILL NO. 2063

Page 1, line 2, after "tobacco" insert "prevention and", replace "advisory" with "executive", and after "committee" insert "; to provide a statement of legislative intent; to provide for reports to the legislative council; to provide for retroactive application; and to declare an emergency"

Page 1, line 11, replace the first "18,600,000" with "12,882,000" and replace the second "18,600,000" with "12,882,000"

Page 1, line 12, replace the first "18,600,000" with "12,882,000" and replace the second "18,600,000" with "12,882,000"

Page 1, line 13, replace the second "0.00" with "4.0" and replace the third "0.00" with "4.0"

Page 1, after line 13, insert:

"**SECTION 2. APPROPRIATION.** There is appropriated out of any moneys in the tobacco prevention and control trust fund, not otherwise appropriated, the sum of $62,403, or so much of the sum as may be necessary, to the comprehensive tobacco control advisory committee for the purpose of defraying the expenses of the committee, developing, implementing, and administering the comprehensive tobacco control and prevention plan, and contracting with a consultant to facilitate the development of the comprehensive plan, for the period beginning with January 1, 2009, and ending July 1, 2009.

SECTION 3. LEGISLATIVE INTENT - REPORT TO LEGISLATIVE COUNCIL. Any act of the tobacco prevention and control executive committee or its employees is an act of the state of North Dakota functioning in its sovereign and governmental capacity. As a state entity, the committee is subject to accountability requirements including laws relating to state audits, fiscal management, records retention, and procurement. Employees of the committee are part of the state classified system. Before September 1, 2010, the tobacco prevention and control executive committee shall report to the legislative council on implementation of the comprehensive plan and outcomes achieved.

SECTION 4. RETROACTIVE APPLICATION. Section 2 of this Act is retroactive to January 1, 2009.

SECTION 5. EMERGENCY. This Act is declared to be an emergency measure."

Renumber accordingly

Date: 2-4-09

Roll Call Vote #: 4

2009 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. SB 2063

Senate Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number further amend to include report

Action Taken ☐ Do Pass ☐ Do Not Pass ☐ Amended ☐ Rerefer to Appropriations

☒ Adopt Amendment ☐ Reconsider

Motion Made By Sen. Dever Seconded By Sen. Heckaman

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee, Chairman	✓		Senator Joan Heckaman	✓	
Senator Robert Erbele, V.Chair	✓		Senator Richard Marcellais	✓	
Senator Dick Dever	✓		Senator Jim Pomeroy	✓	

Total (Yes) 6 No 0

Absent 0

Floor Assignment

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

Date: 2-4-09

Roll Call Vote #: 5

2009 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. SB 2063

Senate Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken ☒ Do Pass ☐ Do Not Pass ☒ Amended ☐ Rerefer to Appropriations

☐ Adopt Amendment ☐ Reconsider

Motion Made By Sen. Dever Seconded By Sen. Heckaman

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee, Chairman	✓		Senator Joan Heckaman	✓	
Senator Robert Erbele, V.Chair	✓		Senator Richard Marcellais	✓	
Senator Dick Dever	✓		Senator Jim Pomeroy	✓	

Total (Yes) 6 No 0

Absent 0

Floor Assignment Senator Dever

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

REPORT OF STANDING COMMITTEE

SB 2063: Human Services Committee (Sen. J. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2063 was placed on the Sixth order on the calendar.

Page 1, line 2, after "tobacco" insert "prevention and", replace "advisory" with "executive", and after "committee" insert "; to provide a statement of legislative intent; to provide for reports to the legislative council; to provide for retroactive application; and to declare an emergency"

Page 1, line 11, replace the first "18,600,000" with "12,882,000" and replace the second "18,600,000" with "12,882,000"

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Page 1, after line 13, insert:

"**SECTION 2. APPROPRIATION.** There is appropriated out of any moneys in the tobacco prevention and control trust fund, not otherwise appropriated, the sum of $62,403, or so much of the sum as may be necessary, to the comprehensive tobacco control advisory committee for the purpose of defraying the expenses of the committee, developing, implementing, and administering the comprehensive tobacco control and prevention plan, and contracting with a consultant to facilitate the development of the comprehensive plan, for the period beginning with January 1, 2009, and ending July 1, 2009.

SECTION 3. LEGISLATIVE INTENT - REPORT TO LEGISLATIVE COUNCIL. Any act of the tobacco prevention and control executive committee or its employees is an act of the state of North Dakota functioning in its sovereign and governmental capacity. As a state entity, the committee is subject to accountability requirements including laws relating to state audits, fiscal management, records retention, and procurement. Employees of the committee are part of the state classified system. Before September 1, 2010, the tobacco prevention and control executive committee shall report to the legislative council on implementation of the comprehensive plan and outcomes achieved.

SECTION 4. RETROACTIVE APPLICATION. Section 2 of this Act is retroactive to January 1, 2009.

SECTION 5. EMERGENCY. This Act is declared to be an emergency measure."

Renumber accordingly

2009 SENATE APPROPRIATIONS

SB 2063

2358

Bridge the dental gap

Whatever the subcommittee would like. This is not a function of state government.

Senator Fischer can't support either bill SB 2356 and 2358.

Senator Mathern what if we amend this.

Senator Fischer said he understood the need.

Senator Kilzer I much prefer the dental loan payback then getting into the equipment business. I think we should put a do not pass. Senator Kilzer yes, Senator Fischer yes, Senator Mathern no. The committee recommends a DO NOT PASS ON SB 2356.

2358

Was this in the governor's budget and not in optional package?

Arvy said it was not.

Senator Mathern: Gives money to students of dentistry for 3 years and if they practice for three years their loan payment is taken care of.

Senator Fischer recommends do pass and all three agree on a Do Pass for 2358.

2412 the bill on Fetal Alcohol Syndrome was heard today in committee.

Senator Fischer we asked for legislative council to get information for us.

Senator Kilzer I think we should see the results of the history of it.

Maybe we can have a quick meeting after we get those emails.

Senator Kilzer any other things we should know about.

Senator Fischer SB 2063 passed on the floor today. That never came here. It was rereferred to appropriations today.

Senator Kilzer as I looked at the amendment put on, work to be done by the auditor and fiscal review and even by legislative council to oversee their work, others will look at that before we ask for the committee to look at it. It is coming back to us.

Senator Mathern said that we will hear it formally.

Senator Kilzer dismissed the subcommittee meeting on SB 2004 and the other bills discussed.

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. SB 2063

Senate Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: February 13, 2009

Recorder Job Number: 9454

Committee Clerk Signature Rose Laning

Minutes:

Chairman Holmberg called the committee hearing to order at 10:30 AM in regards to SB 2063 concerning an appropriation to defray expenses of tobacco prevention and control executive committee, provide legislative intent, provide reports to Legislative Council, and provide retroactive application and to declare an emergency.

Chairman Holmberg stated that the committee will be focusing on the financial aspects of this bill only. The committee needs to be done at 11:00 sharp so marshal your testimony accordingly. He asked if there was any opposition to the bill and there was none.

Kathleen Manscow, Chairman, Tobacco Prevention & Control Advisory Committee (Written attached testimony # 1) provided information on how the funds appropriated in SB 2063 will be spent and accounted for. Also provided information on the need for the program, the progress of the advisory committee to date, the best practice categories, the current levels of funding in the best practice categories and how the new funds will be used to meet the recommended programming and levels of spending.

She will pass out additional testimony from other organizations.

Senator Krauter: Do you support the amendments that the House put on?

Kathleen Manscow: Yes, we do support that because looking at the spreadsheet you will notice that there are dollars that are ready for federal funds going to the State Health Department and also help community help trust funds going to the State Health Department.

Senator Fischer I am looking on Page 4 and the numbers I find aren't quite accurate. It's much more than 100% for administration and management component.

Kathleen Manscow: the percentage is just the percentage of the current recommended that the Health Department or North Dakota currently stands and when the administration and manage component is rounded it is 100%.

Senator Fischer You don't recommend we go over 100% of administration.

Kathleen Manscow: No we don't. We have looked at this very closely and we believed that by working together they can stay close to recommended amounts.

Senator Fischer: What was percentage 10 years ago.

Kathleen Manscow: In terms of the Youth smoking rate, it has been cut in half. In terms of the adult smoking rate, that rate has declined very little just about 2 %. The plan will have time framed goals.

Senator Fischer: How many ex-smokers on the advisory committee?

Kathleen Manscow: To my knowledge I believe there are two former smokers.

Senator Christmann: There are some statistics on page eleven. Is that over year or biennium?

Kathleen Manscow: In the first 5 years.

Senator Christmann: Can you get us the numbers that it would be otherwise and what it will be with this in place so that in the end of 5 years we can check to see how we are doing? We don't' want to wait 5 years and wonder if this worked or if it would have been that anyways. We need to know how you are arriving at numbers so in time we know how we are doing:

Kathleen Manscow: I can provide you that the copy of this report that outlines how they looked at the numbers and came up with these projected savings in terms of lives.

V. Chair Grindberg: Will the group that has now been formed be providing those progress reports or will we have unbiased usage of tobacco that you seek out as a group to report?

Kathleen Manscow: We will actually have both. We not only intend to use the department of health to continue the surveys they currently use. We will also be conducting an independent evaluation from outside evaluators.

Wanda Rose: President, ND Nurses Association, (Written attached testimony # 2) spoke in favor of the bill.

Carla Smith: ND Society of Respiratory Care, she testified in favor of SB 2063. We were ailing people who were affected by smoking. We strongly support this bill.

Carol Russell: Past President, California Tobacco Control, she testified in favor of SB 2063. We support everything Kathleen Manscow said and we support section 3.

Senator Christmann: How is their overall budget doing?

Carol Russell: We could really use the money for our program.

Chairman Holmberg closed the hearing on SB 2063.

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. SB 2063

Senate Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: February 16, 2009

Recorder Job Number: 9598

Committee Clerk Signature

Minutes:

SB 2063 provided for an appropriation for defraying the expenses of the comprehensive tobacco prevention and control executive committee.

Senator Fischer moved Do Pass.

Senator Wardner seconded.

A Roll Call vote was taken. Yea: 14 Nay: 0 Absent: 0

Motion carried. It returns to Human Services where Senator Dever will carry the bill.

Date: 2-16-09
Roll Call Vote #: 1

2009 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2063

Senate _____ Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken ☒ Do Pass ☐ Do Not Pass ☐ Amended

Motion Made By Fischer Seconded By Wardner

Representatives	Yes	No	Representatives	Yes	No
Senator Krebsbach	✓		Senator Seymour	✓	
Senator Fischer	✓		Senator Lindaas	✓	
Senator Wardner	✓		Senator Robinson	✓	
Senator Kilzer	✓		Senator Warner	✓	
V. Chair Bowman	✓		Senator Krauter	✓	
Senator Christmann	✓		Senator Mathern	✓	
V. Chair Grindberg	✓				
Chairman Holmberg	✓				

Total Yes 14 No 0

Absent 0

Floor Assignment back to Human Services

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

Dever

REPORT OF STANDING COMMITTEE

SB 2063, as engrossed: Appropriations Committee (Sen. Holmberg, Chairman) recommends **DO PASS** (14 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed SB 2063 was placed on the Eleventh order on the calendar.

2009 HOUSE APPROPRIATIONS

SB 2063

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. SB 2063

House Appropriations Committee
Human Resources Division

☐ Check here for Conference Committee

Hearing Date: 3/10/09

Recorder Job Number: 10625

Committee Clerk Signature Morgan Rennerfeldt

Minutes:

Chairman Pollert: Opened the hearing on SB 2063.

Chairman Weisz: Your policy committee is here merely for informational purposes. I thought it was important being that this is generally a human service issue that we understand what is going on as far as Measure 3 and the tobacco dollars. That is why I requested we have a joint hearing. It is just for our informational purposes.

Senator Dever: It is an honor to come to this joint committee hearing. I am here to explain what the Senate did in the amendments to SB 2063 and not to speak in any position to it. As you may know SB 2063 came to our committee simply as an appropriation. An appropriation for $18.6 million. As I understand it, the CDC recommendation for the State of ND for comprehensive Tobacco, Prevention, and Control plan was $9.3 million per year. The major appropriation in the bill is reduced to $12,882,000 and there will be others to speak in greater detail to this. My understanding is that was reduced because the other amount was part of programs already being done through the health department that satisfied the requirements of the comprehensive tobacco prevention plan. That is section 1 of the bill. Section 2 of the bill is an appropriation for $62,403. It was requested for us that we put an emergency clause and retroactive provision in the bill back to January 1. The reason for that is the committee was

charged in Measure 3 with developing a plan within the first 6 months. They started on January 1 so six months would be July 1. They needed the money to provide the compensation for the members of the committee as they do the work leading up to that. I think they were looking at also involving a consultant with that. Rather than putting a retroactive application on the entire appropriation. We asked them to decide how much money they needed in order to accomplish that part of it. That is the retroactive application which is often found in section 4. It requires the emergency clause in section 5. What we did in the Senate with legislative intent is Senator Fischer and I visited with Kathleen Mangskau who you are going to hear form. We expressed to them some of the concerns that we had as Measure 3 was written. It allowed them some authority that we didn't feel comfortable with like contracting, borrowing money and loaning money, hiring employees. We weren't quite sure how the accountability of that should come together. To express our concerns to them, they considered themselves to be a state agency or kind of like a state agency. We weren't quite sure what that was. We together visited with the attorney general and actually in his absence the deputy attorney general and put together the legislative intent language that essentially treats them. One night I found several references to state agencies, boards, and commissions. All of those references fall together and are subject to guidelines and restrictions as far as a human resources goes and purchasing, contracting and all those other kinds of things. We think that the legislative intent language in section 3, we don't consider it to be the final word on the subject at all. We consider it to be a framework to see the opportunity to improve. One of the things mentioned in the Senate was that the legislative intent should report to the legislative council. It might be better to separate that into another section just because it is not intent doesn't mean it's not requirement. The chairman of the Senate Appropriations Committee suggested that maybe

they should report to the budget section. You might want to consider if that would be more appropriate.

Representative Ekstrom: Was there any consideration giving to adding language that has to do with open meeting laws?

Senator Dever: There wasn't any consideration given to that but I think it being treated as a state agency board or commission that they would be subject to that just as well. If any of you know, I don't generally feel comfortable with legislative intent language. He thought it would be appropriate in this circumstance. I should make one other point too. As you know with an initiative measure is passed it requires a 2/3 vote to overturn any part of the measure. The emergency clause on here only applies to the retroactive portion of the appropriation for that. We avoided trying to do anything that would require a 2/3 vote and set it aside. It was a mutual consent. It was the vote of the people. The point was made that 10 years from now they think they can have an excellent program that will show some major reductions in tobacco use. The point that I mad back to that is it means in 2 years we are talking about the plan and not the administration of it. Our interest is providing the accountability that you see in the bill.

Chairman Weisz: You mentioned that the Deputy Attorney General thought the legislative intent was ok in that case. Is that because you couldn't determine if they are indeed a state entity? Why is intent ok when as you already alluded to the concerns of accountability? My question is why intent and why not just saying you have to?

Senator Dever: We did not ask for a formal Attorney General's opinion. I think if we would have we probably would have gotten the same thing but possibly a little bit more refined. To put in code what we intend to be, it might require a 2/3 vote to set aside the whole measure. It was their interpretation that they are to be treated through the same guidelines and restrictions as any other entity would.

Representative Bellew: Can you tell me how much money is in the tobacco prevention and control trust fund at this time?

Senator Dever: I don't know and don't take a position at this time. I'm here just to explain what we did. Others might be able to tell you.

Chairman Pollert: There is what we get called green sheets. We are trying to get copies to everyone. Our section has it but the copier jammed up.

Representative Kerzman: Is there supporting legislation or policy that deals with the selection of the committee and the makeover of the committee?

Senator Dever: I think all of that is spelled out in the measure itself. I would suspect as it was provided to our committee they will be prepared to provide it to you. It is all spelled out in there.

Representative Ekstrom: On the second page of the green sheet we have authorized 4 FTE positions. Those aren't appearing at the front of the green sheet. Is that just an oversight?

Sheila Sandness: The reason to that is when the bill was first introduced there were no FTE's. They were added by the Senate. There was no authorization for FTE's.

Kathleen Mangskau: Handout Testimony (Attachment A). 14:00- 31:00 (Attachment B)

Representative Wieland: On page 11 you talked about the report and the campaign for tobacco free kids. I didn't see anywhere where the time frame from those statistics, or where that would take place. Did that report mention the timeframe in which it would take place?

Kathleen Mangskau: Yes many of those are in the first 5 years. We can look for the healthcare savings in the first 5 years. Some of these reductions are actually yearly and their report details which are yearly and which are in the first 5 years.

Representative Conrad: These 4 FTE's, is that enough? Is that what you need to get the job done?

Kathleen Mangskau: The committee has worked closely with this. We believe working together with the Health Department that should be adequate to get it started. We always need to look at how the program is going to be implemented. If for some reason we don't need 4 we aren't going to hire 4. We want this money to go as long as possible. We will look at the best way we can to make this effective and efficient. At this point we do believe we would need approximately four.

Chairman Pollert: Where were the 4 FTE's? They aren't run through the Dept. of Health?

Kathleen Mangskau: The 4 FTE's would be the advisory committee FTE's.

Chairman Pollert: I'm curious to as far as I'm trying to run down how we went from 18.6 t0 12.882. Did that total come from attachment C? Take the total of the 18.6 less the CDC funding, less the community health trust funding to come up with 12.8?

Kathleen Mangskau: Please refer to attachment C. At the time we put together this attachment we were working with the health department. They had approximately $470,000 that they were looking at placing under the tobacco control program. Our advisory committee believes that it is not the best average approach. As a result you see that we have indicated that we will need 12.882. If they do not place that $470,000 under the best practice program in their state then we would need $470,000 less.

Representative Kreidt: I have a couple questions. Going through your advisory committee and selection, the Governor was to select these committee's from a list that was given by whom to the Governor?

Kathleen Mangskau: The measure outlines were the groups that were to provide names to the governor for his selection. That includes the Medical Association, The Nurses Association, The ND Public Health Association, the Society for Respiratory Care, and one public member.

Representative Kreidt: Looking through it I know who pushed the initiative and who is on the sponsoring committee. A lot of those names appear on the sponsoring committee of Measure 3. They are kind of winding up on this advisory committee. The executive committee was made up of 2 members that were on the sponsoring committee for Measure 3. Is that a coincidence or how did that happen?

Kathleen Mangskau: The individuals applied to their specific organizations to indicate their interests. They organizations narrowed that down to the names that they actually submitted. It seems understandable that the people working on this measure would be interested in serving on that committee because they have an extreme interest in tobacco prevention and control and preventing the loss of life, the economic cost, and death and disability to ND.

Representative Kreidt: You have meetings and I notice in there a quorum makes up the meeting. In your regulations you can meet without having a quorum. I've never been associated with a board or committee. Could you explain that to me?

Kathleen Mangskau: You are correct. They can hold meetings but to conduct the business and make decisions that are substantive they have to have a quorum. In the minutes of the meetings you will find that if there is not a quorum they can't actually make those types of decisions.

Representative Nelson: As I understand it then, if a proposal comes before this committee, that committee will approve or not approve a program or an appropriation from the committee. Is that correct?

Kathleen Mangksau: The advisory committee is currently starting to establish the procedures. The way it looks right now is that the procedure will move forward once the plan is put in place we will outline the types of things that are best practice. Then the entities can actually respond to a request for proposal and indicate how they would meet those requirements and put forth a

best practice approach. They would be actually submitting an application to the advisory committee for each of the components that would be put out for request for proposal.

Representative Nelson: In every case other than the salary and the FTE's that will be paid from the trust or money that flows into the account, it will be sent back on a grant basis? Is that correct?

Kathleen Mangskau: Primarily for new areas yes there are some areas where the money may actually be through a contract sent through the State Health Department. Some examples would be currently having a quitline in place. We aren't going to rebid that quitline. They already have an established well working program in place. They need some enhancements to that program. Those cases the way the money would flow is probably to a grant from the Health Department where they could report on the results of those moneys back to the advisory committee.

Representative Nelson: With that, explain to me the tobacco control cessation quitline component of the community health trust fund that is no longer there. It has all been moved over to one line. Are they brought together in that line item and funded at the $3.388 million number. Where did tobacco quitline, local health, and tobacco programs line, and coordinator and operating expenses go?

Kathleen Mangskau: I believe you are referring to the health department budget.

Representative Nelson: I am.

Kathleen Mangskau: In those areas, the money that they currently have in those areas, they are still going to be spending that money on tobacco control. Yes they have been put together in that one line item. That is how we looked at those numbers and said we need less because they are already doing this. That number was actually subtracted from our $9.3 million per year that we would be requesting or $18.6 per biennium.

Representative Nelson: In deciding what number to fund the community health trust fund at, did you just take the total available dollars and use the 80% that was specified in Measure 3 as the magic number to get the $3.388 or was there some science to that?

Kathleen Mangskau: I believe that the Health Department and Office of Management and Budget in putting this budget together looked at the money available in that trust fund and took the 80%.

Representative Nathe: On Page 9 of your testimony you talk about reporting during a reasonable period of time on the results of the program. What is the reasonable period of time? Two years, five years?

Kathleen Mangskau: What we plan to be doing in this is there will be annual reviews as it says we are going to look to see if they are doing best practice. As you all know when we look at outcomes, typically you don't see outcomes in a short period of time. The outcomes reduce death, disability, those sorts of things take longer to accrue. The things we will be able to report on is are we seeing more individuals using a statewide quitline. Are we seeing the number of youths who try to quit or quit attempts go up. Those are the things you can report on in the shorter term. In the longer term, when we see the reductions in disease and death and the healthcare savings those are much longer and you can see in CA those are the types of things that we say after 5 years we can report on. You don't see those in s9x months.

Representative Nathe: I have another question on the CDC recommendation, how do they come up with that number?

Kathleen Mangksau: They look at programs in other states that have been successful. They try to model programs and look at the research that has been done in each of these components. They look at a number of things including the smoking rates, the geographic distribution as a rural, there is a whole variety of things. I can't give you all of those from

memory but they are outlined in the best practices book. If you would like I could refer that information that says exactly how they are derived.

Representative Nelson: Let's look back 10 years as to how the recommended CDC levels of escalated in that period.

Kathleen Mangskau: I believe I could provide that with the same information that I will be providing to the committee for Rep. Nathe. What they did is include inflationary increases in the recommended levels. That is all detailed in the best practice book.

Representative Nelson: So they just build in a CPI index, and no additional programs?

Kathleen Mangskau: They actually changed some of the programming. If you look at the way it was before it had more components. They found now that some of the things they looked at previously are better when combined and working together. There are actually five components now in the program. There have been some changes. The new best practices book actually details all of those. What may be best is if I actually provide you with that book and let you know what pages to reference. It spells out the inflationary and how the numbers are come up with. I can be very specific and say refer to page 18 paragraph 3, etc.

Chairman Pollert: Say we have a bill come in specifically dealing with strokes. Could the legislator fund that if that is the best management practice, could you fund it out of this fund?

Kathleen Mangskau: If it was a best practice, it could be funded. When we look at the best practices, the way we look at a lot of those other programs is by reducing tobacco use, you are going to impact all of those programs. Those programs need to be working together. Our advisory committee right now is investigating some policy and environmental change training that we can work with the chronic disease programs on. We are looking at the possibility of working together on those. To just say randomly that a program is best practiced, it really has to be evidence based and it has to look at reducing that. How does the reduction in tobacco

use impact that type of a program. It would need to be looked at to see if it is a best practice program. What we want to stay away from is funding anything and everything down the road 5-10 years now, we can't show results. Our intent is that we want to fund programs that we know work and will make a difference so that we will have those health care savings in ND.

Chairman Pollert: I understand that but let's say someone brings forward a bill and it is a best management practice. Could he have that appropriation come out of that tobacco fund?

Kathleen Mangskau: I'm not sure of the answer of that. The way the measure was written, the allocation goes into a tobacco prevention and control trust fund. The legislature appropriates the money for the advisory committee to develop this plan. To me it appears that it is appropriated to develop and implement this plan.

Chairman Pollert: If I'm a legislator, odds are that it is a very good chance and something dealing with a stroke, would the legislator look unfavorably as far as a general fund appropriation because it should come out of this?

Kathleen Mangskau: I can't answer that question.

Chairman Pollert: I know I am just trying to figure out a funding mechanism. Let's say the bill sponsor would have to go in front of the advisory committee first and ask if it is a good allocation of that?

Kathleen Mangskau: That sounds like a reasonable approach. What we would determine first is that if it is the best practice. If it is, it is probably going to be in the plan which means funding could flow to that type of project if it is a best practice approach. What we are looking at is by developing request for proposals for the components of the plan to carry this out what we are hoping to do is get the best contractors and groups possible to carry out this work.

Representative Porter: In the FTE portion, the 4 FTE's are going to be employed by the committee. Where is their office located, who sets their salary ranges out of HR, how is that mechanism going to work?

Kathleen Mangskau: Because this entity is responsible for using the same types of measures as other state entities. They would have to follow the state classification system and work through the personnel to make sure salaries are in line. The executive committee has the responsibility to set the compensation but they must apply all the same rules that other agencies apply.

Representative Porter: As far as the office and location of these 4 employees, where will they be located?

Kathleen Mangskau: The actual location has not been determined. A lot of the things we are looking at are how we are working with the health department and which of those categories are funded by them which are currently being worked out. As any other entity or commission, we would be looking for space that is as reasonable as we could find it.

Representative Porter: That kind of tends to tell me that you won't be in the capitol or renting space from dept of health. You will be offsite with an office?

Kathleen Mangskau: At this time we don't know the answer. We don't know if there is room in the health department for additional FTE's or what other available sights there are in the capitol complex. We have not yet investigated that.

Representative Porter: In the 4 positions, could you give me a brief description of what each of those 4 positions and what their responsibility would be.

Kathleen Mangskau: At this time we believe we will need an executive director because of contracting, contracts that will be carried out. We would need an individual to carry out those activities. We will need an administrative assistant to assist in carrying out those activities. We

will need an accountant because of the amount of money coming out we will need to be accountable for that. Using the systems like PeopleSoft and that sort of thing. Then we have a 4th position because we are adding some new components here that are not really largely in place before the communications and evaluation components. That is where we are looking at the use of additional staff people to carry out the functions of those oversee the granting in those areas and the programs and services that will be provided. Whether or not it is provided in the health department or this agency to carry out the additional activities, they would need an additional FTE as well.

Representative Porter: As we look at this plan as we are going forward and doing the 1,3,5,7 and 10 years out from now being the baseline, what happens in those instances if those key benchmarks aren't met and your goals come up short and the CDC plan doesn't fit ND?

Kathleen Mangskau: That is one of the things we are doing now. In developing this plan we are looking and seeing what CDC recommends. How does that adopt to ND and how do we put it in place? The CDC guidelines are general. They don't give you specifics. What we would do with a plan like this is for instance if we find we are falling short of those benchmarks, that means that we need to adopt. That is why ongoing evaluation is critical in monitoring. We need to make sure we are meeting those benchmarks. If we aren't, what the challenges are and how do we remove those challenges of meeting those benchmarks. That is part of the ongoing evaluation that we plan to be doing on this program on a weekly, monthly, yearly basis.

Chairman Pollert: The 4 FTE's, did you say they are state employees?

Kathleen Mangskau: Yes.

Chairman Pollert: So if they are state employees, going through the HR system if you want to add FTE's do you need to come to us if you need new employees?

Kathleen Mangskau: Yes. We would need to request additional from the legislator.

Representative Kreidt: Looking at the measure again, if I'm reading it right you as an executive committee could hire as many FTE's as you want. You can employ staff and set their salaries. You can put these people in. Where are you deviating from what the measure says if they are going to be state employees? Your executive committee has the power to do what you want to do. You don't have to go through the state. The only thing I don't read in here is that you can't go build a building but you can do everything else.

Kathleen Mangskau: We believe because we operate as a state entity that we can't go out and hire FTE's. We are subject to the same rules and regulations as any state entity. We would need to have the legislative authority to hire those FTE's.

Representative Kreidt: If you read it correctly the powers of the committee are spelled out. It doesn't say anything about that.

Kathleen Mangskau: Going back to the initiative measure it gives the committee the power to hire the FTE's that are designated by our appropriations bill.

Chairman Pollert: I think we will want a clarification from Legislative Council and as far as if they are going to be state employees and under the HR system.

Representative Porter: We will need to know if they are state employees under that system, does it go under special funds and 100% of that is covered under their funds. Is the general fund picking up the health insurance and the retirement and other benefits that are applied to that?

Chairman Pollert: Kathleen did you have that discussion on the Senate side?

Kathleen Mangskau: No we did not. Basically we talked about the FTE's we needed. Our assumption was that the individuals that would be hired, the funding would actually come out of these special funds.

Chairman Pollert: That is understandable I just want to make sure we are doing everything legally.

Representative Weisz: If 2 years down the road CDC changes their guidelines, and you have the programs in place and it appears it is working. Now you have to change everything again to meet the new guidelines, is that correct?

Kathleen Mangskau: Looking back at the historical perspective on the guidelines, they came out in the 1990's. They revised them in 2007. Looking at the evidence based and what works in state programs, the modifications were minimal. With the research on going we don't anticipate that there will be a huge change again. The modifications were very minimal in the 8-10 years in the first set. If new research comes available I would hope we are going to do it. If it is more cost effective and efficient we want to be there.

Representative Weisz: What if it doesn't appear to apply to ND, we still have no choice. If the so called better way isn't working you are still bound by those guidelines.

Kathleen Mangskau: We must remember when we look at the best practices. The recommendations are general. They aren't totally specific in each state because there is some latitude within the recommendations as to how you do it. It recommends what you do but not how you do it. Each state is geographically different and culturally different. How you implement those recommendations is going to depend on some of those specific characteristics of each state.

Representative Weisz: I'm well aware of that but the dollars sure don't appear to be guidelines only as far as following this.

Kathleen Mangskau: If we look at the best practice document you will see that there is a range. There is a recommended level and a range. You will find in ND that in one component because we have been lacking in it for so many years, we might need to spend a little more. In

another component maybe because we have done a good job in that component it is possible that we would spend a little less. That is the goal of our advisory committee to use those ranges. Not to stick with one total number, we need to do what is best for ND.

Representative Nelson: You said earlier in your testimony that you don't want to duplicate some of the things that are being done. I'm curious as to when we go forward with the FTE's that you are asking for in this. It would seem to me that there may be some efficiencies that may be garnered by the committee and by the programs and what is taking place. I'm curious as to why the health department is calling for any less FTE in their tobacco programs. I'm wondering if you agree that there may be some efficiencies that would possibly permit some shifting of duties if not the elimination of jobs in the health department.

Kathleen Mangskau: When we looked at putting the program together, currently for the amount of dollars and type of programming that the health department does, they are pretty much on track for what CDC recommends for their infrastructure to carry this out. We will be adding new programs, services, and also additional dollars to be accountable for. That is where the additional 4 FTE come in. We aren't looking at the things they are doing to reduce what they are doing. We are looking to enhance what they are doing. That is one of the reasons when we are looking at these components. They aren't saying you do the quitline and we will too. That is duplication. We are looking at saying, they are doing the quitline and doing a good job. As a result there are a few things missing in that component. Let's give them the dollars and resources to make those things happen. We believe we are looking at this efficiently by enhancing where we can enhance within their structure and creating new FTE where there isn't anybody in place already.

Representative Nelson: Let's just say that the legislator said we aren't going to fund quitline. What would you do then?

Kathleen Mangskau: If the legislator said they weren't going to fund the quitline that would be a best practice. We would hope that the legislator would look to the guidelines for best practices and knowing how to reduce death and disability in ND in making their decisions as well.

Representative Nelson: Obviously if we didn't do that we wouldn't have looked at it that way. If we didn't fund Quitline position would you fund it through your committee? That would be an option or how would you go forward with that?

Kathleen Mangksau: It certainly would be a dilemma because we would be looking at the retraining of staff and taking a working program out of operation and trying to change it. It would be difficult to do that with a program in place. If it's something that is not funded in the health department like basically now that position is CDC funded. It is a requirement that they have that position. They would lose federal dollars as well.

Representative Nelson: let's take that aside and say it is not a federally funded program. Would you use a different one that has some state general fund mechanism in it? Is it something you would look at? If the program was important enough would you look at funding it from the committee level rather than the health department budget?

Kathleen Mangskau: It's a difficult dilemma here. I'm trying to think of a scenario and in almost all cases we are supplanting or doing the things that this measure is specifically prohibiting. There is no general fund money in the health department budget. It is federal money and special fund money. It is difficult to imagine that we wouldn't be doing that .If it is already in their budget and the money by Measure 3 has been appropriated through the community health trust fund to remove that would be requiring us to supplant which is prohibited.

Chairman Pollert: We had DHS up there for 4 weeks straight. We are just trying to get an idea how this is going to work because it is new. We are trying to figure this out into everything.

Representative Weisz: When we originally passed the tobacco healthcare trust fund, the legislator specifically wanted to ensure that a lot of that money went locally. The local public health unit was in charge because they would be best able to determine what works in their communities. That is all gone under this proposal. I can tell that under your advisory committee represents a broad section of the state.

Kathleen Mangskau: If we looked at the best practices component 50% of the dollars go to local state and community interventions. That is a significant amount of these dollars because they recognize that changes happen in communities. In addition 1/3 of the members of the advisory committee are local public health department representatives. They are from various areas in the state. We have one from the Northwest, one from the Southeast, and one from the central portion of the state. Part of their role is to make sure that the state and local community interventions are addressed in here. That is the roll they are playing. In the component they are developing right now which is the state and community intervention component, all of those individuals are sitting on that committee to help develop the component. With 1/3 of the members representing local health departments they do have a good voice in the committee.

Jack McDonald: *My name is Jack McDonald. I'm appearing here today on behalf of the ND Society for Respiratory Care. These are the respiratory therapists who work with lung problems and diseases on a daily basis in ND. We have some 286 members. They do strongly support any efforts to promote tobacco cessation. They would certainly be supportive of this proposal. We look forward to working with the people dealing with this effort. If you have any questions I will try to answer them.*

Herbert Wilson: Handout testimony (Attachment B)

Roseanne Sand: Handout testimony (Attachment C)

Chairman Pollert: I would say we want to make sure that is too. None of us want to be on the front page of irresponsibility. I think we are on the same track. If there are any changes on the House side because this is in appropriations, we have to have our bills out by a week from Friday. We will probably be looking at amendments sometime around the 18th or 20th. Is there any other testimony for HB 2063?

Sheila Sandness: You had asked me to check on the state employee issue. I did some checking with Allen Knudson and he believes you have appropriated the funds and authorized the FTE that they are state employees subject to HRMS. If the director is appointed it could be a non classified position. The benefits would also come out of the funds because that is how it is appropriated.

Chairman Pollert: So we would have to have some language or is it just assumed?

Sheila Sandness: With the appropriation you are giving them the 4 FTE's and the appropriation so they are subject to that. A clarification would probably need to come on that executive director position whether that is classified or non-classified.

Chairman Pollert: Any other information that the committee needs?

Representative Ekstrom: Just a point on how the process will work. Will the policy committee be giving us a recommendation?

Chairman Pollert: This is an appropriations hearing. We invited them to bring knowledge forward. If someone from the policy committee wants to bring amendments forward be sure to talk to someone on our committee on what you want to do.

Representative Weisz: Our policy committee will not be making a recommendation on this. I felt that it was important for our policy committee understand the ramifications and what is involved with this bill. We won't be making a recommendation.

Chairman Pollert: We noticed it was important too. With that we will close the hearing on SB 2063.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. SB 2063

House Appropriations Committee
Human Resources Division

☐ Check here for Conference Committee

Hearing Date: 4/7/09

Recorder Job Number: 11761

Committee Clerk Signature

Minutes:

Chairman Pollert: Called the meeting to order. Took roll call and every member was present. We will start on SB 2063. Is there any discussion? This is the bill dealing with the comprehension tobacco control for the executive committee advisory council.

Representative Nelson: I have distributed a proposed amendment .0201. I would move these amendments .0201.

Representative Kreidt: I second that.

Representative Nelson: What the proposed amendment does is section 1 it appropriates the $12,882,000 million that came to us from the Senate. It authorizes 2 FTE's to the Department of Health. In section 2 it appropriates $62,403 for the work that has been done by the advisory committee. I believe the emergency clause at the end of the bill allows that to be used in this biennium. Section 3 of the bill transfers $4,100,000 from the tobacco and prevention control trust fund from the community health trust fund. As you know with the passage of Measure 3 many have been funded out of the Community Health Trust fund no longer will be able to be funded out of there. This is an effort to fund those programs. Many are good health related programs. It's important that we are able to utilize the community health trust fund. Section 4 requires the Department of Health to report to the budget section quarterly during the interim.

Section 5 is basically the advisory committee, it changes the authority of the advisory committee and the plan that is associated with tobacco prevention and cessation is given to the department of health which has been administrating the program throughout the past history and we think they have done an admiral job in doing that. Section 6 explains the duties of the advisory committee. Section 7 gives the Department of Health the development of the plan. That is basically the amendment. The highpoints are that we feel the people in the subcommittee that there is a duplication in 2063 in the form that came to us from the Senate. The health department and local public health has worked very well in implementing cessation dollars and prevention. We think that the boiler plate is in place. The additional money continues to be there. With that additional money the sources that are in place to administer the programs will be allowed to build upon the stronger foundation that already exists. That is the reason for the amendment. We think that with the additional money that is put into the community health trust fund that we can continue to fund the Women's Way programs and so forth which certainly need funding in the future.

Chairman Pollert: So the CDC recommendation is still intact the way it came over from the Senate?

Representative Nelson: The CDC best practice recommendation is exactly how it came from the Senate the $12,883,000 is what came from the Senate. With that, in addition to the 80%, was a $3,088,000 is what the number is. That would get us to the CDC best practice recommendation.

Chairman Pollert: Basically the tobacco advisory council is still going to be able to give advice on how the dollars are distributed? Can you explain that to me a little more? Are they still going to have input to the Department of Health on what they are going to be doing?

Representative Nelson: The advisory committee will continue to work as they have. They will advice the department of health in that capacity as I see this. The executive committee would no longer have a purpose. I should mention that in section 12 of the bill and amendment in 2017 this would all have to be reauthorized when the money runs out that the repeal section would grant a sunset at the end of 2017.

Representative Kerzman: In your estimation does this meet the demands of the major 3 and express the concerns of the people?

Representative Nelson: To answer that question, I think you would have to individually look at what each individual voted on with Measure 3. I think with the people I have talked to, it does. I think what the voice that was heard was that more funding needed to be put into prevention and cessation. This does meet those goals. I don't think people were voting on a new agency of state government in all likelihood. That is one of the fundamental problems with initiative measures. You put an idea in place and the specifics of how this particular deal will be implemented is not discussed by a very few. That is why it was so important in our estimation. I think Representative Ekstrom was paramount in her belief that the money needed to be left alone. I think that is what the people said in Measure 3, that more money had to be put into the program with the recommendation. This amendment would allow the Department of Health to Implement.

Representative Kerzman: I appreciate that but one of the concerns I have had floating around is with Measure 3 we jeopardize some of our future water funding. If we leave the money in here is it going to alleviate the problem at all?

Representative Nelson: I can't speak into the future. We have no effort to restore money into water development in these amendments. I suppose one could argue that at the end of 2017 there was a provision in Measure 3 that allowed a committee to utilize that. It is addressed that

the legislator would utilize that. That is the only reference to water in these amendments the way that we look at it and the way it would be implemented. In the time period between now and 2017 this money would be utilized for tobacco prevention and cessation. The only other source of funding that would be used in the trust fund would be the $4.1 million to the community health trust fund. That would be a reach to say that it would ever be used for water development.

Representative Ekstrom: To be fair there were discussions floated in terms of diverting some of the money towards the trust fund. We said absolutely not and stopped it in its tracks.

Chairman Pollert: I understand those were out there as well.

Representative Metcalf: I'm very concerned mainly because this amendment is not putting money in place where it is not supposed to be. It is intended for tobacco cessation. It is going to be up to the health department to ensure that the money being put in this particular area is going to be property used. I realize that 20% can be used for tobacco cessation. I understand for Women's Way and whatever else that needs to be done, some of this can be used in that respect. The great majority of it has to be without question. Is that the way this particular amendment reads?

Representative Nelson: The way it reads is the way the initiative measure was read. It is 80% of the money currently in the community health trust fund would be used for cessation and prevention programs which are funded from the community health trust fund. The additional $12 million would authorize the department of health to grant with the advisory committee. It would certainly be a part of the programs that needed to be funded with the health department and the 2 additional FTE's that they would get would administrate grants for the programs in the department of health that have been involved with the cessation and prevention programs up until currently. That would continue and that would be the roll that the health department

would be placed in. They would basically have more money to deal with the programs that already exist and possibly some new ones.

Representative Metcalf: I appreciate that confidence that you are showing here. However I know that these health units are grossly underfunded at this point. Are they going to assume that they can use his money for other purposes? Or what will ensure that they keep this money in tobacco cessation?

Representative Nelson: I think the programs are in place. I don't think they can divert the money out of the programs now. The Department of Health would have controls in place to ensure that when they send granting authority to public health for a specific purpose that the money would be used for that. I appreciate your concern about the funding level of public health. There is no intention in these amendments to divert money outside of a cessation and prevention programs. That is what the money is supposed to be used for and that is the intention that it would be used for.

Representative Kreidt: In section 9, there is an audit of the comprehensive plan that has to be done once during a biennium to ensure that those funds are going where they are directed to be spent. As long as reports to the budget sections are done on an annual basis. We have checks and balances that have been put in place to see that it happens the way the amendment reads.

Representative Ekstrom: The idea that we would do quarterly reports to the budget section to monitor the progress as well as the implementation of the plan to ensure it is being followed. I think we are trying to send a strong message that this is where it needs to go and we are going to keep an eye on that.

Chairman Pollert: I would have to believe that the tobacco advisory council will be having daily talks. There will be contact to make sure the intent of the CDC practices are being

followed. That is the way this reads to me. I would have to believe that at least this section would look unfavorably and it's not a threat to local health units to take care of something else. I know they are very strong on tobacco cessation. Any other discussion? If not we will take a roll call vote on the adoption of the amendments. It passes 7-1-0.

Representative Nelson: I move a do pass as amended.

Representative Ekstrom: I second that.

Chairman Pollert: Is there any other discussion? If not we will take a roll call vote. It passes 7-1-0.

Representative Nelson: I will carry this bill.

2009 HOUSE STANDING COMMITTEE MINUTES

SB 2063

House Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: April 7, 2009

Recorder Job Number: 11768

Committee Clerk Signature Holly N. Sand

Minutes:

Chm. Svedjan called the meeting of the House Appropriations Committee to order. We have an event that begins tonight at 6 pm. Come in casual attire. OMB and Legislative Council will be there. I am told Rep. Carlisle will also be there.

Rep. Wald just handed me a list of tonight's sponsors. Rep. Svedjan read the list of sponsors. Clerk, Holly Sand, called the roll and a quorum was declared.

Chairman Svedjan: We are going to start today with 2063 and comes to us from the HR section.

Rep. Nelson: The amendments for SB 2063 are .0201. and I would **move those amendments.**

Rep. Kreidt: Second.

Rep. Nelson: I'll explain what the amendments do. Section 1 of bill does appropriate the $12.882 million which is the best practice recommendations for the tobacco cessation and prevention program recommended by the Senate and agreed to by the advisory committee. There are two FTEs included in Section 1 that would go to the Health Dept. for implementation of the plan. Section 2 is a retroactive payment for the advisory committee which would go back to January 1, when they started holding meetings at $62,000. The retroactive payment is in Section 14 of the amendments as well. Section 3 is a transfer from the tobacco control trust

fund of $4.1 million to the community health trust fund. That is 10% of the appropriation and consistent with the 10% that has been appropriated into the community health trust fund in the past from tobacco settlement dollars. Section 4 does require budget section report each budget section meeting in the interim on the progress of the program. Section 5, the responsibility for the comprehensive plan is given to the Dept. of Health which has been in control of the prevention cessation programs in the past and administered by them with the passage of this amendment as well. Also in that section it eliminates the need for the executive committee because of the transfer to the Dept. of Health. Section 6, the major change there is in subsection 5, where it sets the compensation for the committee at legislative assembly rates It reiterates what the advisory committee acts as an advisory role in that section as well as Section 7. Section 9 requires an audit be done on the program each biennium. In Section 13 the money in the trust fund does continue until 2017 and we sunset the committee at the end of that biennium. The committee would either go away or be reauthorized at that point.

Rep. Onstad: On the section where it goes to the State Health Dept., since the beginning of tobacco dollars that came into the state, the State Health Dept. has been in charge of that aspect and has put very little towards tobacco cessation. What makes you think it is going to be any better now?

Rep. Nelson: I don't necessarily agree with your analysis. I think the way the program is working today is the Health Dept. administers grants as well as programs. The local public health units are in charge of a number of cessation programs in the area. The quit line has been a phenomenal success. The concern you have was probably addressed by the major three and the fact the people of ND wanted more money that would be towards those programs. That is exactly what occurs with the passage of this amendment and the bill with the

additional $12.8 million and that is addition to the $3.1 million in the community health trust fund that's been funding the quit line and comprehensive programs.

Rep. Onstad: The community health trust fund has funded a lot of other heart and colonoscopy programs, but has not been a function of tobacco itself. That is the point I want to make. I don't know why you are considering this type of amendment when we as the people did vote to put dollars towards tobacco cessation because it has not been done that way in the past.

Rep. Nelson: In Measure 3 it also stipulates that 80% of the money in the community health trust fund must be spent towards tobacco prevention and cessation so that directive is loud and clear in the initiated measure. That will be done.

Rep. Onstad: What is the other 20% going to?

Rep. Nelson: That will continue to have multi uses. There are a number of health care programs, the physician loan program, EMS grants, Women's Way, colon rectal cancer, and dental loan. Most programs have been funded out of the community health trust fund in the past. There was never a directive where all of that money had to be spent on prevention and cessation.

Rep. Onstad: I think that is where we are going to have a major difference. The dollars in the community health trust fund are to implement tobacco cessation programs which have they have not. That is where Measure 3 has come about because of that situation. I'm going to object to this particular amendment.

Rep. Skarphol: We have spent $34,839,000 since the 1999 biennium on tobacco prevention and control primarily.

Rep. Kreidt: In Section 9 the audit. There has to be transparency here on how those dollars are funded and they follow the comprehensive plan that has been placed out and we do have

the $12 million plus that is being added to the program and reporting to budget section on a quarterly basis.

Rep. Nelson: In this biennium in the community trust fund, $6.138 million is being spent on a number of programs. Tobacco coordinator, the advisory committee, city, county and state employee cessation quit line as well as the local health tobacco programs. To say that little money is being spent on health related programs is simply not true.

Rep. Pollert: We did not (inaudible) with the 9.3 or the CDC required that what they want is in these amendments plus the reporting mechanism.

Rep. Kaldor: Section 13 of the amendment, the effect date, it says Section 12 of the act becomes effective July 2017. What are we repealing in Section 12?

Rep. Nelson: There are several elements that are being repealed. Starting with 2401 is the advisory committee, plan, executive committee and the fund, that committee would be in charge of the comprehensive plan. With the amendment, that goes under the control of the Dept. of Health rather than the executive committee as well as the advisory council.

Rep. Kaldor: So the advisory committee that monitors to make sure they are following CDC best practices is repealed at that point and time?

Rep. Nelson: That section a code is repealed, but they are still in the amendment in Section 6 and 7.

Rep. Kaldor: The repealer eliminates that advisory committee which is created in 23-4202. If the effective date 2017, that means the advisory committee will disappear, according to this amendment?

Rep. Nelson: That is correct in 2017.

Rep. Kaldor: On subsection 3 of Section 5, the over struck language; you have eliminated the executive committee which was part of the initiated measure. Does the committee know what

the vote requirement will be for that particular amendment to be effective? Will this require a two-thirds vote?

Rep. Nelson: It is our understanding that if this amendment passes and the bill goes forward, yes a two-thirds majority would be required for the implementation of this bill.

Rep. Wald: I had Council do some research and as of July 1, 2007, between the ages of 12 and 18, there were 60,714 children in ND in that age group. Based on the information compiled by Council, we could send every kid in ND between 12 and 18 years of age a check every year for $312 and ask them not to smoke. Maybe that might be the way to go.

Rep. Kaldor: I appreciate the committee's work on this and I think that the question whether or not we should send out money to bribe kids to quit is one issue. Tobacco related illnesses are a major cost to the taxpayers of ND and to the country. We are addicted to tobacco taxes so we speak out of both sides of our mouths when we talk about this issue. We want their money, but we also want people to quit. The people of ND spoke at the last election on this issue mainly because I think they saw what happened going back to the original law suit and they way the dollars were divided. There are several aspects of the CDC program and what your committee will fund, there is no question more dollars will fund communication, disparity and those other elements that have not been addressed in the past and that is a positive thing. To suggest we are going to get two-thirds of the assembly to get rid of this committee that the people passed and decided it was necessary; I would resist these amendments as well. Hope we can pass bill out as Senate passed it out and concur with the voters of ND.

Rep. Pollert: I can agree with Rep. Kaldor half way. I believe the voters on Measure 3 voted to agree with the $9.3 million or the CDC best practices. I don't believe most voters knew they were going to take money out of the water resource trust fund if they had too. I don't believe

that they realized the whole ramifications. In my opinion, they voted on one part and that was to get more money to go to CDC practices.

Rep. Kreidt: I think the voters thought they were going to get more money for smoking cessation, but I don't think they realized they would be setting up another complete arm of government and another entity was going to run this program. I think the Health Dept. has been doing a good job and that is where the program should be run out of. I would hope we would vote in favor of these amendments.

Rep. Nelson: There is over a half a million dollars in the implementation of salaries of the committee. That is an issue that is paramount. We have sat here for 58 days now and gone through every budget in every agency in state government and here we are proposing a new committee whose identity won't change the face of cessation programs. We think the Health Dept. has a positive history of implementing programs as well as local public health units. I would argue with anybody that said that's what people were voting on with Measure 3. In my opinion, they voted on more effort put into tobacco cessation. They didn't vote on more government in this case to do it. I think this is a more efficient use of the funding and the additional money that was utilized in salaries can now be used for program efforts rather than bureaucratic efforts. I stand strongly on the side that the package of these amendments you may see more results rather than less.

Rep. Williams: The point is we need a two-thirds vote to override the general public and I for one am not willing five or six months after the vote to do that. I don't think that makes sense.

Voice Vote on Amendments: Motion Carried.

(Someone asked for a roll call vote.)

Roll Call Vote: 17 yes, 8 no, 0 absent.

Motion Carried.

Rep. Nelson: Move Do Pass on Amended Bill.

Rep. Kreidt: Second.

Rep. Kaldor: I would like to move a substitute motion to further amend. Amendment would be to delete Sections 12 and 13.

Rep. Kroeber: Second.

Rep. Kaldor: I'm concerned about that particular aspect about this because I think we are going to have future legislative sessions that are going to have to deal with this issue. As long as we are fighting the battle, the advisory committee at the very least is an important ingredient in providing guidance and support to the Health Dept. I know Rep. Nelson disagrees with this, but I do recall from an earlier experience in the legislature that the Health Dept. had a very difficult time carrying out its charge with relations to this issue. They had a lot of push back when they tried to do things for cessation and prevention. It even affected the local health units. I want what the people passed to stay in place. If in 2017 the legislature is satisfied that we have done our job and this is working, they can repeal it at that time.

Chairman Svedjan: With the inclusion of Section 13 really allows for the continuation of that group for eight years. 2009-2017.

Roll Call Vote to further amend: 10 yes 15 no, 0 absent.

Motion Failed.

Roll Call Vote for Do Pass As Amended SB 2063: 17 yes, 8 no, 0 absent.

MOTION CARRIED.

BILL CARRIER: Rep. Nelson.

Prepared by the Legislative Council staff for
Representatives Kreidt and Nelson
March 24, 2009

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2063

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to provide an appropriation for defraying the expenses of the state department of health for the development, implementation, and administration of the comprehensive tobacco prevention and control plan; to provide for a transfer; to provide for reports to the budget section; to amend and reenact sections 23-42-01, 23-42-02, 23-42-05, 23-42-06, 23-42-07, and 54-27-25 of the North Dakota Century Code, relating to the comprehensive tobacco prevention and control plan and advisory committee and the tobacco settlement trust fund; to repeal sections 23-42-01, 23-42-02, 23-42-03, 23-42-04, 23-42-05, 23-42-06, and 23-42-07 of the North Dakota Century Code, relating to the tobacco prevention and control executive committee and advisory committee; to provide an effective date; to provide for retroactive application; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. APPROPRIATION. The funds provided in this section, or so much of the funds as may be necessary, are appropriated out of any moneys in the tobacco prevention and control trust fund, not otherwise appropriated, to the state department of health for the purpose of defraying the expenses of the comprehensive tobacco prevention and control plan, for the biennium beginning July 1, 2009, and ending June 30, 2011, as follows:

	Base Level	Adjustments or Enhancements	Appropriation
Salaries and wages	$0	$252,128	$252,128
Grants	0	12,629,872	12,629,872
Total special funds	$0	$12,882,000	$12,882,000
Full-time equivalent positions	0.00	2.00	2.00

SECTION 2. APPROPRIATION. There is appropriated out of any moneys in the tobacco prevention and control trust fund, not otherwise appropriated, the sum of $62,403, or so much of the sum as may be necessary, to the state department of health for the purpose of defraying the expenses of the tobacco prevention and control advisory committee, developing the comprehensive tobacco prevention and control plan, and contracting with a consultant to facilitate the development of the comprehensive plan, for the period beginning January 1, 2009, and ending July 1, 2009.

SECTION 3. COMMUNITY HEALTH TRUST FUND - TRANSFER. The office of management and budget shall transfer the sum of $4,100,000 from the tobacco prevention and control trust fund to the community health trust fund, for the biennium beginning July 1, 2009, and ending June 30, 2011.

SECTION 4. REPORTS TO THE BUDGET SECTION. The state department of health shall report to the budget section quarterly on the implementation of the comprehensive tobacco prevention and control plan and outcomes achieved, for the biennium beginning July 1, 2009, and ending June 30, 2011.

SECTION 5. AMENDMENT. Section 23-42-01 of the North Dakota Century Code is amended and reenacted as follows:

23-42-01. Definitions. As used in this chapter:

1. "Advisory committee" is the nine-member tobacco prevention and control advisory committee ~~responsible to develop the comprehensive plan~~.

2. "Comprehensive plan" means a comprehensive statewide tobacco prevention and control program ~~that~~ developed by the state department of health which is consistent with the centers for disease control and prevention best practices for comprehensive tobacco prevention and control programs and does not duplicate the work of the community health grant program created in chapter 23-38.

3. ~~"Executive committee" means the three-member committee selected by the advisory committee and charged with implementation and administration of the comprehensive plan.~~

4. "Tobacco prevention and control fund" consists of all principal and interest of the tobacco prevention and control trust fund established by section 54-27-25.

SECTION 6. AMENDMENT. Section 23-42-02 of the North Dakota Century Code is amended and reenacted as follows:

23-42-02. Tobacco prevention and control advisory committee - Membership - Terms - Duties - Removal.

1. The advisory board consists of nine North Dakota residents appointed by the governor for three-year terms as follows:

   a. A practicing respiratory therapist familiar with tobacco-related diseases;

   b. Four nonstate employees who have demonstrated expertise in tobacco prevention and control;

   c. A practicing medical doctor familiar with tobacco-related diseases;

   d. A practicing nurse familiar with tobacco-related diseases;

   e. A youth between the ages of fourteen and twenty-one; and

   f. A member of the public with a previously demonstrated interest in fostering tobacco prevention and control.

2. The governor shall select the youth and public member independently; the respiratory therapist from a list of three nominations provided by the North Dakota society for respiratory care; the four tobacco control experts from a list of two nominations per member provided by the North Dakota public health association's tobacco control section; the medical doctor from a list of three nominations provided by the North Dakota medical association; and the nurse from a list of three nominations provided by the North Dakota nurses association. The governor must make the appointments within three weeks of receiving the respective list of nominees. If the governor fails to make an appointment within three weeks, the association that provided the list of nominees shall select the committee member. In the initial appointments for the advisory committee, the governor shall stagger the terms of the members so that the terms of three members expire each fiscal year and that three members are appointed each year by June thirtieth. Accordingly, the governor's initial appointments, in some instances, must be for terms less than three years. The governor shall fill vacancies for the unexpired term as provided in this section.

3. No individual may serve more than two consecutive three-year terms. However, terms of less than three years are not considered in determining an individual's eligibility for reappointment.

4. A quorum of the advisory committee is required to conduct business, but the advisory committee may conduct a meeting with less than a quorum present. A quorum is a majority of the members of the committee. Any action taken requires a vote of the majority of the members present at the meeting.

5. The advisory board shall:

   a. ~~Select the executive committee;~~

   ~~b.~~ Fix the compensation of the advisory committee ~~and the executive committee~~. However, compensation may not exceed compensation allowed to the ~~legislature~~ legislative assembly. Advisory ~~and executive~~ committee members are entitled to reimbursement for mileage and expenses as provided for state officers in addition to any compensation provided;

   ~~c.~~ b. ~~Develop~~ Advise the state department of health on the development of the initial comprehensive statewide tobacco prevention and control program ~~that includes~~, including support for cessation interventions, community and youth interventions, and health communication; and

   ~~d.~~ c. Evaluate the effectiveness of the plan and its implementation as carried out by the state department of health and, before April first of each year, propose any necessary changes to the plan to the ~~executive committee~~ state department of health.

6. The governor may remove any member of the advisory committee for malfeasance in office, but the advisory committee is not subject to section 54-07-01.2.

7. No nomination to, or member of, the advisory committee ~~shall~~ may have any past or current affiliation with the tobacco industry or any industry, contractor, agent, or organization that engages in the manufacturing, marketing, distributing, sale, or promotion of tobacco or tobacco-related products.

SECTION 7. AMENDMENT. Section 23-42-05 of the North Dakota Century Code is amended and reenacted as follows:

23-42-05. Development of the comprehensive plan. The advisory committee shall ~~develop~~ advise the state department of health on the development of the initial comprehensive plan within one hundred eighty days of the initial meeting of the advisory committee. The comprehensive plan must be funded at a level equal to or greater than the centers for disease control and prevention recommended funding level. Funding for the comprehensive plan must supplement and may not supplant any funding that in the absence of this chapter would be or has been provided for the community health trust fund or other health initiatives.

SECTION 8. AMENDMENT. Section 23-42-06 of the North Dakota Century Code is amended and reenacted as follows:

23-42-06. Conflict of interest. No member of the advisory committee ~~or of the executive committee~~ who has a direct and substantial personal or pecuniary interest in a matter before them may vote or take any action on that matter.

SECTION 9. AMENDMENT. Section 23-42-07 of the North Dakota Century Code is amended and reenacted as follows:

23-42-07. Audit. At least once a biennium, the ~~executive committee~~ state department of health shall provide for an independent review of the comprehensive plan to assure that the comprehensive plan is consistent with the centers for disease control and prevention best practices. The ~~executive committee~~ state department of health shall report the results of that review to the governor and to the state health officer on or before September first in each odd-numbered year.

SECTION 10. AMENDMENT. Section 54-27-25 of the North Dakota Century Code is amended and reenacted as follows:

54-27-25. Tobacco settlement trust fund - Interest on fund - Uses.

1. There is created in the state treasury a tobacco settlement trust fund. The fund consists of the tobacco settlement dollars obtained by the state under subsection IX(c)(1) of the master settlement agreement and consent agreement adopted by the east central judicial district court in its judgment entered December 28, 1998 [Civil No. 98-3778] in State of North Dakota, ex rel. Heidi Heitkamp v. Philip Morris, Inc. Except as provided in subsection 2, moneys received by the state under subsection IX(c)(1) must be deposited in the fund. Interest earned on the fund must be credited to the fund and deposited in the fund. The principal and interest of the fund must be allocated as follows:

   a. Transfers to a community health trust fund to be administered by the state department of health. The state department of health may use funds as appropriated for community-based public health programs and other public health programs, including programs with emphasis on preventing or reducing tobacco usage in this state. Transfers under this subsection must equal ten percent of total annual transfers from the tobacco settlement trust fund of which a minimum of eighty percent must be used for tobacco prevention and control.

   b. Transfers to the common schools trust fund to become a part of the principal of that fund. Transfers under this subsection must equal forty-five percent of total annual transfers from the tobacco settlement trust fund.

   c. Transfers to the water development trust fund to be used to address the long-term water development and management needs of the state. Transfers under this subsection must equal forty-five percent of the total annual transfers from the tobacco settlement trust fund.

2. There is created in the state treasury a tobacco prevention and control trust fund. The fund consists of the tobacco settlement dollars obtained by the state under section IX(c)(2) of the agreement adopted by the east central judicial district court in its judgment entered December 28, 1998 [Civil No. 98-3778] in State of North Dakota, ex rel. Heidi Heitkamp v. Philip Morris, Inc. Interest earned on the fund must be credited to the fund and deposited in the fund. Moneys received into the fund are to be administered by the ~~executive committee~~ state department of health for the purpose of creating and implementing the comprehensive plan provided for under chapter 23-42. If in any biennium, the tobacco prevention and control trust fund does not have adequate dollars to fund a comprehensive plan, the treasurer shall transfer money from the water development trust fund to the tobacco prevention and control trust fund in an amount equal to the amount determined necessary by the ~~executive committee~~ legislative assembly to fund a comprehensive plan.

3. Transfers to the funds under this section must be made within thirty days of receipt by the state.

SECTION 11. REPEAL. Sections 23-42-03 and 23-42-04 of the North Dakota Century Code are repealed.

SECTION 12. REPEAL. Sections 23-42-01, 23-42-02, 23-42-05, 23-42-06, and 23-42-07 of the North Dakota Century Code are repealed.

SECTION 13. EFFECTIVE DATE. Section 12 of this Act becomes effective July 1, 2017.

SECTION 14. RETROACTIVE APPLICATION. Section 2 of this Act is retroactive to January 1, 2009.

SECTION 15. EMERGENCY. This Act is declared to be an emergency measure."

Renumber accordingly

Date: 4/7/09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken adopt amendments . 0201

Motion Made By Nelson Seconded By Kreidt

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom	X	
Vice Chairman Bellew	X		Representative Kerzman	X	
Representative Kreidt	X		Representative Metcalf		X
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 7 No 1

Absent 0

Floor Assignment

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

Date: 4/7/09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number SB 2063

Action Taken Do pass as amended

Motion Made By Rep. Nelson Seconded By Rep. Ekstrom

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom	X	
Vice Chairman Bellew	X		Representative Kerzman	X	
Representative Kreidt	X		Representative Metcalf		X
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 7 No 1

Absent 0

Floor Assignment Rep. Nelson

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

Date: 4/7/09
Roll Call Vote #: 1

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2063

Full House Appropriations Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number .0201

Action Taken adopt Amendment .0201

Motion Made By Nelson Seconded By Kreidt

Representatives	Yes	No	Representatives	Yes	No
Chairman Svedjan	✓				
Vice Chairman Kempenich	✓				
Rep. Skarphol	✓		Rep. Kroeber		✓
Rep. Wald	✓		Rep. Onstad		✓
Rep. Hawken	✓		Rep. Williams		✓
Rep. Klein	✓				
Rep. Martinson		✓			
Rep. Delzer	✓		Rep. Glassheim		✓
Rep. Thoreson	✓		Rep. Kaldor		✓
Rep. Berg	✓		Rep. Meyer		✓
Rep. Dosch	✓				
Rep. Pollert	✓		Rep. Ekstrom	✓	
Rep. Bellew	✓		Rep. Kerzman	✓	
Rep. Kreidt	✓		Rep. Metcalf		✓
Rep. Nelson	✓				
Rep. Wieland	✓				

Total (Yes) 17 No 8

Absent 0

Floor Assignment Voice Vote - Carries

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

Date: 4/7/09
Roll Call Vote #: 2/4

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2063

Full House Appropriations Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number .0201

Action Taken Do Pass as Amended .0201

Motion Made By Nelson Seconded By Kreidt

Representatives	Yes	No	Representatives	Yes	No
Chairman Svedjan	✓				
Vice Chairman Kempenich	✓				
Rep. Skarphol	✓		Rep. Kroeber		✓
Rep. Wald	✓		Rep. Onstad		✓
Rep. Hawken	✓		Rep. Williams		✓
Rep. Klein	✓				
Rep. Martinson		✓			
Rep. Delzer	✓		Rep. Glassheim		✓
Rep. Thoreson	✓		Rep. Kaldor		✓
Rep. Berg	✓		Rep. Meyer		✓
Rep. Dosch	✓				
Rep. Pollert	✓		Rep. Ekstrom	✓	
Rep. Bellew	✓		Rep. Kerzman	✓	
Rep. Kreidt	✓		Rep. Metcalf		✓
Rep. Nelson	✓				
Rep. Wieland	✓				

Total (Yes) 17 No 8

Absent 0

Floor Assignment Nelson

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

Date: 4/7/09
Roll Call Vote #: 3

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2063

Full House Appropriations Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number TBD

Action Taken Delete Sections 12 & 13 of Amend. .0201 (and other nec. adj.)

Motion Made By Kaldor Seconded By Kroeber

Absent motion to further amend

Representatives	Yes	No	Representatives	Yes	No
Chairman Svedjan		✓			
Vice Chairman Kempenich		✓			
Rep. Skarphol		✓	Rep. Kroeber	✓	
Rep. Wald		✓	Rep. Onstad	✓	
Rep. Hawken		✓	Rep. Williams	✓	
Rep. Klein		✓			
Rep. Martinson	✓				
Rep. Delzer		✓	Rep. Glassheim	✓	
Rep. Thoreson		✓	Rep. Kaldor	✓	
Rep. Berg		✓	Rep. Meyer	✓	
Rep. Dosch		✓			
Rep. Pollert		✓	Rep. Ekstrom	✓	
Rep. Bellew		✓	Rep. Kerzman	✓	
Rep. Kreidt		✓	Rep. Metcalf	✓	
Rep. Nelson		✓			
Rep. Wieland		✓			

Total (Yes) 10 No 15

Absent 0

Floor Assignment Failed

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

REPORT OF STANDING COMMITTEE

SB 2063, as engrossed: Appropriations Committee (Rep. Svedjan, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (17 YEAS, 8 NAYS, 0 ABSENT AND NOT VOTING). Engrossed SB 2063 was placed on the Sixth order on the calendar.

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to provide an appropriation for defraying the expenses of the state department of health for the development, implementation, and administration of the comprehensive tobacco prevention and control plan; to provide for a transfer; to provide for reports to the budget section; to amend and reenact sections 23-42-01, 23-42-02, 23-42-05, 23-42-06, 23-42-07, and 54-27-25 of the North Dakota Century Code, relating to the comprehensive tobacco prevention and control plan and advisory committee and the tobacco settlement trust fund; to repeal sections 23-42-01, 23-42-02, 23-42-03, 23-42-04, 23-42-05, 23-42-06, and 23-42-07 of the North Dakota Century Code, relating to the tobacco prevention and control executive committee and advisory committee; to provide an effective date; to provide for retroactive application; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. APPROPRIATION. The funds provided in this section, or so much of the funds as may be necessary, are appropriated out of any moneys in the tobacco prevention and control trust fund, not otherwise appropriated, to the state department of health for the purpose of defraying the expenses of the comprehensive tobacco prevention and control plan, for the biennium beginning July 1, 2009, and ending June 30, 2011, as follows:

	Base Level	Adjustments or Enhancements	Appropriation
Salaries and wages	$0	$252,128	$252,128
Grants	0	12,629,872	12,629,872
Total special funds	$0	$12,882,000	$12,882,000
Full-time equivalent positions	0.00	2.00	2.00

SECTION 2. APPROPRIATION. There is appropriated out of any moneys in the tobacco prevention and control trust fund, not otherwise appropriated, the sum of $62,403, or so much of the sum as may be necessary, to the state department of health for the purpose of defraying the expenses of the tobacco prevention and control advisory committee, developing the comprehensive tobacco prevention and control plan, and contracting with a consultant to facilitate the development of the comprehensive plan, for the period beginning January 1, 2009, and ending July 1, 2009.

SECTION 3. COMMUNITY HEALTH TRUST FUND - TRANSFER. The office of management and budget shall transfer the sum of $4,100,000 from the tobacco prevention and control trust fund to the community health trust fund, for the biennium beginning July 1, 2009, and ending June 30, 2011.

SECTION 4. REPORTS TO THE BUDGET SECTION. The state department of health shall report to the budget section quarterly on the implementation of the comprehensive tobacco prevention and control plan and outcomes achieved, for the biennium beginning July 1, 2009, and ending June 30, 2011.

SECTION 5. AMENDMENT. Section 23-42-01 of the North Dakota Century Code is amended and reenacted as follows:

23-42-01. Definitions. As used in this chapter:

1. "Advisory committee" is the nine-member tobacco prevention and control advisory committee ~~responsible to develop the comprehensive plan~~.

2. "Comprehensive plan" means a comprehensive statewide tobacco prevention and control program ~~that~~ developed by the state department of health which is consistent with the centers for disease control and prevention best practices for comprehensive tobacco prevention and control programs and does not duplicate the work of the community health grant program created in chapter 23-38.

3. ~~"Executive committee" means the three member committee selected by the advisory committee and charged with implementation and administration of the comprehensive plan.~~

~~4.~~ "Tobacco prevention and control fund" consists of all principal and interest of the tobacco prevention and control trust fund established by section 54-27-25.

SECTION 6. AMENDMENT. Section 23-42-02 of the North Dakota Century Code is amended and reenacted as follows:

23-42-02. Tobacco prevention and control advisory committee - Membership - Terms - Duties - Removal.

1. The advisory board consists of nine North Dakota residents appointed by the governor for three-year terms as follows:

   a. A practicing respiratory therapist familiar with tobacco-related diseases;

   b. Four nonstate employees who have demonstrated expertise in tobacco prevention and control;

   c. A practicing medical doctor familiar with tobacco-related diseases;

   d. A practicing nurse familiar with tobacco-related diseases;

   e. A youth between the ages of fourteen and twenty-one; and

   f. A member of the public with a previously demonstrated interest in fostering tobacco prevention and control.

2. The governor shall select the youth and public member independently; the respiratory therapist from a list of three nominations provided by the North Dakota society for respiratory care; the four tobacco control experts from a list of two nominations per member provided by the North Dakota public health association's tobacco control section; the medical doctor from a list of three nominations provided by the North Dakota medical association; and the nurse from a list of three nominations provided by the North Dakota nurses association. The governor must make the appointments within three weeks of receiving the respective list of nominees. If the governor fails to make an appointment within three weeks, the association that provided the list of nominees shall select the committee member. In the initial appointments for the advisory committee, the governor shall stagger the terms of the members so that the terms of three members expire each fiscal year and that three members are appointed each year

by June thirtieth. Accordingly, the governor's initial appointments, in some instances, must be for terms less than three years. The governor shall fill vacancies for the unexpired term as provided in this section.

3. No individual may serve more than two consecutive three-year terms. However, terms of less than three years are not considered in determining an individual's eligibility for reappointment.

4. A quorum of the advisory committee is required to conduct business, but the advisory committee may conduct a meeting with less than a quorum present. A quorum is a majority of the members of the committee. Any action taken requires a vote of the majority of the members present at the meeting.

5. The advisory board shall:

   a. ~~Select the executive committee;~~

   ~~b.~~ Fix the compensation of the advisory committee ~~and the executive committee~~. However, compensation may not exceed compensation allowed to the ~~legislature~~ legislative assembly. Advisory ~~and executive~~ committee members are entitled to reimbursement for mileage and expenses as provided for state officers in addition to any compensation provided;

   ~~c.~~ b. ~~Develop~~ Advise the state department of health on the development of the initial comprehensive statewide tobacco prevention and control program ~~that includes~~, including support for cessation interventions, community and youth interventions, and health communication; and

   ~~d.~~ c. Evaluate the effectiveness of the plan and its implementation as carried out by the state department of health and, before April first of each year, propose any necessary changes to the plan to the ~~executive committee~~ state department of health.

6. The governor may remove any member of the advisory committee for malfeasance in office, but the advisory committee is not subject to section 54-07-01.2.

7. No nomination to, or member of, the advisory committee ~~shall~~ may have any past or current affiliation with the tobacco industry or any industry, contractor, agent, or organization that engages in the manufacturing, marketing, distributing, sale, or promotion of tobacco or tobacco-related products.

SECTION 7. AMENDMENT. Section 23-42-05 of the North Dakota Century Code is amended and reenacted as follows:

23-42-05. Development of the comprehensive plan. The advisory committee shall ~~develop~~ advise the state department of health on the development of the initial comprehensive plan within one hundred eighty days of the initial meeting of the advisory committee. The comprehensive plan must be funded at a level equal to or greater than the centers for disease control and prevention recommended funding level. Funding for the comprehensive plan must supplement and may not supplant any funding that in the absence of this chapter would be or has been provided for the community health trust fund or other health initiatives.

SECTION 8. AMENDMENT. Section 23-42-06 of the North Dakota Century Code is amended and reenacted as follows:

23-42-06. Conflict of interest. No member of the advisory committee ~~or of the executive committee~~ who has a direct and substantial personal or pecuniary interest in a matter before them may vote or take any action on that matter.

SECTION 9. AMENDMENT. Section 23-42-07 of the North Dakota Century Code is amended and reenacted as follows:

23-42-07. Audit. At least once a biennium, the ~~executive committee~~ state department of health shall provide for an independent review of the comprehensive plan to assure that the comprehensive plan is consistent with the centers for disease control and prevention best practices. The ~~executive committee~~ state department of health shall report the results of that review to the governor and to the state health officer on or before September first in each odd-numbered year.

SECTION 10. AMENDMENT. Section 54-27-25 of the North Dakota Century Code is amended and reenacted as follows:

54-27-25. Tobacco settlement trust fund - Interest on fund - Uses.

1. There is created in the state treasury a tobacco settlement trust fund. The fund consists of the tobacco settlement dollars obtained by the state under subsection IX(c)(1) of the master settlement agreement and consent agreement adopted by the east central judicial district court in its judgment entered December 28, 1998 [Civil No. 98-3778] in State of North Dakota, ex rel. Heidi Heitkamp v. Philip Morris, Inc. Except as provided in subsection 2, moneys received by the state under subsection IX(c)(1) must be deposited in the fund. Interest earned on the fund must be credited to the fund and deposited in the fund. The principal and interest of the fund must be allocated as follows:

   a. Transfers to a community health trust fund to be administered by the state department of health. The state department of health may use funds as appropriated for community-based public health programs and other public health programs, including programs with emphasis on preventing or reducing tobacco usage in this state. Transfers under this subsection must equal ten percent of total annual transfers from the tobacco settlement trust fund of which a minimum of eighty percent must be used for tobacco prevention and control.

   b. Transfers to the common schools trust fund to become a part of the principal of that fund. Transfers under this subsection must equal forty-five percent of total annual transfers from the tobacco settlement trust fund.

   c. Transfers to the water development trust fund to be used to address the long-term water development and management needs of the state. Transfers under this subsection must equal forty-five percent of the total annual transfers from the tobacco settlement trust fund.

2. There is created in the state treasury a tobacco prevention and control trust fund. The fund consists of the tobacco settlement dollars obtained by the state under section IX(c)(2) of the agreement adopted by the east central judicial district court in its judgment entered December 28, 1998 [Civil No. 98-3778] in State of North Dakota, ex rel. Heidi Heitkamp v.

Philip Morris, Inc. Interest earned on the fund must be credited to the fund and deposited in the fund. Moneys received into the fund are to be administered by the ~~executive committee~~ state department of health for the purpose of creating and implementing the comprehensive plan provided for under chapter 23-42. If in any biennium, the tobacco prevention and control trust fund does not have adequate dollars to fund a comprehensive plan, the treasurer shall transfer money from the water development trust fund to the tobacco prevention and control trust fund in an amount equal to the amount determined necessary by the ~~executive committee~~ legislative assembly to fund a comprehensive plan.

3. Transfers to the funds under this section must be made within thirty days of receipt by the state.

SECTION 11. REPEAL. Sections 23-42-03 and 23-42-04 of the North Dakota Century Code are repealed.

SECTION 12. REPEAL. Sections 23-42-01, 23-42-02, 23-42-05, 23-42-06, and 23-42-07 of the North Dakota Century Code are repealed.

SECTION 13. EFFECTIVE DATE. Section 12 of this Act becomes effective July 1, 2017.

SECTION 14. RETROACTIVE APPLICATION. Section 2 of this Act is retroactive to January 1, 2009.

SECTION 15. EMERGENCY. This Act is declared to be an emergency measure."

Renumber accordingly

2009 TESTIMONY

SB 2063

#1

Testimony
SB No. 2063
Senate Human Services Committee
January 20, 2009, 10:00 a.m.

Good morning Chairman Lee and members of the Senate Human Services Committee. My name is Kathleen Mangskau and I am the chair of the Tobacco Prevention and Control Advisory Committee. I am here to provide information on how the funds appropriated in SB 2063 will be spent. The law passed by the voters in November 2008 directs that the funds in the tobacco prevention and control trust fund be spent to develop and implement a statewide, comprehensive Center for Disease Control and Prevention (CDC)-based best practice tobacco prevention and control program. I will provide background on the need for the program, the progress of the advisory committee to date, the best practice categories, the current levels of funding in the best practice categories and how the new funds will be used to meet the recommended programming and levels of spending.

The Need for a Comprehensive Tobacco Prevention and Control Program

We all know many people who have been impacted by tobacco use suffering from heart or lung disease, or other associated cancers or by the premature death of a loved one. At the first advisory committee meeting, I was struck by the overwhelming impact tobacco use had on the members of the advisory committee and the families and their motivation for wanting to be part of the committee. The toll of tobacco in North Dakota is high and rising health care costs are a concern to many North Dakotans. With the current level of funding for tobacco control efforts in the state, tobacco use continues to kill more than 900 North Dakota residents every year and costs the state $250 million in annual excess health care costs, including $47 million a year in state Medicaid program costs. State productivity losses from smoking total an additional $192 million each year. According to the *North Dakota Behavioral Risk Factor Survey*, one in five

adults in North Dakota smoke, a rate that has changed very little for a more than a decade. The *North Dakota Youth Risk Behavior Survey* indicates that more than one in five kids (21%) still smoke, and one in five high school males (20%) use spit tobacco. These North Dakota youth tobacco use rates are all higher than the national rates. While North Dakota has made strides in reducing youth tobacco use; the tobacco use problem clearly is not solved. The decline in youth rates has flattened but without additional resources and programming, we will not continue to see major changes in those rates. The 2007 Institute of Medicine Report concluded that to effectively reduce tobacco use, "states must maintain over time a comprehensive integrated tobacco control strategy." Research shows that the more states spend on sustained comprehensive tobacco control programs, the greater the reductions in smoking—and the longer states invest in such programs, the greater and faster the impact. North Dakota voters chose to implement a comprehensive strategy when they enacted Measure 3.

The Tobacco Prevention and Control Advisory Committee has primary goals of preventing youth from starting to use tobacco, helping youth and adults to quit tobacco use, eliminating exposure to secondhand smoke and identifying and eliminating tobacco use disparities. Implementing evidence-based, statewide tobacco control programs that are comprehensive, integrated, sustained and accountable have been shown to reduce smoking rates, tobacco-related deaths, and diseases caused by smoking. These programs will prevent or accelerate declines in heart disease, lung diseases and disorders, and once again make lung cancer a rare disease. A comprehensive approach combines educational, clinical, regulatory, economic and social strategies. The plan will have well-defined goals, objectives, and short-term, intermediate and long-term indicators of success.

Progress of Tobacco Prevention and Control Advisory Committee

Governor Hoeven promptly appointed the nine-member advisory committee in December 2008. The appointments became official on January 1, 2009. The Committee convened its first meeting on January 8, 2009 and elected the executive committee and chair, set their meeting dates, determined their operating procedures, and initiated research into best practice approaches in order to prepare for Legislative requests for information and to meet the time constraints (180 days) to develop the plan. The Committee is requesting retroactive spending authority in order to conduct its business and meet that deadline. The CDC has been contacted to provide training on the Best Practice approach for the advisory committee members, local tobacco coordinators and local coalition leaders/members in the latter part of February. The CDC has designated a consultant to assist the state with development of their plan for a comprehensive program. The advisory committee has scheduled meetings to be held as frequently as every other week until the plan is completed. The committee will use the previous and current state tobacco plans as a foundation for the comprehensive plan.

The Executive Committee met with staff from the North Dakota Department of Health on January 15, 2009 to begin working through the roles and responsibilities of each agency so we can be most effective and we do not duplicate efforts. There was a fairly high level of agreement as to which agency could carry out each function most efficiently and effectively. I will outline that information in more detail as I discuss the best practice categories.

Current Funding and Funding Needed

A fact sheet on the CDC Best Practices recommended annual investment for North Dakota is included as Attachment A. The table below shows that North Dakota, with a combination of state tobacco settlement revenues and federal funds, currently spends around $4.4 million per year on

tobacco prevention and control efforts, less than one-half (47%) of the $9.3 million the CDC recommends for a comprehensive tobacco control program each year. Moreover, the percentage spent on tobacco prevention and control efforts may be slightly overestimated as 100 percent of the Community Health Trust fund state aid funding to local health departments is not spent on tobacco prevention and control programming.

A comparison of the recommended per capita spending and the current level of tobacco control spending in North Dakota in 2008 provided by the State Health Department shows that the program is sadly underfunded in many categories and thus North Dakota has not been able to make the progress necessary to protect our citizens and significantly reduce the health and economic burden of tobacco use in the state.

North Dakota Tobacco Control Expenditures by Best Practice Category in 2008

	Per Capita Recommendation	ND Spending	Percentage of Recommendation ND Spends
State and Community Interventions	$ 7.37	$3.90	53%
Health Communication Interventions	$ 1.86	$0.27	15%
Cessation Interventions	$ 3.52	$1.14	32%
Surveillance and Evaluation	$ 1.28	$0.15	12%
Administration and Management	$ 0.64	$0.75	101%
*Other Funds in ND (State Aid)		$0.74	
Total	**$14.67**	**$6.95**	**47%**

How the Trust Funds will be Spent

The Strategic Contribution Fund currently brings in approximately $13.8 million per year. That money will be put in a trust fund to support a comprehensive approach to tobacco prevention and control in North Dakota beyond the ten years in which North Dakota receives those funds. Using the projected levels of tobacco prevention and control funding from the CDC and the Community Health Trust Fund, each year approximately $6.2 million dollars of the Tobacco Prevention and Control Trust funds would be spent to bring North Dakota up to the recommended funding level for a comprehensive approach. The remaining $7.6 million would remain in the trust to fund tobacco prevention and control beyond the nine remaining years the Strategic Contribution Fund payments are coming to the state. At this funding level and if the CDC support for tobacco control remains about the same as it currently is, the funding should support programs for more than 16 years.

The state plan the advisory committee will develop, with input from North Dakota residents, will outline the programs and services needed to implement a Best Practice comprehensive program in North Dakota. The Advisory Committee will work closely with the North Dakota Department of Health to put in place programs and services where the current programming is lacking and to avoid duplication. Some of the programs and services may involve contracting with the North Dakota Department of Health to enhance their current programming where needed. A grants program will be established to fund missing components of the current program and enhance areas where funding is inadequate. The advisory committee will determine which grants would be funded based on the Best Practice approach. These funds will enhance and not duplicate, replace or supplant the current programs funded by the Department of Health through the existing CDC funds and the Community Health Trust Fund. The funds will be allocated not only to local communities, but also to statewide organizations capable of carrying out programs to

enhance efforts to prevent initiation among youth, promote quitting among youth and adults, reduce and eliminate exposure to secondhand smoke and eliminate disparities in tobacco use among specific populations. Attachment B shows the recommended funding for tobacco prevention and control efforts in North Dakota by Best Practice category and shows the estimated funds that will be available from the CDC and the Community Health Trust Fund and the projected amount that will be needed from the Tobacco Prevention and Control Trust Fund in the 2009-2011 biennium.

Best Practice Components

State and Community Interventions

Coordinated and combined intervention efforts of statewide and local programs working together have the greatest long-term impact. This component supports the state and local community effort to mobilize coalitions to develop state and community level programs and policies to counter pervasive pro-tobacco influences. At the current tobacco control funding level, many counties in the state do not have enough funding to maintain staffing to carry out tobacco prevention activities, youth programs that include tobacco prevention activities, and implement culturally appropriate interventions. The new funds from the trust can be used to enhance support to local and tribal programs, law enforcement, and agencies that can conduct programs reaching specific populations with high tobacco use rates such as Native Americans, pregnant women, lower socio-economic populations and the school to work population aged 18-30. Greater emphasis needs to be placed on engaging communities and providing training so local communities implement policies and strategies to reduce tobacco use. As evidence-based programs are implemented, additional efforts to collaborate with other chronic disease programs and support efforts to promote prevention programs and cessation efforts would create synergy of consistent health promotion messages and multiple avenues to provide services. This

component will be jointly implemented by the Tobacco Advisory Committee and the State Health Department.

Health Communication Interventions

There is strong evidence that sustained earned and paid media in combination with other interventions and strategies is effective in reducing tobacco use. Exposure to counter marketing ads is associated with greater pro-health attitudes and beliefs and produces significant declines in smoking rates among adults and youth as well as slowing initiation among youth. Paid media is also needed to recruit target populations with high tobacco use rates to the quitline and local cessation programs. Currently, no funding is available for statewide media efforts to educate youth and very limited funding is available to educate the public about the dangers of secondhand smoke. Funding can also be used to provide greater outreach of the quitline services and to conduct market research so public education efforts can be effectively targeted. Health communication messages that are sustained and appropriately targeted can greatly impact health behaviors. This component will be implemented by the Tobacco Prevention and Control Advisory Committee.

Cessation

Interventions to increase cessation encompass a broad array of policy, system, and population-based measures. Sustaining, expanding and promoting cessation services through the statewide quitline and local treatment programs is needed. Promoting coverage for tobacco dependence treatment under both public and private insurance will increase the number of individuals receiving treatment. Individual and group counseling and coverage of all FDA approved medications will enhance current efforts. Currently only limited medications are provided. Eliminating cost and other barriers to treatment for underserved populations as well as making health systems changes to effectively reach all at risk populations will work to reduce tobacco

use. Funding training for health professionals in the use of the Public Health Service Guidelines and for the quitline and local cessation services will reach more tobacco users and increase the number who successfully quit. Providing cessation services to youth in a variety of medium, including web-based, internet and text messaging, will reach out to younger populations in methods they prefer to use. This component will be implemented primarily by the Department of Health.

Surveillance and Evaluation

This component develops systems to monitor attitudes, behaviors and health outcomes and demonstrate accountability for the funds and effectiveness of programs. Surveillance systems are used to assess the prevalence of tobacco use, exposure to secondhand smoke, track trends and identify disparities and measure progress in eliminating those disparities. It includes the evaluation of health communication efforts, cessation and community interventions and conducting surveys such as the Youth Tobacco Survey, Adult Tobacco Survey and the inclusion of tobacco questions in the Behavior Risk Factor Survey, the Youth Risk Behavior Survey and surveys regarding cessation and quitline services. The funding will support additional evaluation of programs and services and could provide for outside evaluation of the statewide quitline and other program activities. Current funding has limited the program primarily to process evaluation. With the new funding we will be able to conduct outcome evaluation and provide the program the capability to look at changes over time in diseases caused by tobacco use and secondhand smoke. This component will be jointly implemented. The Department of Health will be responsible for the surveillance and the Tobacco Advisory Committee will be responsible for the evaluation.

Administration and Management

This component provides support to employ qualified state staff for oversight, training and technical assistance to local programs. It includes coordinating statewide programs such as the quitline and collaboration with partners for public education efforts, strategic planning and provides for real time fiscal management, effective communication, education of decision makers on the health effects of tobacco and evidence-based effective programs and policy interventions. The state has used primarily CDC funding to develop a cadre of staff and contractors capable of carrying out these functions. The grants program would coordinate closely with the state program on training and technical assistance efforts. Minimal funding would be needed to support the staff to manage the grants program and evaluation. This component will be jointly implemented.

The specific programs and projects that will be funded in each component will be determined by the Advisory Committee based on the comprehensive Best Practice plan.

Accountability

The law requires that prior to April 1 of each year, that the advisory committee evaluate the effectiveness of the plan and propose any necessary changes to the executive committee. In addition, the law requires that at least once a biennium the executive committee will provide for an independent review of the comprehensive plan to assure the plan is consistent with the Centers for Disease Control and Prevention Best Practices for Comprehensive Tobacco Control Programs. A report of that review will be sent to the Governor and the State Health Officer before September 1 in each odd numbered year.

Like other state agencies, this state agency will be subject to the fiscal reporting requirements, audit procedures and other state requirements including state personnel laws, procurement laws, record management requirements, and open meeting and record laws.

Requested Amendments

Attachment D is the list of requested amendments to the bill. Some of the requested amendments are procedural to create consistency with the law, and the remaining amendments are necessary to actively engage the committee in carrying out the work of developing and implementing the plan according to the timelines in the law.

The substantive amendments are:

- Continuing appropriation – to carry out the work of the work of developing and implementing the plan.
- Retroactive spending authority – to reimburse the committee members for the work they are currently doing in developing the plan and preparing legislative information and to pay for expenses incurred in developing the plan (e.g. copies, consultants, etc).
- Emergency clause – to allow the committee to complete the plan in the required time frame.

Measurable Outcomes

The programs implemented with the Tobacco Prevention and Control Trust Funds will sharply reduce smoking and other tobacco use in the state. The number of people in the state who suffer and die prematurely because of smoking and other tobacco use will be reduced. Our work force and our children will be healthier. We will save money by reducing government, business, and household costs caused by smoking and other tobacco use.

A comprehensive statewide tobacco prevention and control program is a coordinated effort to establish smoke-free policy and social norms, to promote and assist tobacco users to quit and to prevent youth from starting tobacco use. Research indicates greater effectiveness with multi-component interventions that are integrated. The more the state invests, the greater the reduction in smoking—and the longer the state invests, the greater and faster the impact. For example, in California, home of the longest running comprehensive program, smoking rates among adults declined from 22.7 percent in 1998 to 13.3 percent in 2006. As a result, compared with the rest of the country, heart disease deaths and lung cancer incidence in California have declined at accelerated rates. Among women in California, the rate of lung cancer deaths decreased while it continued to increase in other parts of the country. Since 1998, lung cancer incidence in California has been declining four times faster than in the rest of the nation. The tobacco use epidemic can be stopped. We know these programs work.

In 2007, the Institute of Medicine of the National Academies of Sciences, the President's Cancer Panel, and the CDC each issued reports that concluded there is overwhelming evidence that comprehensive state tobacco prevention programs substantially reduce tobacco use and recommended that every state fund its program at the CDC-recommended level. Since these reports, even more evidence has accumulated on the power of state investments in tobacco prevention and cessation. For example, earlier studies found that for every dollar spent, state tobacco prevention programs can, in their early years, save $3.00 or more just in reduced state health care expenditures. New research has strengthened those findings, demonstrating that state programs secure even larger returns on investment if tobacco prevention programs are sustained for over ten or more years at adequate levels. In California's tobacco prevention program they found that for every dollar the state spent on its tobacco control program, the state saved $50 in total healthcare costs. This study confirms that the cost-saving benefits from

sustained state investments in effective tobacco control programs quickly grow over time to dwarf the state expenditures; producing massive gains for the state not only in terms of improved public health and increased worker productivity but in reduced government, business, and household costs. Because of this legislation, North Dakota is posed on the brink to realize similar results.

According to a report issued by the *Campaign for Tobacco Free Kids* in September 2008, fully funding North Dakota's tobacco prevention and cessation efforts at the CDC-recommended level will have a significant impact on the health and economy of the state. The report states that a fully funded tobacco prevention program would:

- ***Reduce youth smoking by 12.7%;***
- ***Stop 4,570 North Dakota kids from becoming addicted adult smokers;***
- ***Save 1,460 kids from dying from smoking;***
- ***Prompt more than 3,480 current adult smokers to quit for good; and***
- ***Save more than 920 North Dakota adults from dying prematurely from smoking.***

In terms of fiscal impact, the report states that fully funding the state tobacco prevention program with average results would strengthen the state's economy by increasing worker productivity and reducing future smoking-caused health care and smoking-caused other costs in the state by more than $113 million after five years. "Using conservative, research-based estimates, the smoking declines from a comprehensive Best Practice program will lock-in more than $113 million in future smoking-caused health expenditure reductions, including more than $11.9 in future cuts to state Medicaid program expenditures." The projections would grow even larger after the first five years of a fully-funded program.

Research shows that that on average in North Dakota, the impact of a fully-funded program would reduce adult smoking by 1,200 in the first year. These adult smoking reductions would continue to grow each year the program is in place. The 5-year heart-stroke savings would be $1.1 million and 5-year pregnancy savings would be $920,000. North Dakota's health care costs would be reduced by approximately $2.0 million in the first five years just from fewer smoking-caused heart attacks, strokes and fewer smoking-affected births.

We are fortunate to live in North Dakota where our economy is good. Investing in tobacco prevention and control as the people directed by enacting Measure 3 will create future health care savings that can be dedicated to other state efforts in the future when our economy may not be as strong.

Thank you. I would be happy to answer any questions you may have.

Attachment A – *Best Practices for Comprehensive Tobacco Control Programs – North Dakota*
Attachment B – North Dakota Tobacco Prevention and Control Funding by Best Practice Category
Attachment C – Tobacco Prevention and Control Trust Fund Estimated Revenues and Expenditures 2009-2011
Attachment D – Amendments

Best Practices for Comprehensive Tobacco Control Programs

North Dakota 2007

According to the Centers for Disease Control and Prevention (CDC), the recommended level of investment for tobacco prevention and control in North Dakota is **$9.3 million per year, or $14.67 per capita.**

Tobacco use is the single most preventable cause of death and disease in the United States.

- Half of all long-term smokers die prematurely from smoking-related causes.

In North Dakota, an estimated 900 adults are projected to die each year from smoking.

- For each person who dies, another 20 people are suffering with at least one serious tobacco-related illness.
- If current smoking rates among people younger than age 18 continue, an estimated 11,000 of these North Dakota youth are projected to die from smoking.

The economic impact of tobacco use is equally staggering.

- North Dakota spends approximately $247 million each year in smoking-attributable medical expenses, including an estimated $47 million on smoking-attributable Medicaid medical costs.
- North Dakota also loses an estimated $190 million each year in lost productivity from an experienced workforce that dies prematurely. Additional costs occur each year in medical treatment and lost productivity as a result of exposure to secondhand smoke.

The more states spend on comprehensive tobacco control programs, the greater the reductions in smoking—and the longer states invest in such programs, the greater and faster the impact.

- Evidence-based statewide tobacco control programs that are comprehensive, sustained, and accountable have been shown to reduce the number of tobacco-related deaths and disease.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion
Office on Smoking and Health

Best Practices

North Dakota 2007

for Comprehensive Tobacco Control Programs

In fiscal year 2006, North Dakota earned $23.3 million in revenue from the sale of tobacco products, and was eligible to receive $21.3 million from their legal settlement with the tobacco industry. Of the $44.7 million North Dakota receives in revenue from their tobacco excise taxes and settlement, 21% would fund North Dakota's tobacco prevention and control program at the level of investment recommended by the CDC.

According to the Centers for Disease Control and Prevention (CDC), the recommended level of investment for tobacco prevention and control in North Dakota is **$9.3 million per year**, or **$14.67 per capita.**

I. State and Community Interventions
CDC recommends that North Dakota invest $7.37 per capita annually in state and community interventions because multiple societal resources working together will have the greatest long-term population impact.

II. Health Communication Interventions
CDC recommends that North Dakota invest $1.86 per capita annually in health communications because media interventions work to prevent tobacco use initiation, promote cessation, and shape social norms.

III. Cessation Interventions
CDC recommends that North Dakota invest $3.52 per capita annually in tobacco cessation. Tobacco use treatment is an effective and highly cost-effective intervention.

IV. Surveillance and Evaluation
CDC recommends that North Dakota invest $1.28, or 10% of tobacco control program costs, per capita annually in state surveillance and program evaluation because publicly financed programs should be accountable and demonstrate effectiveness.

V. Administration and Management
CDC recommends that North Dakota invest $0.64, or 5% of tobacco control program costs, per capita annually in administration and management because complex, integrated programs require experienced staff to provide fiscal management, accountability, and coordination.

Reference: Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs—2007.* Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; October 2007.

Tobacco Prevention and Control Funding
By Best Practice Category
Estimated for 2009-2011

Attachment B

Best Practice Category	Recommended Funding Level	Recommended Funding Range	CDC Funding	Community Health Trust Funding	Tobacco Trust Funding
State and Community Interventions	$ 9,300,000	$8,400,000 - $13,600,000			
Health Communications Interventions	$ 2,418,000	$1,600,000 - $5,000,000			
Cessation Interventions	$ 4,464,000	$2,600,000 - $6,600,000			
Surveillance and Evaluation	$ 1,674,000	$1,200,000 - $2,600,000			
Administration and Management	$ 744,000	$600,000 - $1,200,000			
Total	$ 18,600,000	$14,400,000 - $29,000,000	$ 2,800,000	$ 3,388,000	$ 12,412,000

Tobacco Prevention and Control Trust Fund			
	2007-09 Appropriation	2007-09 Estimated Spending	2009-11 Budget Request
Beginning Balance	$0	$0	$0
Revenue: Transfers from the Tobacco Settlement Trust Fund, Strategic Contribution Funds	$0	$13,800,000	$27,600,000
Expenditures:	$0	$	$18, 600,000
State and local programs	$0	$0	$ 9,300,000
Health communications	$0	$0	$ 2,418,000
Cessation programs	$0	$0	$ 4,464,000
Data collection, program monitoring and evaluation	$0	$0	$ 1,674,000
Administration and management	$0	$0	$ 744,000

PROPOSED AMENDMENTS TO SENATE BILL 2063

Page 1, line 1, after "to" insert: "create and enact a new section to the North Dakota Century Code to"

Page 1, line 1, replace the second "an" with "a continuing"

Page 1, line 2, after "tobacco" insert "prevention and"

Page 1, line 2, replace "advisory" with "executive"

Page 1, line 2, after "committee" insert "; to allow for payment of committee expenses prior to July 1, 2009; to declare an effective date; and to declare an emergency"

Page 1, line 4, after "**1.**" Insert "**CONTINUING**"

Page 1, line 4, after "**APPROPRIATION.**" Replace the remainder of the bill with

"All money in the tobacco prevention and control fund and all funds received by the tobacco prevention and control executive committee from whatever source are appropriated on a continuing basis to the committee for the purpose of defraying the expenses of the committee in developing, implementing and administering the comprehensive plan.

SECTION 2. APPROPRIATION. PAYMENT OF COMMITTEE EXPENSES INCURRED PRIOR TO JULY 1, 2009. Any moneys received by the executive committee prior to July 1, 2009 through grants or from other sources, are hereby appropriated to the committee to defray the expenses of the committee, and the development, implementation and administration of the comprehensive tobacco control and prevention plan. The executive committee may authorize and pay for expenses incurred prior to the effective date of this appropriation and prior to the receipt of any moneys.

SECTION 3. EFFECTIVE DATE. This Act becomes effective immediately upon its filing with the secretary of state.

SECTION 4. EMERGENCY. This Act is declared to be an emergency measure."

Renumber accordingly

#2

Testimony
Senate Human Services Committee
Statement of Jodi L. Radke
January 20, 2009, 10:00 am
SB 2063

Good Morning Chairman Lee and members of the Senate Human Services Committee. Thank you for your time this morning to hear my testimony. My name is Jodi Radke. I am the Director of the Rocky Mountain/Great Plains Region for the Campaign for Tobacco Free Kids, which includes the state of North Dakota. Our agency, for those who may not be familiar, is based in Washington DC. I, however, am based in Colorado. Our agency has the luxury of working strictly and solely on the issue of tobacco control policy at the local, state, national and international level.

My testimony this morning reflects our agency's support for the Committee to appropriate $9.3 million annually to tobacco control programming in North Dakota, which is the recommendation by the CDC for the state of North Dakota.

What I would like to address in my testimony this morning are two things, **why** states should fund tobacco control programs at CDC levels and to outline what North Dakota can expect if a fully funded tobacco control program at the CDC level is implemented over time.

Why fully fund a program?

A fully funded program saves lives and saves money.

States should fully fund tobacco control programming at the CDC recommended funding levels because we know these programs are effective. They work. Evidence-based, statewide tobacco control programs that are comprehensive, sustained and accountable have been shown to reduce smoking rates, tobacco-related deaths, and diseases caused by smoking. The more a state invests, the **greater** the reduction in smoking, and, the **longer** the state invests, the greater and faster the impact.

In Florida, between 1998-2002, a comprehensive program reduced smoking rates among middle school students by 50% and among high school students by 35%. Other states, such as Maine, New York and Washington, have seen 45% to 60% reductions in youth smoking with sustained comprehensive statewide programs. Between 2000 and 2006, New York reported that the prevalence of adult and youth smoking declined faster than the US as a whole.

In California, home of the longest running comprehensive program, smoking rates among adults declined from 22.7 percent in 1998 to 13.3 percent in 2006. Compared with the rest of the country, heart disease deaths and lung cancer incidence in California have declined at accelerated rates. Among women in California, the rate of lung cancer

deaths decreased while it continued to increase in other parts of the country. Since 1998, lung cancer incidence in California has been declining four times faster than in the rest of the nation. The tobacco use epidemic can be stopped. We know these programs work.

Earlier studies have found that state tobacco prevention programs can, in their early years, save $3.00 or more just in reduced state health care expenditures for every dollar spent. New research has strengthened those findings, demonstrating that state programs secure even larger returns on investment if tobacco prevention programs are sustained for over ten or more years at adequate levels. In California's tobacco prevention program they found that for every dollar the state spent on its tobacco control program, the state saved $50 in total healthcare costs. This study confirms that the cost-saving benefits from sustained state investments in effective tobacco control programs quickly grow over time to dwarf the state expenditures; producing massive gains for the state not only in terms of improved public health and increased worker productivity but in reduced government, business, and household costs.

States should not linger any longer. The research is clear. And, if we as a nation fully funded and sustained a tobacco control program in each state, we would meet IOM's best-case scenario of reducing adult tobacco prevalence to 10% by 2025.

What can North Dakota expect?

We issued a report last September that analyzed what outcomes a fully funded tobacco control program in North Dakota could expect. A fully funded program at CDC recommended levels would accomplish the following:

- ***Reduce youth smoking by 12.7%;***
- ***Stop 4,570 North Dakota kids from becoming addicted adult smokers;***
- ***Save 1,460 kids from dying from smoking;***
- ***Prompt more than 3,480 current adult smokers to quit for good; and***
- ***Save more than 920 North Dakota adults from dying prematurely from smoking.***

"Using conservative, research-based estimates, the smoking declines from a comprehensive Best Practice program will lock-in more than $113 million in future smoking-caused health expenditure reductions, including more than $11.9 in future cuts to state Medicaid program expenditures. " The projections would grow even larger after the first five years of a fully-funded program.

Research shows that that on average, the impact of a fully-funded program would reduce adult smoking by 1,200 in the first year. These adult smoking reductions would continue

to grow each year the program is in place. The 5-year heart-stroke savings would be $1.1 million and 5-year pregnancy savings would be $920,000. North Dakota's health care costs would be reduced by approximately $2.0 million in the first five years just from fewer smoking-caused heart attacks, strokes and fewer smoking-affected births.

I'd like to close by saying...

"If Congress and the states show the political will to implement proven solutions, we will win one of the most significant public health victories in our nation's history. If our leadership fails to do so, it will be a tragic missed opportunity for the nation's health and for North Dakota." Thank you.

#3

Testimony in support of SB 2063: Appropriations for Measure 3
Comprehensive Tobacco Control Program.

By:
Carol M. Russell, MPH
897 Southport Loop
Bismarck, ND 58504
701-255-1028
January 20, 2009

My name is Carol Russell. I grew up in Minot and after I retired I moved to Bismarck. Before I retired, I was Chief of Program Services for the California's landmark Tobacco Control Program at the California Department of Public Health.

I am immensely proud that North Dakota has stepped up to the plate to take on tobacco control in a significant way. Your leadership is important to the health of the people you represent. It reflects the values and heritage that I associate with our fine state. You can also be proud of the many skilled and knowledgeable staff and volunteers who will make your program a success. You are extremely lucky for this.

Tobacco use is the leading cause of preventable deaths – a major cause of cancer, cardiovascular and respiratory diseases. The price for this is high -- deaths are the equivalent of 2 jumbo jets crashing every day with no survivors. The price is high for North Dakota too. The 2007 adult smoking rate in 2007 was almost 21%. And 2004 data for the state's American Indians was close to 50%. The adult prevalence rate in California is 13%. There's no reason North Dakota can't do the same.

I know how important the pocket book is to frugal North Dakotans. You should know that researchers at the University of California found an $86 billion dollar reduction in per capita personal health care costs between 1989 when the program began and 2004. That's B as in Billion -- a reduction associated with the program. Again, there's no reason North Dakota can't do the same favor for its people.

Thank you.

#4

Same given to Senate approps on 2-13-09

WRITTEN TESTIMONY OF
VICKI VOLDAL ROSENAU

HEARING ON
"SENATE BILL 2063"
A BILL for an Act to provide an appropriation for defraying the expenses of the comprehensive tobacco control advisory committee.

BEFORE THE
HUMAN SERVICES COMMITTEE
NORTH DAKOTA SENATE
JANUARY 20, 2009

Good morning, Chairman Lee and Members of the Senate Human Services Committee. I am Vicki Voldal Rosenau from Valley City, and I'm speaking on behalf of myself. Thank you for allowing me to share some information with you in regard to SB 2063.

While I do represent myself, it is relevant to note that for a number of years I have been a member of Tobacco-Free North Dakota (TFND), a statewide organization dedicated to reducing tobacco addiction in North Dakota, thus preventing the diseases, preventable deaths and tremendous economic burden that tobacco use causes in our state. As a result, I know that the members of TFND join me in supporting the speedy enactment of Senate Bill 2063 in a form that will quickly release all the funds the new tobacco control advisory committee needs to begin the work of building a truly comprehensive program as soon as possible -- so that North Dakota can begin to see the resultant declines in deadly tobacco-caused diseases and healthcare costs as soon as possible. We support prompt passage of an appropriation bill that will refrain from imposing Legislative micro-managing on this critical disease-prevention program, and that will instead entrust to our state's capable public-health professionals the full responsibility for making the detailed decisions needed to produce a statewide program that is faithful to the recommendations laid down in the U.S. Centers for Disease Control's "Best Practices for Comprehensives Tobacco Control Programs-2007."

North Dakota's public health community has made good progress in its ongoing battle against tobacco, but until now, the resources dedicated to tobacco control have not been adequate to support the kind of fully comprehensive approach that, in other states, has been proven to drive down heart disease and lung cancer incidence. At present, we have specific tobacco-control deficits or gaps that must be filled before this same life-saving capacity can be established in North Dakota. Some examples are:

- Need to fund an immediate increase in the availability of both community and worksite cessation classes; and nicotine patches, Zyban, Chantix and other

OVER →

cessation-support pharmaceuticals -- so that every North Dakotan needing these services can readily obtain them cost-free.

- Need update and greatly increase the statewide campaign (primarily media-based) to continuously promote enrollment in the ND Tobacco Quitline (for both cigarette and spit-tobacco users).
- Widespread funding shortages have prevented local public health units from being able to offer enough hours/adequate pay to hire and retain the qualified personnel needed to facilitate cessation classes and to implement local strategies achieve the social norm changes that will make tobacco progressively less desirable.
- Both inflation and recent cuts in funds allocated to community health units have eroded the quality and infrastructure of the fundamental community-based tobacco-control programs. Many veteran tobacco-prevention professionals are tackling unreasonable workloads and are experiencing serious burnout. Hence, there is an urgent need for new funds to expand staffing in some units, and to provide high-quality professional education/training updates to staff in all units.
- Resources are needed to initiate and sustain interventions based on emerging strategies to promote cessation and provide specialized support unique to high-risk populations such as: pregnant moms, 18-24 year olds, lower socio-economic community (including homeless citizens), blue collar workers, Native Americans, newly-arrived Americans, and LBGT communities.
- Need for a major investment in population-based tobacco-prevention messaging that is high-impact as well as strategically science-based and culturally appropriate. This is critical to establishing the strong, non-tobacco-use social norm upon which all the other tobacco-control components depend.
- Resources to mount an all-new, multi-component Smoke-Free-Movies intervention to help prevent youth initiation of tobacco use in North Dakota. (The viewing of movies that depict favorite actors smoking is the single most powerful influence causing teenagers to start smoking!)
- Resources to initiate a statewide campaign of tobacco-control messaging that utilizes popular high-tech strategies such as viral marketing, blogs, social networking internet sites and web pages.

I urge you to expeditiously appropriate full funding for North Dakota's new CDC-based, comprehensive tobacco control program, so that these and other deficiencies in the current, limited program can be remedied. Just as soon as the Legislature appropriates these funds (recently allocated by North Dakota voters), the serious work of saving lives and dollars by curbing tobacco addiction can move forward with more vigor and promise than ever before.

Thank you again for receiving this testimony.

Good morning, committee members. My name is Dr. Herbert J. Wilson and I'm here to testify on behalf of the American Lung Association of North Dakota. The mission of the Lung Association is the "prevention and control of lung disease." Approximately 90% of all lung disease is the result of tobacco use. We know that prevention is the key to our mission.

Last fall, the voters of North Dakota came together and supported efforts to fully fund and implement a comprehensive tobacco control program. The Centers for Disease Control (CDC) has compiled "Best Practices for Tobacco Control" along with recommendations for funding those efforts. Senate Bill 2063 provides the necessary appropriation to begin the work on preventing the number one cause of premature death in North Dakota – tobacco use. North Dakota serves as a model to the rest of the country in these efforts.

I urge you to vote yes, in supporting the immediate allocation of those dollars so together we can work to reduce the harm and destruction caused by tobacco use.

Thank you.

#6

Cancer Action Network™
American Cancer Society®

Testimony

Senate Bill 2063

Senate Human Services Committee

Tuesday, January 20, 2009

Deborah Knuth
Government Relations Director, North Dakota
American Cancer Society Cancer Action Network

Good morning, Chairperson Lee and members of the Senate Human Services Committee. My name is Deborah Knuth, and I am the government relations director for the American Cancer Society Cancer Action Network in North Dakota. I'm here today to offer the ACS CAN's support of SB 2063 being appropriated in order to fund CDC based statewide tobacco control programs.

You will hear this morning from experts testifying that they will develop a comprehensive statewide tobacco control program with coordinated efforts to establish smoke free policies and social norms in order to promote and assist tobacco users to quit, and to prevent initiation of tobacco use. This comprehensive approach should and will combine educational, clinical, regulatory, economic and social strategies.

In closing, CDC recommends that states establish and sustain tobacco control programs that contain the following overarching components:

- State and Community Interventions
- Health Communication Interventions
- Cessation Interventions
- Surveillance and Evaluation
- Administration and Management

North Dakota has been given the opportunity to invest in such programs giving us the chance to lead the nation in reducing smoking rates, tobacco related deaths, and diseases caused by smoking.

I have attached additional information regarding best practices for comprehensive tobacco control programs for your perusal.

Thank you for giving me this opportunity to speak before you today.

Deborah Knuth, Government Relations Director
ACS CAN Great West
North Dakota

Best Practices for Comprehensive Tobacco Control Programs—2007
Fact Sheet

- *Best Practices for Comprehensive Tobacco Control Programs—2007* describes an integrated programmatic structure for implementing interventions proven to be effective and provides the recommended level of annual investment to prevent tobacco use initiation among youth and young adults, promote cessation among adults and young people, eliminate exposure to secondhand smoke, and identify and eliminate tobacco-related disparities.

- *Best Practices—2007* refines the guidance provided by the Centers for Disease Control and Prevention (CDC) in 1999, reflecting:

    - additional state experiences in implementing comprehensive tobacco control programs;
    - new scientific literature on comprehensive programs and specific interventions;
    - an evaluation of how 10 states implemented and modified the original guidance; and
    - technical consultation provided by an expert panel.

- CDC recommends that states establish and sustain tobacco control programs that contain the following overarching components:

    - State and Community Interventions
    - Health Communication Interventions
    - Cessation Interventions
    - Surveillance and Evaluation
    - Administration and Management

- Across all states and the District of Columbia, the per capita recommended level of investment ranges from $9.23 to $18.02. The recommended level of investment is CDC's best approximation of what it would cost, based on each state's specific characteristics, to implement with sufficient intensity the evidence-based components of a comprehensive tobacco control program.

- Evidence-based, statewide tobacco control programs that are comprehensive, sustained, and accountable have been shown to reduce smoking rates, tobacco related deaths, and diseases caused by smoking.

- Further, research shows that the more states spend on comprehensive tobacco control programs, the greater the reductions in smoking—and the longer states invest in such programs, the greater and faster the impact.

- The tobacco use epidemic can be stopped. If states sustained their recommended level of investment for 5 years, there would be an estimated 5 million fewer smokers. As a result, hundreds of thousands of premature tobacco related deaths would be prevented. Longer-term investments would have even greater effects.

Executive Summary

Tobacco* use is the single most preventable cause of death and disease in the United States. People begin using tobacco in early adolescence; almost all first use occurs before age 18. An estimated 45 million American adults currently smoke cigarettes. Annually, cigarette smoking causes approximately 438,000 deaths. For every person who dies from tobacco use, another 20 suffer with at least one serious tobacco-related illness. Half of all long-term smokers die prematurely from smoking-related causes. In 2004, this addiction costs the nation more than $96 billion per year in direct medical expenses as well as more than $97 billion annually in lost productivity. Furthermore, exposure to secondhand smoke causes premature death and disease in nonsmokers. In 2005, the Society of Actuaries estimated that the effects of exposure to secondhand smoke cost the United States $10 billion per year.

Nearly 50 years have elapsed since the first Surgeon General's Advisory Committee concluded: "Cigarette smoking is a health hazard of sufficient importance in the United States to warrant appropriate remedial action." There now is a robust evidence base about effective interventions. Yet, despite this progress, the United States has not yet achieved the goal of making tobacco use a rare behavior. A 2007 Institute of Medicine (IOM) report presented a blueprint for action to "reduce smoking so substantially that it is no longer a public health problem for our nation." The two-pronged strategy for achieving this goal includes not only strengthening and fully implementing currently proven tobacco control measures, but also changing the regulatory landscape to permit policy innovations. Foremost among the IOM recommendations is that each state should fund a comprehensive tobacco control program at the level recommended by the Centers for Disease Control and Prevention (CDC).

We know how to end the epidemic. Evidence-based, statewide tobacco control programs that are comprehensive, sustained, and accountable have been shown to reduce smoking rates, tobacco-related deaths, and diseases caused by smoking. Recommendations that define a comprehensive statewide tobacco control intervention have been provided in the Surgeon General's reports *Reducing Tobacco Use* (2000) and *The Health Consequences of Involuntary Exposure to Tobacco Smoke* (2006), the Task Force for Community Preventive Services' *Guide to Community Preventive Services* (2005), IOM's *Ending the Tobacco Problem: A Blueprint for the Nation* (2007), the Public Health Service's Clinical Practice Guideline *Treating Tobacco Use and Dependence* (2000), and the National Institutes of Health's State-of-the-Science Conference Statement *Tobacco Use: Prevention, Cessation, and Control* (2006) and President's Cancer Panel Annual Report *Promoting Health Lifestyles: Policy, Program and Personal Recommendations for Reducing Cancer Risk* (2007).

A comprehensive statewide tobacco control program is a coordinated effort to establish smoke-free policies and social norms, to promote and assist tobacco users to quit, and to prevent initiation of tobacco use. This comprehensive approach combines educational, clinical, regulatory, economic, and social strategies. Research has documented the effectiveness of laws and policies in a comprehensive tobacco control effort to protect the public from secondhand smoke exposure, promote cessation, and prevent initiation, including increasing the unit price of tobacco products and implementing smoking bans through policies, regulations, and laws; providing insurance coverage of tobacco use treatment; and limiting minors' access to tobacco products. Additionally, research has shown greater effectiveness with multi-component intervention efforts that integrate the implementation of programmatic and policy interventions to influence social norms, systems, and networks.

* In this document, the term "tobacco" refers to the use of manufactured, commercial tobacco products including, but not limited to, cigarettes, smokeless tobacco, and cigars.

Executive Summary

This document updates *Best Practices for Comprehensive Tobacco Control Programs—August 1999.* This updated edition describes an integrated programmatic structure for implementing interventions proven to be effective and provides the recommended level of state investment to reach these goals and reduce tobacco use in each state. It is important to recognize that these individual components must work together to produce the synergistic effects of a comprehensive tobacco control program. Based on the evidence of effectiveness documented in scientific literature, the most effective population-based approaches have been defined within the following overarching components:

I. State and Community Interventions
State and community interventions include supporting and implementing programs and policies to influence societal organizations, systems, and networks that encourage and support individuals to make behavior choices consistent with tobacco-free norms. The social norm change model presumes that durable change occurs through shifts in the social environment, initially or ultimately, at the grassroots level across local communities. State and community interventions unite a range of integrated programmatic activities, including local and statewide policies and programs, chronic disease and tobacco-related disparity elimination initiatives, and interventions specifically aimed at influencing youth.

II. Health Communication Interventions
An effective state health communication intervention should deliver strategic, culturally appropriate, and high-impact messages in sustained and adequately funded campaigns integrated into the overall state tobacco program effort. Traditional health communication interventions and counter-marketing strategies employ a wide range of efforts, including paid television, radio, billboard, print, and web-based advertising at the state and local levels; media advocacy through public relations efforts, such as press releases, local events, media literacy, and health promotion activities; and efforts to reduce or replace tobacco industry sponsorship and promotions. Innovations in health communication interventions include more focused targeting of specific audiences as well as fostering message development and distribution by the target audience through appropriate channels.

III. Cessation Interventions
Interventions to increase cessation encompass a broad array of policy, system, and population-based measures. System-based initiatives should ensure that all patients seen in the health care system are screened for tobacco use, receive brief interventions to help them quit, and are offered more intensive counseling services and FDA-approved cessation medications. Cessation quitlines are effective and have the potential to reach large numbers of tobacco users. Quitlines also serve as a resource for busy health care providers, who provide the brief intervention and discuss medication options and then link tobacco users to quitline cessation services for more intensive counseling. Optimally, quitline counseling should be made available to all tobacco users willing to access the service.

IV. Surveillance and Evaluation

State surveillance is the process of monitoring tobacco-related attitudes, behaviors, and health outcomes at regular intervals. Statewide surveillance should monitor the achievement of overall program goals. Program evaluation is used to assess the implementation and outcomes of a program, increase efficiency and impact over time, and demonstrate accountability. A comprehensive state tobacco control plan—with well-defined goals, objectives, and short-term, intermediate, and long-term indicators—requires appropriate surveillance and evaluation data systems. Collecting baseline data related to each objective and performance indicator is critical to ensuring that program-related effects can be clearly measured. For this reason, surveillance and evaluation systems must have first priority in the planning process.

V. Administration and Management

Effective tobacco prevention and control programs require substantial funding to implement, thus making critical the need for sound fiscal management. Internal capacity within a state health department is essential for program sustainability, efficacy, and efficiency. Sufficient capacity enables programs to plan their strategic efforts, provide strong leadership, and foster collaboration between the state and local tobacco control communities. An adequate number of skilled staff is also necessary to provide or facilitate program oversight, technical assistance, and training.

The primary objective of the recommended statewide comprehensive tobacco control program is to reduce the personal and societal burden of tobacco-related deaths and illnesses. Research shows that the more states spend on comprehensive tobacco control programs, the greater the reductions in smoking—and the longer states invest in such programs, the greater and faster the impact. States that invest more fully in comprehensive tobacco control programs have seen cigarette sales drop more than twice as much as in the United States as a whole, and smoking prevalence among adults and youth has declined faster as spending for tobacco control programs has increased.

In California, home of the longest-running comprehensive tobacco control program, adult smoking rates declined from 22.7% in 1988 to 13.3% in 2006. As a result, compared with the rest of the country, heart disease deaths and lung cancer incidence in California have declined at accelerated rates. Due to the program-related reductions in smoking, lung cancer incidence has been declining four times faster in that state than in the rest of the nation. Among women in California, the rate of lung cancer deaths decreased while it increased in other parts of the country. Because of this accelerated decline, California has the potential to be the first state in which lung cancer is no longer the leading cancer cause of death.

Implementing a comprehensive tobacco control program structure at the CDC-recommended levels of investment would have a substantial impact. For example, if each state sustained its recommended level of funding for 5 years, an estimated 5 million fewer people in this country would smoke. As a result, hundreds of thousands of premature tobacco-related deaths would be prevented. Longer-term investments would have even greater effects.

The tobacco use epidemic can be stopped. We know what works, and if we were to fully implement the proven strategies, we could prevent the staggering toll that tobacco takes on our families and in our communities. We could accelerate the declines in cardiovascular mortality, reduce chronic obstructive pulmonary disease, and once again make lung cancer a rare disease. If we as a nation fully protected our children from secondhand smoke, more than one million asthma attacks and lung and ear infections in children could be prevented. With sustained implementation of state tobacco control programs and policies (e.g., increases in the unit price of tobacco products), IOM's best-case scenario of reducing adult tobacco prevalence to 10% by 2025 would be attainable.

Prepared by the North Dakota [redacted]ive Council
staff for Senator J. Lee
July 2008

#7

SURVEY OF AGENCY ALCOHOL, DRUG, TOBACCO, AND RISK-ASSOCIATED BEHAVIOR PREVENTION PROGRAMS

During the 2001-02 interim, the Budget Committee on Government Services studied programs dealing with prevention and treatment of alcohol, tobacco, and drug abuse and other kinds of risk-associated behavior which are operated by various state agencies. The committee studied whether better coordination among the programs within those agencies may lead to more effective and cost-efficient ways of operating the programs and providing services. At that time, a survey of agency alcohol, drug, tobacco, and risk-associated behavior programs was conducted and the results were placed in a table. That information was updated during the 2003-04 interim by the Budget Committee on Government Services as part of that committee's study of the state's long-term prison needs and the needs of individuals with mental illness, drug and alcohol addictions, and physical or developmental disabilities.

On November 14, 2005, a letter was sent to the relevant agencies requesting an update of the table for the Advisory Commission on Intergovernmental Relations.

In April 2008, the same agencies were requested to update the information for this table.

Alcohol, Drug, Tobacco, and Other Risk-Associated Behavior Programs	2007-09 Biennium Amount and Funding Source for Each Program			Detail of Sources of Federal and Special Funds	Restrictions on Uses of Funds	Anticipated Uses of Funds
	General Fund	Federal and Special Funds	Total Funds			
State Department of Health						
Community health grant program		$3,760,000	$3,760,000	Tobacco master settlement funds through the community health trust fund with 8% toward tobacco	Funds go to local public health units for preventive health services in schools and communities with an emphasis on tobacco control.	Funds for tobacco prevention and control in schools and communities
Statewide tobacco cessation for primary prevention, including city/county/state programs and the quitline		1,069,000	1,069,000	Tobacco master settlement funds	Funds support a statewide toll-free telephone counseling and referral quitline and cessation in the community.	100% of funds will support the statewide tobacco cessation statewide.
Tobacco prevention and control for disease control and prevention		2,540,260	2,540,260	Centers for Disease Control and Prevention (CDC)	Restricted to tobacco control, cannot be used for direct services or cessation services	100% for tobacco control
Abstinence education grant program		178,160	178,160	Health Resources and Services Administration - Section 510 abstinence education grant program	Funds go to community organizations, schools, and other entities to provide abstinence - Only educational activities and events.	70% of funds are used for abstinence education at the community level and 30% is used for administrative functions.
Rape prevention and education		183,000	183,000	CDC	The grant is restricted to sexual violence prevention and/or surveillance.	The funds are used for developing programs to address primary prevention of sexual violence at the local level.
EMPOWER (Enhancing and Making Programs and Outcomes Work to End Rape)		100,000	100,000	CDC	Increase the comprehensive primary prevention program planning and evaluation capacity of the State Department of Health and the North Dakota Council on Abused Women's Services	Collaborate with other partners on a statewide basis to enhance and train local domestic violence/rape crisis agencies to provide primary prevention to violence.
State/tribal suicide prevention grant		800,000	800,000	Substance Abuse and Mental Health Services Administration	Funds are used for prevention and early intervention of suicide among youth aged 10 to 24.	Data collection on completed and attempted suicides of North Dakota youths and develop local suicide prevention and awareness programs
Title X family planning and Title V supplement		437,712	437,712	CDC	Funds to be used for the provision of family planning, medical, laboratory, and counseling services	100% for the provision of clinical, laboratory, contraceptive supplies, and counseling family planning services to men and women. The total identified represents the funding for risky behavior which is 15% of funds received.
Child passenger safety		534,388	534,388	Department of Transportation and Title V (maternal and child health block grant)	Funds to be used for child passenger safety projects for school-age populations	Used to purchase car seats, training, and projects designed to increase child restraint and seatbelt use by young children

Alcohol, Drug, Tobacco, and Other Risk-Associated Behavior Programs	2007-09 Biennium Amount and Funding Source for Each Program			Detail of Sources of Federal and Special Funds	Restrictions on Uses of Funds	Anticipated Uses of Funds
	General Fund	Federal and Special Funds	Total Funds			
Comprehensive sexually transmitted disease prevention systems (CSPS) and HIV (AIDS) prevention programs		1,730,221	1,730,221	CDC	Limited to prevention of syphilis, gonorrhea, chlamydia, and AIDS prevention services	Funding is used for grant administration for sexually transmitted disease counseling and intervention. It is also used to support chlamydia and AIDS testing in high-risk individuals. Approximately 3% to 5% of total funds are directed to risky behavior, recognition/reduction. Funding is generally used for disease intervention.
Total - State Department of Health		$11,332,741	$11,332,741			

Alcohol, Drug, Tobacco, and Other Risk-Associated Behavior Programs	2007-09 Biennium Amount and Funding Source for Each Program			Detail of Sources of Federal and Special Funds	Restrictions on Uses of Funds	Anticipated Uses of Funds
	General Fund	Federal and Special Funds	Total Funds			
Attorney General						
Residential substance abuse treatment for state prisoners grant program - A passthrough grant for addiction treatment of state prisoners		$86,351	$86,351	Residential substance abuse treatment for state prisoners grant program - Corrections Program Office, United States Department of Justice	Residential substance abuse treatment grant funds are awarded to states to assist them in implementing and enhancing residential treatment activities for offenders operated by state and local correctional agencies.	Funds are available to the Department of Corrections and Rehabilitation and local agencies that meet the requirements. Funds are used for the treatment unit located at the State Penitentiary. Funds are used exclusively for program operations.
Narcotics section - Includes enforcement activities for all Bureau of Criminal Investigation agents who investigate drug crimes, dealers, and manufacturers	$2,200,000		2,200,000			95% of the funds are used for operations. 5% of the funds are used for equipment.
Domestic cannabis eradication/suppression program - A federal grant used for marijuana enforcement and elimination		10,000	10,000	Domestic cannabis eradication/suppression program - Drug Enforcement Administration, United States Department of Justice	Funds must be used for law enforcement efforts in eradicating and investigating marijuana trafficking in the state.	Funds are used for purchasing equipment and supplies used in marijuana investigation and eradication efforts.
Midwest high-intensity drug trafficking area - Federal cooperative agreement aimed at the growing methamphetamine problem in this region		1,051,184	1,051,184	Midwest high-intensity drug trafficking area - Office of National Drug Control Policy Office of the President	Funds must be used to measurably reduce and disrupt the importation, distribution, and clandestine manufacturing of methamphetamine in the six-state region--Iowa, Kansas, Missouri, Nebraska, North Dakota, and South Dakota.	Funds are used for personnel, operating expenses, and confidential funds in methamphetamine investigation and eradication efforts.
Justice assistance grant (formerly known as the Edward Byrne Memorial law enforcement assistance grant program)		1,073,347	1,073,347	Justice assistance grant program - United States Department of Justice	A certain percentage of the funds must be passed through to local jurisdictions. There are six legislative purpose areas for which the funds can be used.	Administrative funds (approximately 10%) are used to manage grant contracts to ensure compliance with federal regulations. Grant funds (approximately 90%) are awarded to local units of government, state agencies, and Indian tribes for criminal justice purposes.
Community Oriented Policing Services (COPS) methamphetamine initiative		631,328	631,328	COPS office, United States Department of Justice	Funds may be used to establish and enhance the methamphetamine reduction effort and increase coordination efforts and information sharing.	Funds are used for the postseizure analysis team efforts to share intelligence on local, state, and federal levels.
Total - Attorney General	$2,200,000	$2,852,210	$5,052,210			

Alcohol, Drug, Tobacco, and Other Risk-Associated Behavior Programs	2007-09 Biennium Amount and Funding Source for Each Program			Detail of Sources of Federal and Special Funds	Restrictions on Uses of Funds	Anticipated Uses of Funds
	General Fund	Federal and Special Funds	Total Funds			
Department of Corrections and Rehabilitation						
Bismarck Transition Center - A community-based transition center located in Bismarck. The program provides employment, treatment, and other transitional programming for offenders to achieve meaningful stability and lasting sobriety before release from prison.	$4,162,021		$4,162,021			Contract for transitional services and staff to manage the program.
Tompkins Rehabilitation and Corrections Center (TRCC) - The TRCC is a drug and alcohol intensive treatment program located on the campus of the State Hospital. The program requires a minimum of 100 days of treatment followed by community supervision.	4,522,026		4,522,026			Purchase services from the State Hospital
Female inmate transition and community placement - This program provides a continuum of treatment and program services for females to transition from prison to the community.	2,697,390		2,697,390			Contract for transitional services
Jail-based treatment - The department contracts with the North Central Correctional and Rehabilitation Center located in Rugby for drug and alcohol treatment for male inmates.	1,631,044		1,631,044			Contract for treatment services
Male inmate transition - This program provides transitional services to male inmates located in Fargo.	1,233,690		1,233,690			Contract for transitional services
Alternatives to incarceration - Programs providing alternatives to incarceration, including halfway houses, treatment, detention, and other correctional programming	2,659,646	$1,316	2,660,962	Federal funds - Edward Byrne Memorial law enforcement assistance grant	Edward Byrne Memorial law enforcement assistance funds are restricted to offender housing and offender treatment.	Contract for services
Drug court - The drug court programs are court-supervised programs that target nonviolent participants whose major problems stem from substance abuse.	192,000		192,000			Contract for treatment services
Faith-based programming	500,000		500,000			Contract for housing
Institutional treatment - Adult - Conduct assessments and provide treatment for inmates with addiction and mental health issues.	5,003,386		5,003,386			Salaries - Approximately $4.6 million Operating expenses - Approximately $400,000

Alcohol, Drug, Tobacco, and Other Risk-Associated Behavior Programs	2007-09 Biennium Amount and Funding Source for Each Program			Detail of Sources of Federal and Special Funds	Restrictions on Uses of Funds	Anticipated Uses of Funds
	General Fund	Federal and Special Funds	Total Funds			
Institutional treatment - Juvenile - Conduct assessments and provide treatment for inmates with addiction and mental health issues.	1,133,616	457,778	1,591,394			Salaries - Approximately $1.4 million Operating expenses - Approximately $200,000
Community services - Juvenile - The majority of this funding is provided to political subdivisions for juvenile programs and is not required to be used for drug or alcohol programs.	1,297,708	2,760,322	4,058,030	Federal funds OJJDP - $1.2 million Title IVE/XIX reimbursements - $700,000 Title V - $200,000 JAIBG - $660,000	Majority of funding must be passed through to local units of government.	Grants and contracts
Total - Department of Corrections and Rehabilitation	$25,032,527	$3,219,416	$28,251,943			

Alcohol, Drug, Tobacco, and Other Risk-Associated Behavior Programs	2007-09 Biennium Amount and Funding Source for Each Program			Detail of Sources of Federal and Special Funds	Restrictions on Uses of Funds	Anticipated Uses of Funds
	General Fund	Federal and Special Funds	Total Funds			
Department of Human Services						
Treatment services provided at the human service centers	$7,616,022	$13,351,114	$20,967,136	Substance abuse prevention and treatment (SAPT) block grant - $7,011,567	The state shall not expend grant funds on the following: To provide inpatient hospital services To make cash payments to intended recipients of services To purchase or improve land; purchase, construct, or permanently improve any building or other facility; or purchase major medical equipment To satisfy any requirement for the expenditure of nonfederal funds To provide financial assistance to any entity other than a public or nonprofit private entity To provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs	To provide treatment of substance abuse, including alcohol and other drugs Preference for admission into treatment services is in the following order: Pregnant injecting drug users Pregnant substance users Injecting drug users All other substance abusers
				Medical assistance - $4,094,774	None	
				Social services block grant - $1,453,559	None	
				Collections - $791,214	None	
Treatment services provided at the State Hospital	2,768,450	5,575,549	8,343,999	Medical assistance - $74,477	None	To provide inpatient treatment of substance abuse, including alcohol and other drugs Program operations - $8,343,999/100%
				Insurance collections and payments from the Department of Corrections and Rehabilitation - $5,501,072	Payments from Department of Corrections and Rehabilitation need to be spent toward the population placed by the Department of Corrections and Rehabilitation.	
Prevention related to substance abuse		2,234,811	2,234,811	SAPT block grant - $2,234,811	Funds are limited to primary prevention activities only. See additional restrictions for the SAPT grant on the first page for the Department of Human Services.	To develop and implement a comprehensive prevention program which includes a broad array of prevention strategies directed at individuals not identified to be in need of treatment.

Alcohol, Drug, Tobacco, and Other Risk-Associated Behavior Programs	2007-09 Biennium Amount and Funding Source for Each Program			Detail of Sources of Federal and Special Funds	Restrictions on Uses of Funds	Anticipated Uses of Funds
	General Fund	Federal and Special Funds	Total Funds			
						Implementation shall use a variety of strategies, including: Regional prevention coordination College-focused strategies Program operations - $551,047/25% Grants/contracts - $1,683,764/75%
Methamphetamine and other substance abuse residential treatment services	1,357,000		1,357,000			To provide residential treatment for methamphetamine and other substance users Grants/contracts - $1,357,000/100%
Program and policy related to substance abuse	283,032	745,048	1,028,080	SAPT block grant - $716,248 Other funds remaining from Oxford House loan fund - $28,800	See additional restrictions for the SAPT grant on the first page for the Department of Human Services.	To provide technical assistance, training, and outcome management policy to treatment and prevention fields Program operations - $1,028,080/100% Grants/contracts - $0/0%
Data information systems		250,000	250,000	DASIS - $250,000	Must be used to develop and implement substance abuse data management	Contract for outcome evaluation and client followup Grants/contracts - $250,000/100%
Governor's fund for safe and drug-free schools and communities - Funding is provided as grants to high-risk areas for enforcement and education		857,174	857,174	Safe and drug-free schools and communities grant - $857,174	At least 10% of this amount shall be used for law enforcement education partnerships. No more than 5% of this amount can be used for administrative costs.	To provide drug and violence prevention programs and activities through grants to parent groups, community action/job training agencies, community-based organizations, and other entities Priority shall be given to programs and activities for: Children and youth not normally served by state or local educational agencies Populations that need special or additional resources Grants/contracts - $857,174/100%
Department of Justice underage drinking grant - Funding is used for underage drinking prevention programs.		700,000	700,000	Enforcing underage drinking laws grant. This program is funded by the Department of Justice - $700,000.	Cannot be used to supplant state or local funds Funding can be suspended if: Failure to adhere to requirements or conditions placed on the grant Failure to submit reports timely Filing a false certification Other good cause shown	To support and enhance state efforts, in cooperation with local jurisdictions, to enforce laws prohibiting the sale of alcoholic beverages to or the consumption of alcoholic beverages by minors Activities may include: Statewide task forces and local law enforcement and prosecutorial agencies Public advertising programs to educate establishments about statutory prohibitions and sanctions Innovative programs to prevent and combat underage drinking Operating expenses - $7,680/1.1% Grants/contracts - $692,320/98.9%
Total - Department of Human Services	$12,024,504	$23,713,696	$35,738,200			

Alcohol, Drug, Tobacco, and Other Risk-Associated Behavior Programs	2007-09 Biennium Amount and Funding Source for Each Program			Detail of Sources of Federal and Special Funds	Restrictions on Uses of Funds	Anticipated Uses of Funds
	General Fund	Federal and Special Funds	Total Funds			
Department of Transportation						
Occupant protection program				National Highway Traffic Safety Administration (NHTSA) - Section 402 funds	Funds are restricted for occupant protection programs. Funds may not be used to supplement state or local funds.	
Child passenger safety program (funds provided to the State Department of Health's injury prevention program)		$290,000[1]	$290,000[1]			Purchase of car seats, training, and projects to increase child restraint and seatbelt use by children
Occupant protection enforcement programs		300,000	300,000			Conduct overtime enforcement of seatbelt use
Media/public information and education		600,000	600,000			Paid media and coordination of earned media for occupant protection. Includes electronic (TV, radio) and print (billboard, indoor ads, etc.) media, editorials, public service announcements, appearances on news shows, etc., to promote various enforcement and social norming messages.
Alcohol program				NHTSA - Section 410 incentive funds. These are funds provided to states based on the state's ability to meet stringent criteria related to impaired driving/alcohol laws, program operations, or data elements.	Funds are restricted for alcohol countermeasures. Funds may not be used to support state or local funds.	
Parents listen, educate and discuss (LEAD)		250,000	250,000	Section 410		Parents LEAD uses a peer approach to educating parents to talk about alcohol with their children. A spokesperson who lost her son to binge drinking shares her story. The parents LEAD website provides additional resources.
Prevention programs on university/college campuses		40,000	40,000	Section 410		
Alcohol/impaired driving enforcement programs		600,000	600,000	Section 410		Conduct saturation patrols, sobriety checkpoints, alcohol sales compliance checkers, and server training
Media/public information and education		750,000	750,000	Section 410		Paid media and coordination of earned media for impaired driving prevention. Includes electronic (TV, radio) and print (billboard, indoor ads, etc.) media, editorials, public service announcements, appearances on news shows, etc., to promote various enforcement and social norming messages.
Alcohol forum		40,000	40,000	Section 402		A forum for professionals to discuss issues related to alcohol and impaired driving prevention
Safe Communities		1,000,000	1,000,000	Section 402		Safe Communities are grassroots coalitions that address data-driven community injury issues (primarily seatbelt use and impaired driving) through various public information and education programs.
Total - Department of Transportation		$3,580,000	$3,580,000			

[1]Not included in totals.

Alcohol, Drug, Tobacco, and Other Risk-Associated Behavior Programs	2007-09 Biennium Amount and Funding Source for Each Program[1]			Detail of Sources of Federal and Special Funds	Restrictions on Uses of Funds	Anticipated Uses of Funds
	General Fund	Federal and Special Funds	Total Funds			
Department of Public Instruction						
Title IV safe and drug-free schools and communities program - Funding for reducing alcohol, drug, and tobacco use through education and prevention activities		$2,690,456	$2,690,456	Department of Education	For prevention activities and early intervention - Not to be used for treatment or entertainment	Local education agencies' grants (93%) Technical assistance to local education agencies (4%) Administration (3%)
21st century community learning centers provide funds for out-of-school programs, including academics, enhanced academic programming, arts, and recreation		9,615,430	9,615,430	Department of Education	Must serve students attending school with 40% or greater free and reduced lunches, must have a community-based partner, and must occur when school is not in session	95% to local education agencies and community-based organizations 3% for technical assistance 2% for administration
Total - Department of Public Instruction		$12,305,886	$12,305,886			

[2]Estimated.

Alcohol, Drug, Tobacco, and Other Risk-Associated Behavior Programs	2007-09 Biennium Amount and Funding Source for Each Program			Detail of Sources of Federal and Special Funds	Restrictions on Uses of Funds	Anticipated Uses of Funds
	General Fund	Federal and Special Funds	Total Funds			
Judicial branch						
Juvenile drug court	$474,918	$200,000	$674,918	Enforcement of underage drinking laws grant (passthrough from Department of Human Services)	Support innovative programs to prevent underage drinking	90% of the funds are used for alcohol and drug testing and analysis and monitoring; 10% of the funds are used for education and training.
Total - Judicial branch	$474,918	$200,000	$674,918			

Alcohol, Drug, Tobacco, and Other Risk-Associated Behavior Programs	2007-09 Biennium Amount and Funding Source for Each Program			Detail of Sources of Federal and Special Funds	Restrictions on Uses of Funds	Anticipated Uses of Funds
	General Fund	Federal and Special Funds	Total Funds			
National Guard						
State military counterdrug operations - Supports law enforcement agencies in interdiction efforts with intelligence analysis and aviation reconnaissance, along with supporting state and local coalitions and school education and prevention programs		$450,000	$450,000	Department of Defense through the National Guard Bureau		
Total - National Guard		$450,000	$450,000			

Alcohol, Drug, Tobacco, and Other Risk-Associated Behavior Programs	2007-09 Biennium Amount and Funding Source for Each Program			Detail of Sources of Federal and Special Funds	Restrictions on Uses of Funds	Anticipated Uses of Funds
	General Fund	Federal and Special Funds	Total Funds			
North Dakota Higher Education Consortium for Substance Abuse Prevention						
Coordinates and supports the prevention efforts and programs of each North Dakota University System campus	$199,228		$199,228			To develop and implement a statewide environmental management model in higher education to provide campuses with skills, attitudes, abilities, and knowledge that will enable them to address collegiate alcohol and substance abuse
Total - North Dakota Higher Education Consortium for Substance Abuse Prevention	$199,228		$199,228			

Agency Summary Report	2005-07 Biennium Amount and Funding Source for Each Agency			2007-09 Biennium Amount and Funding Source for Each Agency		
	General Fund	Federal and Special Funds	Total Funds	General Fund	Federal or Special Funds	Total Funds
State Department of Health	$0	$12,217,228	$12,217,228	$0	$11,332,741	$11,332,741
Attorney General's office	2,050,412	3,347,344	5,397,756	2,200,000	2,852,210	5,052,210
Department of Corrections and Rehabilitation	16,952,066	3,910,833	20,862,899	25,032,527	3,219,416	28,251,943
Department of Human Services	10,513,997	20,471,943	30,985,940	12,024,504	23,713,696	35,738,200
Department of Transportation	0	1,170,000	1,170,000	0	3,580,000	3,580,000
Department of Public Instruction	0	11,372,019	11,372,019	0	12,305,886	12,305,886
Judicial branch	224,849	238,411	461,260	474,918	200,000	674,918
National Guard	0	350,000	350,000	0	450,000	450,000
North Dakota Higher Education Consortium for Substance Abuse Prevention	150,000	147,000	297,000	199,228	0	199,228
Total - All agencies	$29,891,324	$53,222,778	$83,114,102	$39,931,177	$57,653,949	$97,585,126

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Leann Tschider
Director of Membership
Office Manager

Annette Weigel
ministrative Assistant

Senate given to House Approps 3-10-09

Senate given to Senate Approps 2-13-09

Testimony in Support of SB 2063
Senate Human Services Committee
January 20, 2009

Madam Chairman Lee and members of the Committee. I'm Bruce Levi and I serve as the Executive Director of the North Dakota Medical Association. The North Dakota Medical Association is the professional membership organization for North Dakota physicians, residents and medical students.

The North Dakota Medical Association endorsed the Initiated Measure to develop and implement a comprehensive statewide tobacco prevention and control plan. NDMA is the professional membership organization for North Dakota physicians, residents and medical students. A physician, Dale Klein, MD, of Mandan was appointed by Governor John Hoeven to serve on the comprehensive tobacco control advisory committee established by the initiated measure. NDMA supports SB 2063 as the vehicle for implementing a comprehensive tobacco prevention and control as envisioned.

Tobacco use is the single most preventable cause of death and disease in the United States. Physicians in North Dakota are in the unique position of seeing the tragic effects of smoking and second-hand smoke in their patients on a daily basis, including cases of heart disease, lung cancer, emphysema, bronchitis, pneumonia, sinusitis, and ear infections in both adults and children.

Nearly 50 years have elapsed since the first Surgeon General's Advisory Committee concluded: "Cigarette smoking is a health hazard of sufficient importance in the United States to warrant appropriate remedial action." There now is a robust evidence base about effective interventions. In 2000, North Dakota's physicians through NDMA adopted policy supporting the development in our state of a science-based, comprehensive tobacco prevention and dependence treatment program.

A 2007 Institute of Medicine (IOM) report presented a blueprint for action to

"reduce smoking so substantially that it is no longer a public health problem for our nation." The two-pronged strategy for achieving this goal includes not only strengthening and fully implementing currently proven tobacco control measures, but also changing the regulatory landscape to permit policy innovations. Foremost among the IOM recommendations is that each state should fund a comprehensive tobacco control program at the level recommended by the Centers for Disease Control and Prevention (CDC).

We know how to end the epidemic. Evidence based, statewide tobacco control programs that are comprehensive, sustained, and accountable have been shown to reduce smoking rates, tobacco-related deaths, and diseases caused by smoking.

In addition, reducing the burden of preventable disease is a broad strategy recognized by the American Medical Association and other physician groups for addressing rising health care costs. It has been shown that tobacco control programs not only reduce smoking and prevent disease, but also quickly and substantially reduce health care costs.

Thank you. We urge a "Do Pass" on SB 2063.

Sen. Dever 2-4-09 #9

PROPOSED AMENDMENTS TO SENATE BILL 2063

Page 1, line 2, after "tobacco" insert "prevention and"

Page 1, line 2, replace "advisory" with "executive"

Page 1, line 2, after "committee" insert "; to declare the intent of the legislature and the tobacco prevention and control committee and provide reports to the legislative council; to allow for payment of committee expenses prior to July 1, 2009; to allow for retroactive application; to declare an effective date; and to declare an emergency"

SECTION 2. INTENT. ~~It is understood by the legislative assembly and the tobacco prevention and control advisory and executive committees that~~ all acts of the tobacco prevention and control advisory and executive committees and their employees are the acts of the state of North ~~Dakota~~ functioning in its sovereign and governmental capacity. As a state entity the committee is subject, ~~as are other state agencies,~~ to accountability requirements including laws providing for state audit, fiscal management, records retention, and procurement requirements. Employees must be part of the classified system. The tobacco prevention and control executive committee shall report to the legislative council on implementation of the comprehensive plan and outcomes achieved at least once a biennium and as the legislative council otherwise deems necessary.

SECTION 3. APPROPRIATION. PAYMENT OF COMMITTEE EXPENSES INCURRED PRIOR TO JULY 1, 2009. There is hereby appropriated to the committee the sum of $62,403 to defray the expenses of the committee, and to provide resources for the development, implementation and administration of the comprehensive tobacco control and prevention plan and to contract with a consultant to facilitate the development of the comprehensive plan.

SECTION 4. RETROACTIVE APPLICATION. Section 3 of this Act is retroactive to January 1, 2009.

SECTION 5. EFFECTIVE DATE. Section 3 of this Act becomes effective immediately upon its filing with the secretary of state.

SECTION 6. EMERGENCY. This Act is declared to be an emergency measure."

Renumber accordingly

2-4-09

#10

Tobacco Prevention and Control Funding
By Best Practice Category
Estimated for 2009-2011
DRAFT

Attachment D

Best Practice Category	Recommended Funding Level	Recommended Funding Range	CDC Funding	Community Health Trust Funding	Tobacco Trust Funding	Questionable Best Practice	Tobacco Trust Funding
State and Community Interventions	$ 9,300,000	$8,400,000 - $13,600,000	$ 1,614,880	$ -	$ 7,685,120		$ 7,685,120
Health Communications Interventions	$ 2,418,000	$1,600,000 - $5,000,000	$ 432,500	$ -	$ 1,985,500		$ 1,985,500
Cessation Interventions	$ 4,464,000	$2,600,000 - $6,600,000	$ 160,640	$ 3,093,000	$ 1,210,360	$ 470,000	$ 1,680,360
Surveillance and Evaluation	$ 1,674,000	$1,200,000 - $2,600,000	$ 216,526	$ 155,000	$ 1,302,474		$ 1,302,474
Administration and Management	$ 744,000	$600,000 - $1,200,000	$ 375,454	$ 140,000	$ 228,546		$ 228,546
Total	$ 18,600,000	$14,400,000 - $29,000,000	$ 2,800,000	$ 3,388,000	$ 12,412,000		$ 12,882,000

$470,000 of the $3,093,000 is questionable that it would be best practice and would require an additional $2,115,000 ouf of Tobacco Trust Fund over a 9 year period

2-4-09

NORTH DAKOTA DEPARTMENT OF HEALTH
TOBACCO PROGRAMS

Direct Tobacco Programs	2007-09 Budget					2009-11 Executive Budget				
	General Fund	Federal Fund	Community Health Trust Fund	Other Special Funds	Total	General Fund	Federal Fund	Community Health Trust Fund	Other Special Funds	Total
Tobacco Coordinator and Operating Expenses			139,397		139,397					0
Advisory Committee			100,000		100,000					0
City/County & State Employee Cessation			260,000		260,000					0
School Health			1,880,000		1,880,000					0
Community Health			1,880,000		1,880,000					0
State Aide*			940,000		940,000					0
Tobacco Quit Line			1,069,000		1,069,000					0
Community Health Tobacco Programs					0			3,388,768		3,388,768
Tobacco Measure 3**					0				2,891,634	2,891,634
American Legacy Special Funds				76,650	76,650					0
CDC Tobacco Prevention and Control		2,577,323			2,577,323		2,677,556			2,677,556
Total	0	2,577,323	6,268,397	76,650	8,922,370	0	2,677,556	3,388,768	2,891,634	8,957,958

*The State Aide to Local Public Health Units is not required to be used for Tobacco Programs.
In Fiscal Year 2007 approximately 20% of the State Aide was used for Tobacco Programs.

**Appropriation authority provided for potential contracts from the Tobacco Measure 3 Funding.

Programs Related to Tobacco Use	2007-09 Budget					2009-11 Executive Budget				
	General Fund	Federal Fund	Community Health Trust Fund	Other Special Funds	Total	General Fund	Federal Fund	Community Health Trust Fund	Other Special Funds	Total
Heart Disease and Stroke Prevention		494,420			494,420		852,675			852,675
CDC Oral Health Prevention		321,338			321,338		501,240			501,240
Cancer Prevention and Control	100,000	4,139,772			4,239,772	250,000	3,955,128			4,205,128
Colorectal Cancer Screening (Pilot Project)	50,000		150,000		200,000					0
Total	150,000	4,955,530	150,000	0	5,255,530	250,000	5,309,043	0	0	5,559,043

Other Federal Programs that Partner with the Tobacco Program- Small unidentifiable portions of these programs are devoted to tobacco use in combination with the program's primary purpose

Preventive Health Block Grant (PH)
Maternal and Child Health Block Grant (MCH)
BRFSS-Chronic Disease Prevention
Diabetes Control Cooperative Agreement
Family Planning
Women, Infant and Children Program (WIC)
School Health

#

#12

Who Uses Tobacco in North Dakota

Adult Tobacco Use

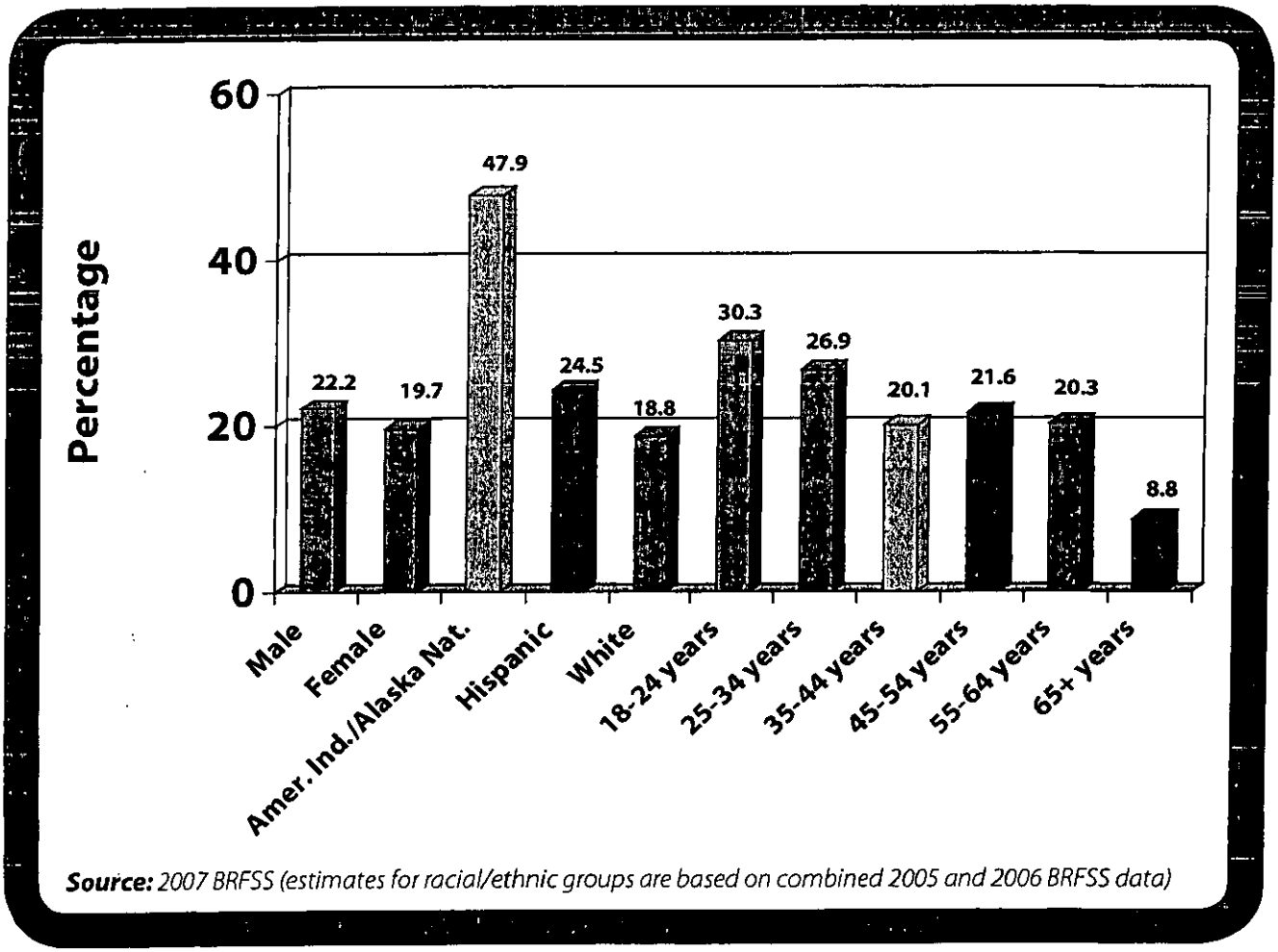
- In North Dakota, 20.9 percent of adults smoke compared to the national average of 19.8 percent.[9]
- In North Dakota, 4.7 percent of adults use smokeless tobacco compared to the national average of 3.0 percent.[10]
- In North Dakota, 3.7 percent of adults smoke cigars compared to the national average of 5.6 percent.[11]
- Each year, 49.1 percent of North Dakota's adult smokers try to quit.

Disparities in Tobacco Use

Disparities refers to the burden of tobacco use among population groups that are affected at a higher rate.

- Cigarette use among American Indians is more than twice as high as the overall state rate, at 47.9 percent.[9, 10]
- Pregnant women in North Dakota smoke at a rate of 18.4 percent compared to the national average of 11.4 percent.[12, 13]
- People in the 18- to 24-year-old age group smoke at a rate of 30.3 percent compared to the overall smoking rate of 20.9 percent.[9]

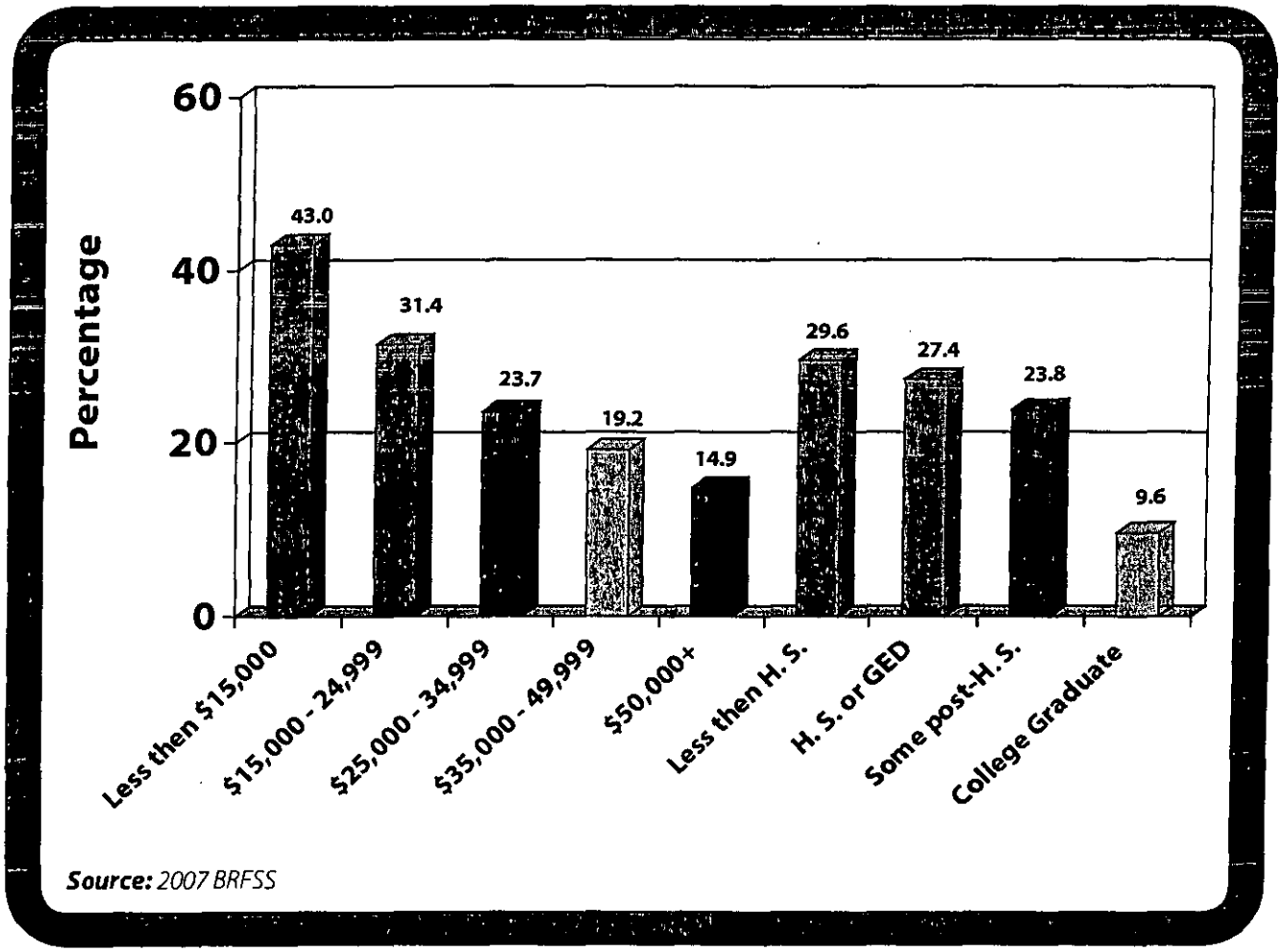
Percentage of Population Groups Who Smoke in North Dakota



Source: *2007 BRFSS (estimates for racial/ethnic groups are based on combined 2005 and 2006 BRFSS data)*

- Males smoke at a slightly higher rate than females.
- American Indians smoke at a much higher rate than other population groups.
- In general, smoking rates in North Dakota decrease as age increases.

Percentage of Population Groups Who Smoke in North Dakota



Source: *2007 BRFSS*

- In general, the higher a person's income, the less likely he or she is to smoke.
- In general, the more education a person has completed, the less likely he or she is to smoke.

Youth Tobacco Use in Grades Nine Through 12

- The percentage of students in grades nine through 12 who currently smoke cigarettes is 21.1 percent.[14]
- Smoking rates increase as students get older. The percentage of students who smoke in ninth grade is 14.7 percent, compared to 32.2 percent who smoke in the 12th grade.[14]
- The percentage of students in this age group who currently use smokeless tobacco products is 11.7 percent.[14] The percentage of males who use spit tobacco is 16.8 percent.[15]
- A quarter of students in grades nine through 12 have ever tried smokeless tobacco. The percentage reported is 25.1 percent.[15]
- Nearly a third of students in grades nine through 12 have ever tried cigars. The percentage reported is 32.7 percent.[15]
- The percentage of students in grades nine through 12 who currently smoke cigars, cigarillos or little cigars is 11.4 percent.[14]
- Nearly 57 percent of current smokers in grades nine through 12 tried to quit smoking during the previous 12 months.[14]
- When students who have tried smoking were asked when they smoked their first whole cigarette, 36.9 percent stated that they smoked their first cigarette before the age of 13.[14]

✓ SB2063

Here is the information about the amount of money that a not-for-profit should spend on administration. Formula 8 shows less than 65%. This relates to the tobacco control money

From: Catie Herman [mailto:CHerman@uwcc.net]
Sent: Thursday, January 22, 2009 3:44 PM
To: Lee, Judy E.
Cc: Deb Clemenson
Subject: RE: Judy Lee has a question

Judy,

Here is the link to the Better Business Bureau's Standards for Charity Accountability: http://us.bbb.org/WWWRoot/SitePage.aspx?site=113&id=4dd040fd-08af-4dd2-aaa0-dcd66c1a17fc that will give you more detailed information.

I believe the two items below answer your question. Please let me know if you have any other questions.

8. Spend at least 65% of its total expenses on program activities.

Formula for Standard 8:

$$\frac{\text{Total Program Service Expenses}}{\text{Total Expenses}} \quad \text{should be at least 65\%}$$

9. Spend no more than 35% of <u>related</u> contributions on fund raising. Related contributions include donations, legacies, and other gifts received as a result of fund raising efforts.

Formula for Standard 9:

$$\frac{\text{Total Fund Raising Expenses}}{\text{Total Related Contributions}} \quad \text{should be no more than 35\%}$$

Thank you. Have a great day!

Catie Herman
Controller/Chief Operating Officer
United Way of Cass-Clay

CHAPTER 23-42
TOBACCO PREVENTION AND CONTROL PROGRAM

23-42-01. Definitions. As used in this chapter:

1. "Advisory committee" is the nine-member tobacco prevention and control advisory committee responsible to develop the comprehensive plan.

2. "Comprehensive plan" means a comprehensive statewide tobacco prevention and control program that is consistent with the centers for disease control best practices for comprehensive tobacco prevention and control programs and does not duplicate the work of the community health grant program created in chapter 23-38.

3. "Executive committee" means the three-member committee selected by the advisory committee and charged with implementation and administration of the comprehensive plan.

4. "Tobacco prevention and control fund" consists of all principal and interest of the tobacco prevention and control trust fund established by section 54-27-25.

23-42-02. Tobacco prevention and control advisory committee - Membership - Terms - Duties - Removal.

1. The advisory board consists of nine North Dakota residents appointed by the governor for three-year terms as follows:

   a. A practicing respiratory therapist familiar with tobacco-related diseases;

   b. Four nonstate employees who have demonstrated expertise in tobacco prevention and control;

   c. A practicing medical doctor familiar with tobacco-related diseases;

   d. A practicing nurse familiar with tobacco-related diseases;

   e. A youth between the ages of fourteen and twenty-one; and

   f. A member of the public with a previously demonstrated interest in fostering tobacco prevention and control.

2. The governor shall select the youth and public member independently; the respiratory therapist from a list of three nominations provided by the North Dakota society for respiratory care; the four tobacco control experts from a list of two nominations per member provided by the North Dakota public health association's tobacco control section; the medical doctor from a list of three nominations provided by the North Dakota medical association; and the nurse from a list of three nominations provided by the North Dakota nurses association. The governor must make the appointments within three weeks of receiving the respective list of nominees. If the governor fails to make an appointment within three weeks, the association that provided the list of nominees shall select the committee member. In the initial appointments for the advisory committee, the governor shall stagger the terms of the members so that the terms of three members expire each fiscal year and that three members are appointed each year by June thirtieth. Accordingly, the governor's initial appointments, in some instances, must be for terms less than three years. The governor shall fill vacancies for the unexpired term as provided in this section.

3. No individual may serve more than two consecutive three-year terms. However, terms of less than three years are not considered in determining an individual's eligibility for reappointment.

4. A quorum of the advisory committee is required to conduct business, but the advisory committee may conduct a meeting with less than a quorum present. A quorum is a majority of the members of the committee. Any action taken requires a vote of the majority of the members present at the meeting.

5. The advisory board shall:

   a. Select the executive committee;

   b. Fix the compensation of the advisory committee and the executive committee. However, compensation may not exceed compensation allowed to the legislature. Advisory and executive committee members are entitled to reimbursement for mileage and expenses as provided for state officers in addition to any compensation provided;

   c. Develop the initial comprehensive statewide tobacco prevention and control program that includes support for cessation interventions, community and youth interventions, and health communication; and

   d. Evaluate the effectiveness of the plan and its implementation and, before April first of each year, propose any necessary changes to the plan to the executive committee.

6. The governor may remove any member of the advisory committee for malfeasance in office, but the advisory committee is not subject to section 54-07-01.2.

7. No nomination to, or member of, the advisory committee shall have any past or current affiliation with the tobacco industry or any industry, contractor, agent, or organization that engages in the manufacturing, marketing, distributing, sale, or promotion of tobacco or tobacco-related products.

23-42-03. Executive committee. The executive committee of the advisory committee consists of three individuals selected by the advisory committee from its membership. The term of each member is for three years. The initial terms of the members must be staggered so that one member serves a three-year term, one member serves a two-year term, and one member serves a one-year term. The determination of initial terms shall be by lot. No individual may serve more than two consecutive three-year terms. However, terms of less than three years are not considered in determining an individual's eligibility for reappointment. The advisory committee shall fill vacancies for the unexpired term. An individual selected to serve on the executive committee is no longer eligible to serve if that individual is not a member of the advisory committee. The executive committee is responsible for the implementation and administration of the comprehensive plan, including the appropriateness of expenditures to implement the comprehensive plan. The executive committee may seek the counsel and advice of the advisory committee in implementing the plan, but the executive committee is the final decisionmaker.

23-42-04. Powers of the executive committee. To implement the purpose of this chapter and, in addition to any other authority granted elsewhere in this chapter, to support its efforts and implement the comprehensive plan, the executive committee may employ staff and fix their compensation, accept grants, property, and gifts, enter contracts, make loans, provide grants, borrow money, lease property, provide direction to the state investment board for investment of the tobacco prevention and control fund, and take any action that any private individual, corporation, or limited liability company lawfully may do except as restricted by the provisions of this chapter.

23-42-05. Development of the comprehensive plan. The advisory committee shall develop the initial comprehensive plan within one hundred eighty days of the initial meeting of the advisory committee. The comprehensive plan must be funded at a level equal to or greater than the centers for disease control recommended funding level. Funding for the comprehensive plan must supplement and may not supplant any funding that in the absence of this chapter would be or has been provided for the community health trust fund or other health initiatives.

23-42-06. Conflict of interest. No member of the advisory committee or of the executive committee who has a direct and substantial personal or pecuniary interest in a matter before them may vote or take any action on that matter.

23-42-07. Audit. At least once a biennium, the executive committee shall provide for an independent review of the comprehensive plan to assure that the comprehensive plan is consistent with the centers for disease control best practices. The executive committee shall report the results of that review to the governor and to the state health officer on or before September first in each odd-numbered year.

MEMORANDUM

To: Senator Judy Lee, Chair and Members of the Senate Human Services Committee

From: Kathleen Mangskau, Chair, Tobacco Prevention and Control Advisory Committee

Date: January 20, 2009

Subject: SB 2063 Additional Materials

Per the request of the Committee, attached are copies of Measure 3,

BALLOT TITLE

This initiated measure would add seven new sections to the North Dakota Century Code and amend N.D.C.C. section 54-27-25 to establish a tobacco prevention and control advisory committee and an executive committee; develop and fund a comprehensive statewide tobacco prevention and control plan; and create a tobacco prevention and control trust fund to receive tobacco settlement dollars to be administered by the executive committee.

FULL TEXT OF THE MEASURE

IF MATERIAL IS UNDERSCORED, IT IS NEW MATERIAL WHICH IS BEING ADDED. IF MATERIAL IS OVERSTRUCK BY DASHES, THE MATERIAL IS BEING DELETED. IF NO MATERIAL IS UNDERSCORED OR OVERSTRUCK, THE MEASURE CONTAINS ALL NEW MATERIAL WHICH IS BEING ADDED.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF NORTH DAKOTA:

SECTION 1. Seven new sections to the North Dakota Century Code are hereby created and enacted as follows:

Definitions. As used in this Act:

1. "Advisory committee" is the nine-member tobacco prevention and control advisory committee responsible to develop the comprehensive plan.
2. "Comprehensive plan" means a comprehensive statewide tobacco prevention and control program that is consistent with the centers for disease control best practices for comprehensive tobacco prevention and control programs and does not duplicate the work of the community health grant program created in chapter 23-28.
3. "Executive committee" means the three-member committee selected by the advisory committee and charged with implementation and administration of the comprehensive plan.
4. "Tobacco prevention and control fund" consists of all principal and interest of the tobacco prevention and control trust fund established by section 2 of this Act.

Tobacco Prevention and Control Advisory Committee – Membership – Terms - Duties - Removal.

1. The advisory board consists of nine North Dakota residents appointed by the governor for three year terms as follows:
   a. A practicing respiratory therapist familiar with tobacco related diseases;
   b. Four non-state employees that have demonstrated expertise in tobacco prevention and control;
   c. A practicing medical doctor familiar with tobacco related diseases;
   d. A practicing nurse familiar with tobacco related diseases;
   e. A youth between the ages of 14 and 21;
   f. A member of the public with a previously demonstrated interest in fostering tobacco prevention and control.

2. The governor shall select the youth and public member independently; the respiratory therapist from a list of three nominations provided by the North Dakota society for respiratory care; the four tobacco control experts from a list of two nominations per member provided by the North Dakota public health association's tobacco control section; the medical doctor from a list of three nominations provided by the North Dakota medical association; and the nurse from a list of three nominations provided by the North Dakota nurses association. The governor must make the appointments within three weeks of receiving the respective list of nominees. If the governor fails to make an appointment within three weeks the association that provided the list of nominees shall select the committee member. In the initial appointments for the advisory committee, the governor shall stagger the terms of the members so that the terms of three members expire each fiscal year and that three members are appointed each year by June 30. Accordingly, the governor's initial appointments must, in some instances, be for terms less than 3 years. The governor shall fill vacancies for the unexpired term as provided in this section.

3. No individual may serve more than two consecutive three-year terms; however terms of less than three years are not considered in determining an individual's eligibility for reappointment.

4. A quorum of the advisory committee is required to conduct business, but the advisory committee may conduct a meeting with less than a quorum present. A quorum is a majority of the members of the committee. Any action taken requires a vote of the majority of the members present at the meeting.

5. The advisory board shall:

   a. Select the executive committee;

   b. Fix the compensation of the advisory committee and the executive committee; however compensation may not exceed compensation allowed to the legislature. Advisory and executive committee members are entitled to reimbursement for mileage and expenses as provided for state officers in addition to any compensation provided;

   c. Develop the initial comprehensive statewide tobacco prevention and control program that includes support for cessation interventions, community and youth interventions, and health communication; and

   d. Evaluate the effectiveness of the plan and its implementation and, prior to April 1 of each year, propose any necessary changes to the plan to the executive committee.

6. The governor may remove any member of the advisory committee for malfeasance in office, but the advisory committee is not subject to section 54-07-01.2.

7. No nomination to, or member of, the advisory committee shall have any past or current affiliation with the tobacco industry or any industry, contractor, agent, or organization that engages in the manufacturing, marketing, distributing, sale, or promotion of tobacco or tobacco related products.

Executive Committee. The executive committee of the advisory committee consists of three individuals selected by the advisory committee from its membership. The term of each member is for three years. The initial terms of the members must be staggered so that one member serves a three-year term, one member serves a two-year term and one member serves a one-year term. The determination of initial terms shall be by lot. No individual may serve more than two consecutive three-year terms; however terms of less than three years are not considered in determining an individual's eligibility for reappointment. The advisory committee shall fill vacancies for the unexpired term. An individual selected to serve on the executive committee is no longer eligible to serve if they are not a member of the advisory committee. The executive committee is responsible for the implementation and administration of the comprehensive plan, including the appropriateness of expenditures to implement the comprehensive plan. The executive committee may seek the counsel and advice of the advisory committee in implementing the plan, but the executive committee is the final decision maker.

Powers of the Executive Committee. To implement the purpose of this Act and, in addition to any other authority granted elsewhere in this Act, to support its efforts and implement the comprehensive plan the executive committee may employ staff and fix their compensation, accept grants, property, and gifts, enter contracts, make loans, provide grants, borrow money, lease property, provide direction to the state investment board for investment of the tobacco prevention and control fund, and take any action that any private individual, corporation, or limited liability company lawfully may do except as restricted by the provisions of this Act.

Development of the Comprehensive Plan. The advisory committee must develop the initial comprehensive plan within 180 days of the initial meeting of the advisory committee. The comprehensive plan must be funded at a level equal to or greater than the centers for disease control recommended funding level. Funding for the comprehensive plan must supplement and may not supplant any funding that in the absence of this Act would be or has been provided for the community health trust fund or other health initiatives.

Conflict of Interest. No member of the advisory committee or of the executive committee who has a direct and substantial personal or pecuniary interest in a matter before them may vote or take any action on that matter.

Audit. At least once a biennium, the executive committee shall provide for an independent review of the comprehensive plan to assure that the comprehensive plan is consistent with the centers for disease control best practices. The executive committee shall report the results of that review to the governor and to the state health officer on or before September 1 in each odd numbered year.

SECTION 2. Amendment. Section 54-27-25 of the 2005 supplement to the North Dakota Century Code is hereby amended and reenacted as follows:

54-27-25. Tobacco settlement trust fund - Interest on fund - Uses.

1. There is created in the state treasury a tobacco settlement trust fund. The fund consists of the tobacco settlement dollars obtained by the state under ~~sections~~ subsection IX (c)(1) ~~(payments) and XI (calculation and disbursement of payments)~~ of the master settlement agreement and consent agreement adopted by the east central judicial district court in its judgment entered December 28, 1998 [Civil No. 98-3778] in *State of North Dakota, ex rel. Heidi Heitkamp v. Philip Morris, Inc.* ~~All~~ Except as provided in subsection 2, moneys received by the state ~~pursuant to the judgment and all moneys received by the state for enforcement of the judgment~~ under subsection IX(c)(1) must be deposited in the fund. Interest earned on the fund must be credited to the fund and deposited in the fund. The principal and interest of the fund must be allocated as follows:

~~1.~~ a. Transfers to a community health trust fund to be administered by the state department of health. The state department of health may use funds as appropriated for community-based public health programs and other public health programs, including programs with emphasis on preventing or reducing tobacco usage in this state. Transfers under this subsection must equal ten percent of total annual transfers from the tobacco settlement trust fund of which a minimum of eighty percent must be used for tobacco prevention and control.

~~2.~~ b. Transfers to the common schools trust fund to become a part of the principal of that fund. Transfers under this subsection must equal forty-five percent of total annual transfers from the tobacco settlement trust fund.

~~3.~~ c. Transfers to the water development trust fund to be used to address the long-term water development and management needs of the state. Transfers under this subsection must equal forty-five percent of the total annual transfers from the tobacco settlement trust fund.

2. There is created in the state treasury a tobacco prevention and control trust fund. The fund consists of the tobacco settlement dollars obtained by the state under section IX (c) (2) of the agreement adopted by the east central judicial district court in its judgment entered December 28, 1998 [Civil No. 98-3778] in *State of North Dakota, ex rel. Heidi Heitkamp v. Philip Morris, Inc.* Interest earned on the fund must be credited to the fund and deposited in the fund. Moneys received into the fund are to be administered by the executive committee for the purpose of creating and implementing the comprehensive plan. If in any biennium, the tobacco prevention and control trust fund does not have adequate dollars to fund a comprehensive plan, the treasurer shall transfer money from the water development trust fund to the tobacco prevention and control trust fund in an amount equal to the amount determined necessary by the executive committee to fund a comprehensive plan.

3. Transfers to the funds under this section must be made within thirty days of receipt by the ~~tobacco settlement trust fund~~ state.

SB 2063

Lee, Judy E.

From: Lee, Gary A.
Sent: Tuesday, January 20, 2009 2:45 PM
To: Lee, Judy E.
Subject: FW: Quit Line.

Judy,

Information on the ND Quitline FYI. I thought it provided some good data on the program.

Michelle used to work for me & is a good, reliable source of information on the smoking issue.

GLee

From: Walker, Michelle L.
Sent: Tuesday, January 20, 2009 1:40 PM
To: Lee, Gary A.
Subject: RE: Quit Line.

Hi Gary -

Thanks again for the inquiry.

The 2008 Clinical Practice Guidelines for Treating Tobacco Use and Dependence states that telephone, group and individual counseling are all effective and should be used in tobacco cessation. Currently, the national average for quit rates for cessation counseling is 20% and that is considered successful. With the North Dakota Tobacco Quitline, we have quit rates of 38% at 6 months and 34% at 12 months. While there are no national Quitline benchmarks in place yet, we have heard anecdotally that North Dakota has extremely high Quitline quit rates.

Since the Quitline started in September 2004, it has received over 9,600 total calls and averages about 250 calls per month. Our Quitline is unique in that our vendors are Mayo Clinic and UND School of Medicine. We have four counselors located in Grand Forks that take over 90% of the ND Quitline calls so residents are receiving counseling from actual North Dakotans.

When an individual enrolls in the Quitline, they receive two 30-minutes assessment calls and then they can have up to four more calls with their counselors for a total of six calls. If the enrollees are un- or under insured, they can also receive a 28-day supply of the nicotine gum, patch or lozenge delivered to them directly at home.

We recently partnered with Medicaid to expand the medication coverage of Medicaid clients IF they enroll in counseling with the Quitline. The combination of counseling and medication is more effective for cessation than either medication or counseling alone.

The Quitline consistently hits it's primary demographic. Almost 16 percent of callers are from disparate populations, 46 percent of callers have less than or equal to a high school education and 41 percent have incomes of less than $25,000.

The Quitline budget is $1,069,000 biannually from the Community Health Grant Trust Fund. We also receive a small amount of federal (CDC) dollars to supplement the program which is about $200,000.

Please let me know if this provides you with the information you needed!

Michelle

http://www.ndhealth.gov/tobacco/Facts/Quitline.pdf

Michelle Walker, BS, RRT
Cessation Coordinator
Division of Tobacco Prevention & Control
North Dakota Department of Health
600 E. Boulevard Ave., Dept. 301
Bismarck, ND 58505-0200
Telephone: 701.328.2315
Fax: 701.328.2036
Email: mlwalker@nd.gov

From: Lee, Gary A.
Sent: Tuesday, January 20, 2009 12:47 PM
To: Walker, Michelle L.
Subject: Quit Line.

Hello Michelle,

We had talked awhile back about the "Quit Line". In that conversation, you provided some information on the success of the "Quit Line" (compared to other types of services, i.e. direct counseling etc), how your program works & funding for it. Could you refresh my memory?

Thank you,

Gary A. Lee
Senator
District 22

My name is Melany Jenkins. I am the Associate Director of Program Services for the North Dakota Chapter and the lead Public Affairs staff.

The mission of the March of Dimes is to improve the health of babies by preventing birth defects, premature birth and infant mortality. I writing this time to testify to you about a very important item related to our mission that directly affects the health of our tiniest North Dakotans, the bill SB 2063 which the funds that the citizens have "allocated" in Measure #3 for tobacco control and prevention will be "appropriated".

Initiated Measure #3 exists to use tobacco settlement dollars for tobacco prevention and control in the state of North Dakota so that our most precious resources, our tiniest North Dakotans will be protected. **The March of Dimes asks that bill SB 2063 appropriate the state Tobacco Settlement payments to fully fund a CDC-based, comprehensive tobacco prevention and cessation program statewide that will; 1) commit funds to cover smoking prevention/cessation programs for pregnant women (Quitline, and Medicaid programs, etc.), 2) commit funds to cover costs of health warning signs, 3) earmark funds to cover training for physicians for 5A counseling for women of childbearing age.**

North Dakota's preterm birth rate at 11.5% is more than 50% higher than the Healthy People 2010 objective of 7.6% and has increased by nearly 14% between 1995 and 2005. While research continues as to the causes of preterm births and low birthweight babies, the state of North Dakota can address one of the known contributing factors of smoking and take measures toward prevention.

The first step in preventing preterm births and low birth weight babies is to identify the causes. **For 50% of preterm births the causes are unknown.** However, studies have shown that women who smoke have a higher risk of having a premature baby or a low birhtweight baby. Cigarette smoking during pregnancy poses many risks for pregnant women and their children, including increased risk of premature delivery. Smoking directly affects fetal growth, and as a result, increases the risk of a baby being born smaller or low birthweight. The harmful effects are directly linked to the amount and duration of smoking during pregnancy. Studies show that women who stop smoking before or early in pregnancy decrease their risk of having a low birthweight baby to nearly that of women who have never smoked. Women who stop smoking later in pregnancy can still significantly increase their chances of a healthy birth outcome. Environmental exposure to tobacco products, passive or second-hand smoke, is also unhealthy

for pregnant women and their newborns. Exposure to second-hand smoke during pregnancy and after birth increases the risk of sudden infant death syndrome (SIDS), which is a key contributor to infant mortality. In addition to perinatal effects, smoking is detrimental to the overall health of women and has been shown to cause lung disease, heart disease, and various cancers including cervical and lung cancer. According to the March of Dimes Prematurity Report card released November 2008, about 24.4% of women of childbearing age in North Dakota smoke that is 1 in 4. A fully funded, smoking prevention and cessation program play a vital role in reducing the rate of preterm births and low birthweight babies in North Dakota and protecting a women's health.

March of Dimes believes in doing its part. The March of Dimes promotes the health benefits of smoking prevention and cessation by providing educational materials for consumers, promoting evidence-based smoking cessation methods, and encouraging research related to smoking cessation during pregnancy. However, this is far from enough to compensate for the growing need of maintaining a strong tobacco prevention and cessation program in the state to offset the increasing number of women of child bearing age who are smoking in North Dakota. Again, **March of Dimes asks that this committee appropriate Tobacco Settlement funds to fully fund the CDC-based, comprehensive tobacco prevention and cessation program that will; 1) cover smoking prevention and cessation programs for pregnant women, 2) cover costs of health warning signs, 3) cover training for physicians for a 5A counseling for women of childbearing age.**

On behalf of the March of Dimes, thank you for the opportunity to comment on the need for state tobacco Settlement dollars to be appropriated to fund tobacco prevention and cessation programs in North Dakota. We thank you for all that you do to protect and improve maternal and child health in North Dakota.

march of dimes

Testimony in support of SB 2063: Appropriations for Measure 3
Comprehensive Tobacco Control Program.

By:
Carol M. Russell, MPH
897 Southport Loop
Bismarck, ND 58504
701-255-1028
February 13, 2009

Same given to House Approp. 3-10-09

My name is Carol Russell. I grew up in Minot and after I retired I moved to Bismarck. Before I retired, I was Chief of Program Services for the California's landmark Tobacco Control Program at the California Department of Public Health.

I am immensely proud that North Dakota has stepped up to the plate to take on tobacco control in a significant way. Your leadership is important to the health of the people you represent. It reflects the values and heritage that I associate with our fine state. You can also be proud of the many skilled and knowledgeable staff and volunteers who will make your program a success. You are extremely lucky for this.

Now it's time for you to step into the 21st century health-wise with this bill. Tobacco use is the leading cause of preventable deaths – a major cause of cancer, cardiovascular and respiratory diseases. The price for this is high -- deaths are the equivalent of 2 jumbo jets crashing every day with no survivors. The price is high for North Dakota too. The 2007 adult smoking rate in 2007 was almost 21%. Data for the state's American Indians are worse. The adult prevalence rate in California is 13% aiming now for 10%. There's no reason North Dakota can't do the same.

I know how important the pocket book is to frugal North Dakotans. You should know that researchers at the University of California found an $86 billion dollar reduction in per capita personal health care costs between 1989 when the program began and 2004. That's B as in Billion -- a reduction associated with the program. Again, there's no reason North Dakota can't do the same favor for its people.

Thank you.

Statement of Support for Senate Bill 2063, To Appropriate Full Funding for North Dakota's "Measure 3 Best Practices Tobacco Prevention & Cessation Program"

February 13, 2009

Tobacco-Free North Dakota (TFND) supports the prompt approval of Senate Bill 2063 in a manner that will faithfully and expeditiously implement the will of the People as expressed by their recent adoption of Initiated Measure # 3. TFND is an all-volunteer, statewide group of individuals and organizations dedicated to curbing the tremendous health, social, and economic toll of tobacco addiction in North Dakota.

By a strong majority, North Dakota voters last November allocated the "Strategic Contribution Fund" portion of North Dakota's decade-old Global Tobacco Settlement payments to: Implementing a comprehensive, science-based program that will reduce youth smoking, avert future tobacco-caused diseases and deaths, and greatly reduce future taxpayer expenditures for tobacco-caused healthcare delivery. Now it is time for the North Dakota Legislature to appropriate those funds so that this proven program can move forward.

As explicitly directed by this historic vote of the citizens and in order to actually achieve the desired life-saving, cost-saving results, all of the allocated funds must be scrupulously invested only in strategies that have been proven effective and specifically adopted as "Best Practices for Comprehensive Tobacco Control Programs" by the nation's leading disease-preventing specialists at the U.S. Centers for Disease Control and Prevention.

It is not surprising that in 2008, fully ten years after the Tobacco Settlement was hammered out, North Dakota voters adopted Initiated Measure 3. In statewide polling conducted at the time of the Settlement, more than nine of every ten North Dakotans indicated they wanted Tobacco Settlement dollars used for effective tobacco-prevention work. In fact, nearly seven of every ten survey respondents wanted at least half of the state's entire settlement payments (not just the "Strategic Contribution Fund") spent on tobacco control efforts.

Tobacco-Free North Dakota urges the 61st Legislative Assembly to enact legislation to appropriate the money necessary to fully fund a "Best Practices" tobacco control program in the manner that will honor the stated wishes of the people of North Dakota.

Sharon E. Buhr, MPH, LRD
President, Tobacco-Free North Dakota
613 Chautauqua Blvd
Valley City, ND 58072
701-845-5197 (h)

Testimony
SB No. 2063
Senate Appropriations Committee
February 13, 2009 10:30 a.m.

Good morning Chairman Holmberg and members of the Senate Appropriations Committee. My name is Kathleen Mangskau and I am the chair of the Tobacco Prevention and Control Advisory Committee. I am here to provide information on how the funds appropriated in SB 2063 will be spent and accounted for. The law passed by the voters in November 2008 directs that the funds in the tobacco prevention and control trust fund be spent to develop and implement a statewide, comprehensive Center for Disease Control and Prevention (CDC)-based best practice tobacco prevention and control program. My testimony includes information on the need for the program, the progress of the advisory committee to date, the best practice categories, the current levels of funding in the best practice categories and how the new funds will be used to meet the recommended programming and levels of spending.

The Need for a Comprehensive Tobacco Prevention and Control Program
We all know many people who have been impacted by tobacco use suffering from heart or lung disease, or other associated cancers or by the premature death of a loved one. At the first advisory committee meeting, I was struck by the overwhelming impact tobacco use had on the members of the advisory committee and the families and their motivation for wanting to be part of the committee. The toll of tobacco in North Dakota is high and rising health care costs are a concern to many North Dakotans. With the current level of funding for tobacco control efforts in the state, tobacco use continues to kill more than 900 North Dakota residents every year and costs the state $250 million in annual excess health care costs, including $47 million a year in state Medicaid program costs. State productivity losses from smoking total an additional $192 million each year. According to the *North Dakota Behavioral Risk Factor Survey*, one in five adults in North Dakota smoke, a rate that has changed very little for a more than a decade. The *North Dakota Youth Risk Behavior Survey* indicates that more than one in five kids (21%) still smoke, and one in five high school males (20%) use spit tobacco. These North Dakota youth tobacco use rates are all higher than the national rates. While North Dakota has made strides in reducing youth tobacco use; the tobacco use problem clearly is not solved. The decline in youth rates has flattened but without additional resources and programming, we will not continue to see major changes in those rates. The 2007 Institute of Medicine Report concluded that to effectively reduce tobacco use, "states must maintain over time a

comprehensive integrated tobacco control strategy." Research shows that the more states spend on sustained comprehensive tobacco control programs, the greater the reductions in smoking—and the longer states invest in such programs, the greater and faster the impact. North Dakota voters chose to implement a comprehensive strategy when they enacted Measure 3.

The Tobacco Prevention and Control Advisory Committee has primary goals of preventing youth from starting to use tobacco, helping youth and adults to quit tobacco use, eliminating exposure to secondhand smoke and identifying and eliminating tobacco use disparities. Implementing evidence-based, statewide tobacco control programs that are comprehensive, integrated, sustained and accountable have been shown to reduce smoking rates, tobacco-related deaths, and diseases caused by smoking. These programs will prevent or accelerate declines in heart disease, lung diseases and disorders, and once again make lung cancer a rare disease. A comprehensive approach combines educational, clinical, regulatory, economic and social strategies. The plan will have well-defined goals, objectives, and short-term, intermediate and long-term indicators of success.

To be effective and achieve the desired results the program must be comprehensive. When treating cancer, a recommended treatment regimen may include chemotherapy, radiation, surgery and the support of family and friends. If we remove the chemotherapy, we do not get the intended results. Likewise in a comprehensive approach, removing a component, or using strategies that are not best practices or evidence-based will impair the committee's ability to reach the desired outcomes.

Progress of Tobacco Prevention and Control Advisory Committee

Governor Hoeven promptly appointed the nine-member advisory committee in December 2008. The appointments became official on January 1, 2009. The Committee convened its first meeting on January 8, 2009 and elected the executive committee and chair, set their meeting dates, determined their operating procedures, and initiated research into best practice approaches in order to prepare for Legislative requests for information and to meet the time constraints (180 days) to develop the plan. The amendment passed by the Senate that requests retroactive spending authority will allow the committee to conduct its business and meet that deadline. The CDC will be in North Dakota on February 20, 2009 to provide training on the Best Practice approach for the advisory committee members, local tobacco coordinators and local coalition leaders/members and other interested parties. The CDC has designated a consultant to assist the state with development of the plan for a comprehensive program. The advisory committee has scheduled meetings to be held as frequently as every other week until the plan is completed.

A timeline for plan development has been completed. The committee will use the previous and current state tobacco plans as a foundation for the comprehensive plan. The second meeting of the committee was held on January 23 and focused on understanding the history of the tobacco control funding in North Dakota and educating the committee on the open records/open meeting responsibilities of state agencies. The third meeting of the committee held on February 6 focused on continued learning about best practices and developing expert panels for each of the best practice components. See attachment A for a list of the Advisory Committee and Executive Committee members.

The Executive Committee met a total of four times in January and February and outlined the roles and responsibilities of the members, reviewed tobacco-related legislation, created a timeline for development of the plan, began acquiring Best Practice resources and carrying out the work of the committee.

The Executive Committee met with staff from the North Dakota Department of Health three times in January and February to continue working through the roles and responsibilities of each agency so we can be most effective and do not duplicate or supplant efforts as required by NDCC § 23-42-05. There was a fairly high level of agreement as to which agency could carry out each function most efficiently and effectively. This information will be useful to this committee as you move to balance responsibilities between the Department of Health and the Advisory Committee. I will outline that information in more detail as I discuss the best practice categories.

Current Funding and Funding Needed

A fact sheet on the CDC Best Practices recommended annual investment for North Dakota is included as Attachment B. The table below shows that North Dakota, with a combination of state tobacco settlement revenues and federal funds, currently spends around $4.4 million per year on tobacco prevention and control efforts, less than one-half (47%) of the $9.3 million the CDC recommends for a comprehensive tobacco control program each year. Moreover, the percentage spent on tobacco prevention and control efforts may be slightly overestimated as 100 percent of the Community Health Trust Fund state aid funding to local health departments is not spent on tobacco prevention and control programming.

A comparison of the recommended per capita spending and the current level of tobacco control spending in North Dakota in 2008 provided by the State Health Department shows that the program is sadly underfunded in many categories and thus North Dakota has not been able to make the progress necessary to protect our

citizens and significantly reduce the health and economic burden of tobacco use in the state. Measure 3 allocated just enough money to get the job done.

North Dakota Tobacco Control Expenditures by Best Practice Category in 2008

	Per Capita Recommendation	ND Spending	Percentage of Recommendation ND Spends
State and Community Interventions	$ 7.37	$3.90	53%
Health Communication Interventions	$ 1.86	$0.27	15%
Cessation Interventions	$ 3.52	$1.14	32%
Surveillance and Evaluation	$ 1.28	$0.15	12%
Administration and Management	$ 0.64	$0.75	101%
*Other Funds in ND (State Aid)		$0.74	
Total	**$14.67**	**$6.95**	**47%**

It has been stated that North Dakota already spends $97 million per biennium to prevent risky behaviors. The report prepared by the Legislative Council outlining the expenditures on risk-associated behavior prevention programs shows that the vast majority of those dollars are spent for treatment. A recent study by the Governor's Prevention Advisory Council on Drugs and Alcohol reports prevention funding at a much lower level. The large amount spent on treatment is further evidence of the need to do more to prevent disease and addiction. A Best Practice approach in tobacco control focuses on funding prevention strategies rather than treatment, thus preventing many of the chronic diseases and cancers caused by tobacco use and thus resulting in health care cost savings.

How the Trust Funds will be Spent

The Strategic Contribution Fund payment to North Dakota is approximately $13.8 million per year. As directed by Measure #3 that money will be deposited in a trust fund, the sole purpose of which is to fund a CDC based comprehensive program in North Dakota. Using the projected levels of tobacco prevention and control funding from the CDC and the Community Health Trust Fund, each year approximately $6.2 million dollars of the Tobacco Prevention and Control Trust funds would be spent to bring North Dakota up to the recommended funding level for a comprehensive approach. The remaining $7.6 million would remain in the trust to fund tobacco prevention and control beyond the nine remaining years the Strategic Contribution Fund payments are coming to the state. At this funding level and if the CDC support for tobacco control remains about the same as it currently is, and the Health Department funded tobacco programs are best practice approaches, the funding should support programs for more than 16 years.

Measure 3 provides that the state plan the advisory committee will develop the programs and services needed to implement a Best Practice comprehensive program in North Dakota. It provides that 80 percent of the current Community Health Trust Fund must be used for tobacco prevention and control programs. The goal here is that all programs should be CDC best practice programs. Measure 3 also provides protections to prevent duplication of effort and to assure that the existing tobacco programs are continued and that moneys from the Tobacco Prevention and Control Trust fund will not be used to supplant or duplicate existing programs. The Advisory Committee is working closely with the North Dakota Department of Health to put in place programs and services where the current programming is lacking and to assure compliance with the prohibition on duplication and supplanting. Some of the programs and services may involve contracting with the North Dakota Department of Health to enhance their current programming where needed. A grants program will be established to fund missing components of the current program and enhance areas where funding is inadequate. The advisory committee will determine which grants will be funded based on the Best Practice approach. These funds will enhance and not duplicate, replace or supplant the current programs funded by the Department of Health through the existing CDC funds and the Community Health Trust Fund. The funds will be allocated not only to local communities, but also to statewide organizations capable of carrying out programs to enhance efforts to prevent initiation among youth, promote quitting among youth and adults, reduce and eliminate exposure to secondhand smoke and eliminate disparities in tobacco use among specific populations. Attachment C shows the recommended funding for tobacco prevention and control efforts in North Dakota by Best Practice category and shows the estimated funds that will be available from the CDC and the Community Health Trust Fund and the projected amount that will be needed from the Tobacco Prevention and Control Trust Fund in the 2009-2011 biennium.

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The Centers for Disease Control and Prevention uses the nearly five decades of research since the first Surgeon General's report was published as a basis for their Best Practices. The Best Practice emphasizes that there is now a robust evidence base about effective interventions. The Best Practice recommendations are based extant-scientific literature and the review of large-scale sustained state programs which have been shown to reduce smoking and the related health and economic consequences. The evidence-based analysis of the literature and the review of outcomes of state tobacco control programs and interventions provide the background for what works in reducing tobacco use and its toll. In addition, national initiatives from the National Institutes of Health, the Substance Abuse and

Mental Health Services Administration and the Agency for Healthcare Research and Quality that supported innovative intervention studies have been used to determine effective interventions. Pages 16-18 of *The Best Practices for Comprehensive Tobacco Control Programs* provide a listing of the resources and references that were used to develop the Best Practice guidance document. The list includes a broad array of public, private and non-profit groups that have conducted the research. The 2007 Institute of Medicine report presented a blueprint for action to "reduce smoking so substantially that it is no longer a public health problem for our nation." The recommendations go on to list as foremost among the recommendations is that each state should fund a comprehensive best practice tobacco control program at the level recommended by the Centers for Disease Control and Prevention.

A total of eight states have met CDC's minimum funding recommendations for one or more years. One state with the longest history of funding for tobacco prevention is California. A recent study titled, "Effect of the California Tobacco Control Program on Personal Health Care Expenditures" analyzed data from 1980 and 2004 on smoking, health care expenditures, and exposure to a tobacco control educational program in California and compared them to a group of 38 control states. Control states were those without comprehensive tobacco control programs prior to 2000 or cigarette tax increases of $0.50 or more per pack over the study period. North Dakota was one of the control states in the study. The researchers found that $86 billion were saved in personal health care expenditure between 1989, the start of the program, and 2004. This grew over time. The personal health care expenditure savings represented about a **50 fold** return on the $1.8 billion spent on the program during the same period.

What do the findings mean? The California Tobacco Control Program has been successful in reducing smoking in California in comparison to other states, and has reduced personal health care expenditures. These cost reductions are substantial, rapid, and grew over time. The focus on social norm change among adults, not primarily on youth prevention, is responsible for such rapid and large reductions in disease and health care costs.

The law passed by the voters in November 2008 makes it possible for North Dakota to have the opportunity to implement a comprehensive best practice tobacco prevention and control program and produce outcomes similar to those in California with significant health care savings.

Best Practice Components

State and Community Interventions

Coordinated and combined intervention efforts of statewide and local programs working together have the greatest long-term impact. This component supports the state and local community effort to mobilize coalitions to develop state and community level programs and policies to counter pervasive pro-tobacco influences. At the current tobacco control funding level, many counties in the state do not have enough funding to maintain staffing to carry out tobacco prevention activities, youth programs that include tobacco prevention activities, and implement culturally appropriate interventions. The new funds from the trust can be used to enhance support to local and tribal programs, law enforcement, and agencies that can conduct programs reaching specific populations with high tobacco use rates such as Native Americans, pregnant women, lower socio-economic populations and the school to work population aged 18-30. Greater emphasis needs to be placed on engaging communities and providing training so local communities implement policies and strategies to reduce tobacco use. As evidence-based programs are implemented, additional efforts to collaborate with other chronic disease programs and support efforts to promote prevention programs and cessation efforts would create synergy of consistent health promotion messages and multiple avenues to provide services. This component will be jointly implemented by the Tobacco Advisory Committee and the State Health Department.

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There is strong evidence that sustained earned and paid media in combination with other interventions and strategies is effective in reducing tobacco use. Exposure to counter marketing ads is associated with greater pro-health attitudes and beliefs and produces significant declines in smoking rates among adults and youth as well as slowing initiation among youth. Paid media is also needed to recruit target populations with high tobacco use rates to the quitline and local cessation programs. Currently, no funding is available for statewide media efforts to educate youth and very limited funding is available to educate the public about the dangers of secondhand smoke. Funding can also be used to provide greater outreach of the quitline services and to conduct market research so public education efforts can be effectively targeted. Health communication messages that are sustained and appropriately targeted can greatly impact health behaviors. This component will be implemented by the Tobacco Prevention and Control Advisory Committee.

Cessation

Interventions to increase cessation encompass a broad array of policy, system, and population-based measures. Services provided by the statewide quitline and local

cessation programs need to expanded and promoted. Promoting coverage for tobacco dependence treatment under both public and private insurance will increase the number of individuals receiving treatment. Individual and group counseling and coverage of all FDA approved medications will enhance current efforts. Currently only limited medications are provided. Eliminating cost and other barriers to treatment for underserved populations as well as making health systems changes to effectively reach all at risk populations will work to reduce tobacco use. Funding training for a systems approach for health professionals in the use of the Public Health Service Guidelines and for the quitline and local cessation services will reach more tobacco users and increase the number who successfully quit. Providing cessation services to youth in a variety of medium, including web-based, internet and text messaging, will reach out to younger populations in methods they prefer to use. This component will be implemented primarily by the Department of Health.

Surveillance and Evaluation

This component develops systems to monitor attitudes, behaviors and health outcomes and demonstrate accountability for the funds and effectiveness of programs. Surveillance systems are used to assess the prevalence of tobacco use, exposure to secondhand smoke, track trends and identify disparities and measure progress in eliminating those disparities. It includes the evaluation of health communication efforts, cessation and community interventions and conducting surveys such as the Youth Tobacco Survey, Adult Tobacco Survey and the inclusion of tobacco questions in the Behavior Risk Factor Survey, the Youth Risk Behavior Survey and surveys regarding cessation and quitline services. Funding is needed to enhance the data collection efforts by the Department of Health to enable them to gather data on specific population groups such as Native Americans and other groups with high tobacco use as well as to increase their sample size to get estimates for local counties or other geographic breakdowns. The funding will support additional evaluation of programs and services and could provide for outside evaluation of the statewide quitline and other program activities. Current funding has limited the program primarily to process evaluation. With the new funding we will be able to conduct outcome evaluation and provide the program the capability to look at changes over time in diseases caused by tobacco use and secondhand smoke. This component will be jointly implemented. The Department of Health will be responsible for the surveillance and the Tobacco Advisory Committee will be responsible for the evaluation.

Administration and Management

This component provides support to employ qualified state staff for oversight, training and technical assistance to local programs. It includes coordinating

statewide programs such as the quitline and collaboration with partners for public education efforts, strategic planning and provides for real time fiscal management, effective communication, education of decision makers on the health effects of tobacco and evidence-based effective programs and policy interventions. The state has used primarily CDC funding to develop a cadre of staff and contractors capable of carrying out these functions. The grants program would coordinate closely with the state program on training and technical assistance efforts. Minimal funding would be needed to support the staff to manage the grants program and evaluation. This component will be jointly implemented.

The specific programs and projects that will be funded in each component will be determined by the Advisory Committee based on the comprehensive Best Practice plan.

Accountability

There are multiple measures in place to assure accountability of this new state entity. The Advisory Committee is appointed by the Governor and members can be removed for malfeasance in office (NDCC § 23-42-02). Like other state agencies, this state agency will be subject to the Office of Management and Budget fiscal controls and fiscal reporting requirements, audit procedures and other state requirements including state personnel laws, procurement laws, record management requirements, open meeting and record laws, and mandated legal representation by an Assistant or Special Assistant Attorney General.

NDCC § 23-42-02 requires that prior to April 1 of each year, that the advisory committee evaluate the effectiveness of the plan and propose any necessary changes to the executive committee. In addition, NDCC § 23-42-07 requires that at least once a biennium the executive committee will provide for an independent review of the comprehensive plan to assure the plan is consistent with the Centers for Disease Control and Prevention Best Practices for Comprehensive Tobacco Control Programs. A report of that review will be sent to the Governor and the State Health Officer before September 1 in each odd numbered year.

State law provides that the Legislative Audit and Fiscal Review may ask for a performance audit. NDCC § 54-10-01(4) provides that the State Auditor shall: Perform or provide for performance audits of state agencies as determined necessary by the state auditor or the legislative audit and fiscal review committee. A performance audit must be done in accordance with generally accepted auditing standards applicable to performance audits.

In addition, public health experts routinely monitor the smoking rates of adults and youth. After North Dakota's CDC based program is fully implemented and a reasonable period of time has passed, legislators and the public will have an opportunity to judge this program based on outcomes and results. That will be the ultimate measure of accountability.

Requested Funding and FTEs

Senate Human Services Amendments

Attachment B is the requested budget approved by the Senate Human Services Committee. The substantive amendments adopted by the Senate Human Services Committee include:

- Establish language affirming that the Advisory Committee is a state agency and will be subject to the same controls and rules as other state agencies and must report to the Legislative Council.
- Provides for retroactive spending authority to allow the Committee to provide for reimbursement for work and expenses completed and pay for future expenses including a consultant to continue the work on the plan so the 180 day deadline can be met.
- Provides an emergency clause to allow the Committee to access the money immediately.
- Allocates 4 FTEs for the Committee's work.

Measurable Outcomes

The programs implemented with the Tobacco Prevention and Control Trust Funds will sharply reduce smoking and other tobacco use in the state. The number of people in the state who suffer and die prematurely because of smoking and other tobacco use will be reduced. Our work force and our children will be healthier. We will save money by reducing government, business, and household costs caused by smoking and other tobacco use.

A comprehensive statewide tobacco prevention and control program is a coordinated effort to establish smoke-free policy and social norms, to promote and assist tobacco users to quit and to prevent youth from starting tobacco use. Research indicates greater effectiveness with multi-component interventions that are integrated. The more the state invests, the greater the reduction in smoking—and the longer the state invests, the greater and faster the impact. For example, in California, home of the longest running comprehensive program, smoking rates among adults declined from 22.7 percent in 1998 to 13.3 percent in 2006. As a result, compared with the rest of the country, heart disease deaths and lung cancer

incidence in California have declined at accelerated rates. Among women in California, the rate of lung cancer deaths decreased while it continued to increase in other parts of the country. Since 1998, lung cancer incidence in California has been declining four times faster than in the rest of the nation. The tobacco use epidemic can be stopped. We know these programs work.

In 2007, the Institute of Medicine of the National Academies of Sciences, the President's Cancer Panel, and the CDC each issued reports that concluded there is overwhelming evidence that comprehensive state tobacco prevention programs substantially reduce tobacco use and recommended that every state fund its program at the CDC-recommended level. Since these reports, even more evidence has accumulated on the power of state investments in tobacco prevention and cessation. For example, earlier studies found that for every dollar spent, state tobacco prevention programs can, in their early years, save $3.00 or more just in reduced state health care expenditures. New research has strengthened those findings, demonstrating that state programs secure even larger returns on investment if tobacco prevention programs are sustained for over ten or more years at adequate levels. In California's tobacco prevention program they found that for every dollar the state spent on its tobacco control program, the state saved $50 in total healthcare costs. This study confirms that the cost-saving benefits from sustained state investments in effective tobacco control programs quickly grow over time to dwarf the state expenditures; producing massive gains for the state not only in terms of improved public health and increased worker productivity but in reduced government, business, and household costs. Because of this legislation, North Dakota is posed on the brink to realize similar results.

According to a report issued by the *Campaign for Tobacco Free Kids* in September 2008, fully funding North Dakota's tobacco prevention and cessation efforts at the CDC-recommended level will have a significant impact on the health and economy of the state. The report states that a fully funded tobacco prevention program would:

- ***Reduce youth smoking by 12.7%;***
- ***Stop 4,570 North Dakota kids from becoming addicted adult smokers;***
- ***Save 1,460 kids from dying from smoking;***
- ***Prompt more than 3,480 current adult smokers to quit for good; and***
- ***Save more than 920 North Dakota adults from dying prematurely from smoking.***

In terms of fiscal impact, the report states that fully funding the state tobacco prevention program with average results would strengthen the state's economy by increasing worker productivity and reducing future smoking-caused health

care and smoking-caused other costs in the state by more than $113 million after five years. "Using conservative, research-based estimates, the smoking declines from a comprehensive Best Practice program will lock-in more than $113 million in future smoking-caused health expenditure reductions, including more than $11.9 in future cuts to state Medicaid program expenditures." The projections would grow even larger after the first five years of a fully-funded program.

Research shows that that on average in North Dakota, the impact of a fully-funded program would reduce adult smoking by 1,200 in the first year. These adult smoking reductions would continue to grow each year the program is in place. The 5-year heart-stroke savings would be $1.1 million and 5-year pregnancy savings would be $920,000. North Dakota's health care costs would be reduced by approximately $2.0 million in the first five years just from fewer smoking-caused heart attacks, strokes and fewer smoking-affected births.

We are fortunate to live in North Dakota where our economy is good. Investing in tobacco prevention and control as the people directed by enacting Measure 3 will create future health care savings that can be dedicated to other state efforts in the future when our economy may not be as strong.

Thank you. I would be happy to answer any questions you may have.

Attachment A – Tobacco Advisory Committee and Executive Committee
Attachment B – *Best Practices for Comprehensive Tobacco Control Programs – North Dakota*
Attachment C – North Dakota Tobacco Prevention and Control Funding by Best Practice Category

See Kathy's other testimony for attachments

Testimony on SB 2063
February 13, 2009
North Dakota Nurses Association
Wanda Rose PhD, RN,BC

Chairman Holmberg and Members of the Senate Appropriations Committee

I am Dr. Wanda Rose, President of the North Dakota Nurses Association and a volunteer lobbyist for the North Dakota Nurses Association.

North Dakota Nurses Association supports full funding of SB 2063.

As nurses, we see daily the damage and devastation that tobacco has caused many human beings. In North Dakota we now we have a historical opportunity to invest in a comprehensive tobacco prevention and control program at the level which the Centers of Disease Control recommends. With sustained implementation of such a program, North Dakota can expect a marked reduction in adult and youth tobacco use prevalence; lives saved from the ravages of tobacco use; and tremendous cost savings to society. This work is so very important and must begin as swiftly as possible. North Dakota Nurses Association supports full funding for tobacco prevention and control, as North Dakota citizens chose last November; the ability to use these funds as expediently as possible; and the appropriations for our public-health and tobacco-prevention professionals to make the crucial decisions regarding the specific details of the new program.

Written Testimony

American Lung Association of North Dakota

Senate Bill 2063

A BILL for an Act to provide an appropriation for defraying the expenses of the comprehensive tobacco control advisory committee.

Before the Appropriations Committee

North Dakota Senate

Friday, February 13, 2009

The American Lung Association of North Dakota's (ALAND) mission is the "prevention and control of lung disease." We know that in order to accomplish this mission we need to work together to reduce the harm and destruction caused by the use of tobacco in North Dakota. Not a day goes by that we don't hear the family stories of loved ones lost to tobacco and the resolve to make things different for our children and grandchildren. A yes, vote for Senate Bill 2063 will do just that.

We no longer have to wonder what can make a difference. The U.S. Centers for Disease Control has researched and published "Best Practices for Comprehensive Tobacco Control Programs 2007". This document is the foundation and framework for the statewide tobacco control program that will result from these funds.

North Dakota is leading the way for the nation with these efforts to utilize the dollars from the tobacco settlement for tobacco control and prevention. Truly, this vote will serve as a beacon across the country on how these funds were meant to be used.

The American Lung Association of North Dakota urges you to appropriate these funds to save lives.

A

DR. Herbert J. Wilson

Testimony
SB No. 2063
House Appropriations Committee, Human Resources Division
March 10, 2009 2:15 p.m.

Good afternoon, Chairman Pollert and members of the Human Resources Division of the House Appropriations Committee. My name is Kathleen Mangskau and I am the chair of the Tobacco Prevention and Control Advisory Committee. I am here to provide information on how the funds appropriated in SB 2063 will be spent and accounted for. The law passed by the voters in November 2008 directs that the funds in the tobacco prevention and control trust fund be spent to develop and implement a statewide, comprehensive Center for Disease Control and Prevention (CDC)-based best practice tobacco prevention and control program. My testimony includes information on the need for the program, the progress of the advisory committee to date, the best practice categories, the current levels of funding in the best practice categories and how the funds will be used to meet the recommended programming and levels of spending.

The Need for a Comprehensive Tobacco Prevention and Control Program
We all know many people who have been impacted by tobacco use suffering from heart or lung disease, or other associated cancers or by the premature death of a loved one. At the first advisory committee meeting, I was struck by the overwhelming impact tobacco use had on the members of the advisory committee and the families and their motivation for wanting to be part of the committee. The toll of tobacco in North Dakota is high and rising health care costs are a concern to many North Dakotans. At the current level of funding for tobacco control efforts in the state, tobacco use continues to kill more than 900 North Dakota residents every year and costs the state $250 million in annual excess health care costs, including $47 million a year in state Medicaid program costs. State productivity losses from smoking total an additional $192 million each year. According to the *North Dakota Behavioral Risk Factor Survey*, one in five adults in North Dakota smoke, a rate that has changed very little for a more than a decade. The *North Dakota Youth Risk Behavior Survey* indicates that more than one in five kids (21%) still smoke, and one in five high school males (20%) use spit tobacco. These North Dakota youth tobacco use rates are all higher than the national rates. While North Dakota has made significant strides in reducing youth tobacco use; the tobacco use problem clearly is not solved. The decline in youth rates has flattened and without additional resources and programming, we will not see major changes in those rates. The 2007 Institute of Medicine Report concluded that to effectively reduce tobacco use, "states must maintain over time a comprehensive integrated tobacco

control strategy." Research shows that the more states spend on sustained comprehensive tobacco control programs, the greater the reductions in smoking—and the longer states invest in such programs, the greater and faster the impact. North Dakota voters chose to implement a comprehensive strategy when they enacted Measure 3.

The Tobacco Prevention and Control Advisory Committee has primary goals of preventing youth from starting to use tobacco, helping youth and adults to quit tobacco use, eliminating exposure to secondhand smoke and identifying and eliminating tobacco use disparities. Implementing evidence-based, statewide tobacco control programs that are comprehensive, integrated, sustained and accountable have been shown to reduce smoking rates, tobacco-related deaths, and diseases caused by smoking. These programs will prevent or accelerate declines in heart disease, lung diseases and disorders, and once again make lung cancer a rare disease. A comprehensive approach combines educational, clinical, regulatory, economic and social strategies. The plan will have well-defined goals, objectives, and short-term, intermediate and long-term indicators of success.

To be effective and achieve the desired results the program must be comprehensive. When treating cancer, a recommended treatment regimen may include chemotherapy, radiation, surgery and the support of family and friends. If we remove the chemotherapy, we do not get the intended results. Likewise in a comprehensive approach, removing a component, or using strategies that are not best practices or evidence-based will impair the committee's ability to reach the desired outcomes.

Progress of Tobacco Prevention and Control Advisory Committee

Governor Hoeven promptly appointed the nine-member advisory committee in December 2008. The appointments became official on January 1, 2009. The Committee convened its first meeting on January 8, 2009 and elected the executive committee and chair, set their meeting dates, determined their operating procedures, and initiated research into best practice approaches in order to prepare for Legislative requests for information and to meet the time constraints (180 days) to develop the plan. The amendment passed by the Senate that requests retroactive spending authority will allow the committee to conduct its business and meet that deadline. The CDC provided training on the Best Practice approach for the advisory committee members, local tobacco coordinators and local coalition leaders/members and other interested parties in North Dakota on February 20, 2009. The CDC has designated a consultant to assist the state with development of the plan for a comprehensive program. The advisory committee has scheduled meetings to be held as frequently as every other week until the plan is completed.

A timeline for plan development has been completed. The committee will use the previous and current state tobacco plans as a foundation for the comprehensive plan. Additional meetings of the committee have focused on understanding the history of the tobacco control funding in North Dakota, educating the committee on the open records/open meeting responsibilities of state agencies, training on best practices and developing expert panels for each of the best practice components. The state and community component panel has started working on the development of that portion of the plan and already have some of their objectives in place. Representatives from the Health Department's Tobacco Prevention and Control Division participate in the meetings to develop the plan and also attend the advisory committee meetings. See attachment A for a list of the Advisory Committee and Executive Committee members.

The Executive Committee meets weekly and has outlined the roles and responsibilities of the members, reviewed tobacco-related legislation, created a timeline for development of the plan, acquired Best Practice resources and scheduled training, and developed a list of competencies for staff that will be necessary to carry out the work of implementing the plan.

The Executive Committee met with staff from the North Dakota Department of Health to work through the roles and responsibilities of each agency so we can be effective and do not duplicate or supplant efforts as required by NDCC § 23-42-05. There was a fairly high level of agreement as to which agency could carry out each function most efficiently and effectively. This information will be useful as we commit. You will move to balance responsibilities between the Department of Health and the Advisory Committee. I will outline that information in more detail as I discuss the best practice categories.

Current Funding and Funding Needed

A fact sheet on the CDC Best Practices recommended annual investment for North Dakota is included as Attachment B. The table below shows that North Dakota, with a combination of state tobacco settlement revenues and federal funds, currently spends around $4.4 million per year on tobacco prevention and control efforts, less than one-half (47%) of the $9.3 million the CDC recommends for a comprehensive tobacco control program each year. Moreover, the percentage spent on tobacco prevention and control efforts may be slightly overestimated as 100 percent of the Community Health Trust Fund state aid funding to local health departments is not spent on tobacco prevention and control programming.

A comparison of the recommended per capita spending and the current level of tobacco control spending in North Dakota in 2008 provided by the State Health

Department shows that the program is sadly underfunded in many categories and thus North Dakota has not been able to make the progress necessary to protect our citizens and significantly reduce the health and economic burden of tobacco use in the state. Measure 3 allocated just enough money to get the job done.

North Dakota Tobacco Control Expenditures by Best Practice Category in 2008

	Per Capita Recommendation	ND Spending	Percentage of Recommendation ND Spends
State and Community Interventions	$ 7.37	$3.90	53%
Health Communication Interventions	$ 1.86	$0.27	15%
Cessation Interventions	$ 3.52	$1.14	32%
Surveillance and Evaluation	$ 1.28	$0.15	12%
Administration and Management	$ 0.64	$0.75	101%
*Other Funds in ND (State Aid)		$0.74	
Total	**$14.67**	**$6.95**	**47%**

It has been stated that North Dakota already spends $97 million per biennium to prevent risky behaviors. The report prepared by the Legislative Council outlining the expenditures on risk-associated behavior prevention programs shows that the vast majority of those dollars are spent for treatment. A recent study by the Governor's Prevention Advisory Council on Drugs and Alcohol reports prevention funding at a much lower level. The large amount spent on treatment is further evidence of the need to do more to prevent disease and addiction. A Best Practice approach in tobacco control focuses on funding prevention strategies rather than treatment, thus preventing many of the chronic diseases and cancers caused by tobacco use and thus resulting in health care cost savings.

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currently is, and the Health Department funded tobacco programs are best practice approaches, the funding should support programs for more than 16 years.

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outcomes of state tobacco control programs and interventions provide the background for what works in reducing tobacco use and its toll. In addition, national initiatives from the National Institutes of Health, the Substance Abuse and Mental Health Services Administration and the Agency for Healthcare Research and Quality that supported innovative intervention studies have been used to determine effective interventions. Pages 16-18 of *The Best Practices for Comprehensive Tobacco Control Programs* provide a listing of the resources and references that were used to develop the Best Practice guidance document. The list includes a broad array of public, private and non-profit groups that have conducted the research. The 2007 Institute of Medicine report presented a blueprint for action to "reduce smoking so substantially that it is no longer a public health problem for our nation." The recommendations go on to list as foremost among the recommendations is that each state should fund a comprehensive best practice tobacco control program at the level recommended by the Centers for Disease Control and Prevention.

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What do the findings mean? The California Tobacco Control Program has been successful in reducing smoking in California in comparison to other states, and has reduced personal health care expenditures. These cost reductions are substantial, rapid, and grew over time. The focus on social norm change among adults, not primarily on youth prevention, is responsible for such rapid and large reductions in disease and health care costs. The law passed by the voters in November 2008 makes it possible for North Dakota to have the opportunity to implement a comprehensive best practice tobacco prevention and control program and produce outcomes similar to those in California with significant health care savings.

Best Practice Components

State and Community Interventions

Coordinated and combined intervention efforts of statewide and local programs working together have the greatest long-term impact. This component supports the state and local community effort to mobilize coalitions to develop state and community level programs and policies to counter pervasive pro-tobacco influences. At the current tobacco control funding level, many counties in the state do not have enough funding to maintain staffing to carry out tobacco prevention activities, youth programs that include tobacco prevention activities, and implement culturally appropriate interventions. The new funds from the trust can be used to enhance support to local and tribal programs, law enforcement, and agencies that can conduct programs reaching specific populations with high tobacco use rates such as Native Americans, pregnant women, lower socio-economic populations and the school to work population aged 18-30. Greater emphasis needs to be placed on engaging communities and providing training so local communities implement policies and strategies to reduce tobacco use. As evidence-based programs are implemented, additional efforts to collaborate with other chronic disease programs and support efforts to promote prevention programs and cessation efforts would create synergy of consistent health promotion messages and multiple avenues to provide services. This component will be jointly implemented by the Tobacco Advisory Committee and the State Health Department.

Health Communication Interventions

There is strong evidence that sustained earned and paid media in combination with other interventions and strategies is effective in reducing tobacco use. Exposure to counter marketing ads is associated with greater pro-health attitudes and beliefs and produces significant declines in smoking rates among adults and youth as well as slowing initiation among youth. Paid media is also needed to recruit target populations with high tobacco use rates to the quitline and local cessation programs. Currently, no funding is available for statewide media efforts to educate youth and very limited funding is available to educate the public about the dangers of secondhand smoke. Funding can also be used to provide greater outreach of the quitline services and to conduct market research so public education efforts can be effectively targeted. Health communication messages that are sustained and appropriately targeted can greatly impact health behaviors. This component will be implemented by the Tobacco Prevention and Control Advisory Committee.

Cessation

Interventions to increase cessation encompass a broad array of policy, system, and population-based measures. Services provided by the statewide quitline and local

cessation programs need to expanded and promoted. Promoting coverage for tobacco dependence treatment under both public and private insurance will increase the number of individuals receiving treatment. Individual and group counseling and coverage of all FDA approved medications will enhance current efforts. Currently only limited medications are provided. Eliminating cost and other barriers to treatment for underserved populations as well as making health systems changes to effectively reach all at risk populations will work to reduce tobacco use. Funding training for a systems approach for health professionals in the use of the Public Health Service Guidelines and for the quitline and local cessation services will reach more tobacco users and increase the number who successfully quit. This component will be implemented primarily by the Department of Health.

Surveillance and Evaluation

This component develops systems to monitor attitudes, behaviors and health outcomes and demonstrate accountability for the funds and effectiveness of programs. Surveillance systems are used to assess the prevalence of tobacco use, exposure to secondhand smoke, track trends and identify disparities and measure progress in eliminating those disparities. It includes the evaluation of health communication efforts, cessation and community interventions and conducting surveys such as the Youth Tobacco Survey, Adult Tobacco Survey and the inclusion of tobacco questions in the Behavior Risk Factor Survey, the Youth Risk Behavior Survey and surveys regarding cessation and quitline services. Funding is needed to enhance the data collection efforts by the Department of Health to enable them to gather data on specific population groups such as Native Americans and other groups with high tobacco use as well as to increase their sample size to get estimates for local counties or other geographic breakdowns. The funding will support additional evaluation of programs and services and could provide for outside evaluation of the statewide quitline and other program activities. Current funding has limited the program primarily to process evaluation. With the new funding we will be able to conduct outcome evaluation and provide the program the capability to look at changes over time in diseases caused by tobacco use and secondhand smoke. This component will be jointly implemented. The Department of Health will be responsible for the surveillance and the Tobacco Advisory Committee will be responsible for the evaluation.

Administration and Management

This component provides support to employ qualified state staff for oversight, training and technical assistance to local programs. It includes coordinating statewide programs such as the quitline and collaboration with partners for public education efforts, strategic planning and provides for real time fiscal management,

effective communication, education of decision makers on the health effects of tobacco and evidence-based effective programs and policy interventions. The state has used primarily CDC funding to develop a cadre of staff and contractors capable of carrying out these functions. The grants program would coordinate closely with the state program on training and technical assistance efforts. Minimal funding would be needed to support the staff to manage the grants program and evaluation. This component will be jointly implemented.

The specific programs and projects that will be funded in each component will be determined by the Advisory Committee based on the comprehensive Best Practice plan.

Accountability

There are multiple measures in place to assure accountability of this new state entity. The Advisory Committee is appointed by the Governor and members can be removed for malfeasance in office (NDCC § 23-42-02). Like other state agencies, this state agency will be subject to the Office of Management and Budget fiscal controls and fiscal reporting requirements, audit procedures and other state requirements including state personnel laws, procurement laws, record management requirements, open meeting and record laws, and mandated legal representation by an Assistant or Special Assistant Attorney General.

NDCC § 23-42-02 requires that prior to April 1 of each year, that the advisory committee evaluate the effectiveness of the plan and propose any necessary changes to the executive committee. In addition, NDCC § 23-42-07 requires that at least once a biennium the executive committee will provide for an independent review of the comprehensive plan to assure the plan is consistent with the Centers for Disease Control and Prevention Best Practices for Comprehensive Tobacco Control Programs. A report of that review will be sent to the Governor and the State Health Officer before September 1 in each odd numbered year.

State law provides that the Legislative Audit and Fiscal Review may ask for a performance audit. NDCC § 54-10-01(4) provides that the State Auditor shall: Perform or provide for performance audits of state agencies as determined necessary by the state auditor or the legislative audit and fiscal review committee. A performance audit must be done in accordance with generally accepted auditing standards applicable to performance audits.

In addition, public health experts routinely monitor the smoking rates of adults and youth. After North Dakota's CDC based program is fully implemented and a reasonable period of time has passed, legislators and the public will have an

opportunity to judge this program based on outcomes and results. That will be the ultimate measure of accountability.

Requested Funding and FTEs
Senate Amendments
Attachment [redacted] is the requested budget approved by the Senate. The substantive amendments adopted include:

- Establish language affirming that the Advisory Committee is a state agency and will be subject to the same controls and rules as other state agencies and must report to the Legislative Council.
- Provides for retroactive spending authority to allow the Committee to provide for reimbursement for work and expenses completed and pay for future expenses including a consultant to continue the work on the plan so the 180 day deadline can be met.
- Provides an emergency clause to allow the Committee to access the money immediately.
- Allocates 4 FTEs for the Committee's work.

Measurable Outcomes
The programs implemented with the Tobacco Prevention and Control Trust Funds will sharply reduce smoking and other tobacco use in the state. The number of people in the state who suffer and die prematurely because of smoking and other tobacco use will be reduced. Our work force and our children will be healthier. We will save money by reducing government, business, and household costs caused by smoking and other tobacco use.

A comprehensive statewide tobacco prevention and control program is a coordinated effort to establish smoke-free policy and social norms, to promote and assist tobacco users to quit and to prevent youth from starting tobacco use. Research indicates greater effectiveness with multi-component interventions that are integrated. The more the state invests, the greater the reduction in smoking—and the longer the state invests, the greater and faster the impact. For example, in California, home of the longest running comprehensive program, smoking rates among adults declined from 22.7 percent in 1998 to 13.3 percent in 2006. As a result, compared with the rest of the country, heart disease deaths and lung cancer incidence in California have declined at accelerated rates. Among women in California, the rate of lung cancer deaths decreased while it continued to increase in other parts of the country. Since 1998, lung cancer incidence in California has

been declining four times faster than in the rest of the nation. The tobacco use epidemic can be stopped. We know these programs work.

In 2007, the Institute of Medicine of the National Academies of Sciences, the President's Cancer Panel, and the CDC each issued reports that concluded there is overwhelming evidence that comprehensive state tobacco prevention programs substantially reduce tobacco use and recommended that every state fund its program at the CDC-recommended level. Since these reports, even more evidence has accumulated on the power of state investments in tobacco prevention and cessation. For example, earlier studies found that for every dollar spent, state tobacco prevention programs can, in their early years, save $3.00 or more just in reduced state health care expenditures. New research has strengthened those findings, demonstrating that state programs secure even larger returns on investment if tobacco prevention programs are sustained for over ten or more years at adequate levels. In California's tobacco prevention program they found that for every dollar the state spent on its tobacco control program, the state saved $50 in total healthcare costs. This study confirms that the cost-saving benefits from sustained state investments in effective tobacco control programs quickly grow over time to dwarf the state expenditures; producing massive gains for the state not only in terms of improved public health and increased worker productivity but in reduced government, business, and household costs. Because of this legislation, North Dakota is posed on the brink to realize similar results.

According to a report issued by the *Campaign for Tobacco Free Kids* in September 2008, fully funding North Dakota's tobacco prevention and cessation efforts at the CDC-recommended level will have a significant impact on the health and economy of the state. The report states that a fully funded tobacco prevention program would:

- ***Reduce youth smoking by 12.7%;***
- ***Stop 4,570 North Dakota kids from becoming addicted adult smokers;***
- ***Save 1,460 kids from dying from smoking;***
- ***Prompt more than 3,480 current adult smokers to quit for good; and***
- ***Save more than 920 North Dakota adults from dying prematurely from smoking.***

In terms of fiscal impact, the report states that fully funding the state tobacco prevention program with average results would strengthen the state's economy by increasing worker productivity and reducing future smoking-caused health care and smoking-caused other costs in the state by more than $113 million after five years. "Using conservative, research-based estimates, the smoking declines from a comprehensive Best Practice program will lock-in more than $113 million

in future smoking-caused health expenditure reductions, including more than $11.9 in future cuts to state Medicaid program expenditures." The projections would grow even larger after the first five years of a fully-funded program.

Research shows that that on average in North Dakota, the impact of a fully-funded program would reduce adult smoking by 1,200 in the first year. These adult smoking reductions would continue to grow each year the program is in place. The 5-year heart-stroke savings would be $1.1 million and 5-year pregnancy savings would be $920,000. North Dakota's health care costs would be reduced by approximately $2.0 million in the first five years just from fewer smoking-caused heart attacks, strokes and fewer smoking-affected births.

We are fortunate to live in North Dakota where our economy is good. Investing in tobacco prevention and control as the people directed by enacting NDCC § 23-42- will create future health care savings that can be dedicated to other state efforts in the future when our economy may not be as strong.

Thank you. I would be happy to answer any questions you may have.

Attachment A – Tobacco Advisory Committee and Executive Committee
Attachment B – *Best Practices for Comprehensive Tobacco Control Programs – North Dakota*
Attachment C – North Dakota Tobacco Prevention and Control Funding by Best Practice Category

Given to Senate Human Services 1-20-09
See attachments to many slides testimony

Attachment A

North Dakota Tobacco Prevention and Control Advisory Committee | 2009

Member Name	Address	County	LD	Phone	Employer	Job title	E-Mail	Appt. Date	Term Ends
acobson, orraine	14055 Highway 13 Milnor ND 58060	Sargent	26	427-5432 W 427-5432 H	Sargent Cty Dist H	Tobacco Prevention Coordinator	ljacobson@nd.gov	1-1-09	6-30-10
Klein, Dale L., MD	Q&R Clinic 9010 NW 18th Street Mandan, ND 58554	Morton	34	661-5088W 663-0053 H	MC1 Health Systems	Family Physician	dklein@mohs.org	1-1-09	6-30-10
Idstrom, Dermit	630 Remington Ave Bismarck ND 58503	Burleigh	47	258-0191 H	AARP	Executive Council	KL4530@hotmail.com	1-1-09	6-30-11
Mangskau, Cathy	98 Country Club Drive Bismarck, ND 58504	Burleigh	8	258-7919 W 258-7919 H	Self-employed	Public Health Consultant	kmconsult@btinet.net	1-1-09	6-30-11
Marion, Nathan	506 Stuttgart Drive Bismarck ND 58504	Burleigh	30	426-7879 W 255-7793 H	T.G.I. Fridays	Host	nate.marion@live.com	1-1-09	6-30-09
McGeary, Pat	2601 Astronaut Drive Bismarck ND 58503	Burleigh	47	355-1597 W 224-1005 H	Bismarck Burleigh Public Health	RN	pmcgeary@nd.gov	1-1-09	6-30-11
Oyloe, Javayne	712 4th Str W Williston, ND 58801	Williams	1	774-6409 W 572-2294 H	Upper Missouri Dist Health Unit	Health Promo Team Leader	joyloe@umdhu.org	1-1-09	6-30-09
Prom, Jeanne	2015 N 16th Street #12 Bismarck ND 58501	Burleigh	35	202-6363 W 255-1519 H	Self Employed	Public Health Consultant	Jeanne679@bis.midco.net	1-1-09	6-30-09
Taylor, Jay	4026 153rd Ave SE Durbin, ND 58059	Cass	22	234-6460 W 347-4493 H	MeritCare Health Systems	Respiratory Therapist	Jay.taylor@meritcare.com	1-1-09	6-30-10

Executive Committee: Kathy Mangskau, Chair
Pat McGeary
Javayne Oyloe

1-22-09

Attachment C

Tobacco Prevention and Control Funding
By Best Practice Category
Estimated for 2009-2011
As adopted by Senate Human Services Committee

Best Practice Category	Recommended Funding Level	Recommended Funding Range	CDC Funding	Community Health Trust Funding	Tobacco Trust Funding
State and Community Interventions	$ 9,300,000	$8,400,000 - $13,600,000	$ 1,614,880	$ -	$ 7,685,120
Health Communications Interventions	$ 2,418,000	$1,600,000 - $5,000,000	$ 432,500	$ -	$ 1,985,500
Cessation Interventions	$ 4,464,000	$2,600,000 - $6,600,000	$ 160,640	$ 3,093,000	$ 1,680,360
Surveillance and Evaluation	$ 1,674,000	$1,200,000 - $2,600,000	$ 216,526	$ 155,000	$ 1,302,474
Administration and Management	$ 744,000	$600,000 - $1,200,000	$ 375,454	$ 140,000	$ 228,546
Total	$ 18,600,000	$14,400,000 - $29,000,000	$ 2,800,000	$ 3,388,000	$ 12,882,000

SB2063 Appropriation-Legal Requirement

Mangskau, Kathleen A.

Sent: Thursday, March 12, 2009 2:11 PM

To: Pollert, Chet A.; Bellew, Larry D.; Kreidt, Gary L.; Nelson, Jon O.; Wieland, Alon C.; Ekstrom, Mary O.; Kerzman, James A.; Metcalf, Ralph E.

Attachments: Measure 3 codified.doc (36 KB)

Chairman Pollert and Members of the House Appropriations Human Resources Division:

At the hearing today on SB 2004 we discussed the paramters of funding set by Measure 3. I may have confused the committee with my answer and wanted to share with you the legal requirement set by the statute. The statute requires that the funding be at the CDC recommended level or above and not at either extreme of the range. The CDC recommended level is currently $9.3 million. I have highlighted the language in the attached statute and pasted it below.

The measure allocated the money to the trust fund and the Legislature appropriates the funds. The amount of the appropriation was set by the statute at the CDC recommended level which I attached in my original testimony for you as Attachment B.

NDCC 23-43-05

The comprehensive plan must be funded at a level equal to or greater than the centers for disease control recommended funding level. Funding for the comprehensive plan must supplement and may not supplant any funding that in the absence of this chapter would be or has been provided for the community health trust fund or other health initiatives.

I apologize if this caused confusion.

Thank you.

Kathleen Mangskau, RDH, MPA
Chair, Tobacco Prevention and Control Advisory Committee
Phone: 701-258-7919
E-mail: kmangskau@nd.gov

MEASURE 3
Effective December 4, 2008

CHAPTER 23-42
TOBACCO PREVENTION AND CONTROL PROGRAM

23-42-01. Definitions. As used in this chapter:

1. "Advisory committee" is the nine-member tobacco prevention and control advisory committee responsible to develop the comprehensive plan.
2. "Comprehensive plan" means a comprehensive statewide tobacco prevention and control program that is consistent with the centers for disease control best practices for comprehensive tobacco prevention and control programs and does not duplicate the work of the community health grant program created in chapter 23-38.
3. "Executive committee" means the three-member committee selected by the advisory committee and charged with implementation and administration of the comprehensive plan.
4. "Tobacco prevention and control fund" consists of all principal and interest of the tobacco prevention and control trust fund established by section 54-27-25.

23-42-02. Tobacco prevention and control advisory committee - Membership - Terms - Duties - Removal.

1. The advisory board consists of nine North Dakota residents appointed by the governor for three-year terms as follows:
   a. A practicing respiratory therapist familiar with tobacco-related diseases;
   b. Four nonstate employees who have demonstrated expertise in tobacco prevention and control;
   c. A practicing medical doctor familiar with tobacco-related diseases;
   d. A practicing nurse familiar with tobacco-related diseases;
   e. A youth between the ages of fourteen and twenty-one; and
   f. A member of the public with a previously demonstrated interest in fostering tobacco prevention and control.
2. The governor shall select the youth and public member independently; the respiratory therapist from a list of three nominations provided by the North Dakota society for respiratory care; the four tobacco control experts from a list of two nominations per member provided by the North Dakota public health association's tobacco control section; the medical doctor from a list of three nominations provided by the North Dakota medical association; and the nurse from a list of three nominations provided by the North Dakota nurses association. The governor must make the appointments within three weeks of receiving the respective list of nominees. If the governor fails to make an appointment within three weeks, the association that provided the list of nominees shall select the committee member. In the initial appointments for the advisory committee, the governor shall stagger the terms of the members so that the terms of three members expire each fiscal year and that three members are appointed each year by June thirtieth. Accordingly, the governor's initial appointments, in some instances, must be for terms less than three years. The governor shall fill vacancies for the unexpired term as provided in this section.
3. No individual may serve more than two consecutive three-year terms. However, terms of less than three years are not considered in determining an individual's eligibility for reappointment.
4. A quorum of the advisory committee is required to conduct business, but the advisory committee may conduct a meeting with less than a quorum present. A quorum is a majority of the members of the committee. Any action taken requires a vote of the majority of the members present at the meeting.

5. The advisory board shall:

a. Select the executive committee;

b. Fix the compensation of the advisory committee and the executive committee. However, compensation may not exceed compensation allowed to the legislature. Advisory and executive committee members are entitled to reimbursement for mileage and expenses as provided for state officers in addition to any compensation provided;

c. Develop the initial comprehensive statewide tobacco prevention and control program that includes support for cessation interventions, community and youth interventions, and health communication; and

d. Evaluate the effectiveness of the plan and its implementation and, before April first of each year, propose any necessary changes to the plan to the executive committee.

6. The governor may remove any member of the advisory committee for malfeasance in office, but the advisory committee is not subject to section 54-07-01.2.

7. No nomination to, or member of, the advisory committee shall have any past or current affiliation with the tobacco industry or any industry, contractor, agent, or organization that engages in the manufacturing, marketing, distributing, sale, or promotion of tobacco or tobacco-related products.

23-42-03. Executive committee. The executive committee of the advisory committee consists of three individuals selected by the advisory committee from its membership. The term of each member is for three years. The initial terms of the members must be staggered so that one member serves a three-year term, one member serves a two-year term, and one member serves a one-year term. The determination of initial terms shall be by lot. No individual may serve more than two consecutive three-year terms. However, terms of less than three years are not considered in determining an individual's eligibility for reappointment. The advisory committee shall fill vacancies for the unexpired term. An individual selected to serve on the executive committee is no longer eligible to serve if that individual is not a member of the advisory committee. The executive committee is responsible for the implementation and administration of the comprehensive plan, including the appropriateness of expenditures to implement the comprehensive plan. The executive committee may seek the counsel and advice of the advisory committee in implementing the plan, but the executive committee is the final decision maker.

23-42-04. Powers of the executive committee. To implement the purpose of this chapter and, in addition to any other authority granted elsewhere in this chapter, to support its efforts and implement the comprehensive plan, the executive committee may employ staff and fix their compensation, accept grants, property, and gifts, enter contracts, make loans, provide grants, borrow money, lease property, provide direction to the state investment board for investment of the tobacco prevention and control fund, and take any action that any private individual, corporation, or limited liability company lawfully may do except as restricted by the provisions of this chapter.

23-42-05. Development of the comprehensive plan. The advisory committee shall develop the initial comprehensive plan within one hundred eighty days of the initial meeting of the advisory committee. The comprehensive plan must be funded at a level equal to or greater than the centers for disease control recommended funding level. Funding for the comprehensive plan must supplement and may not supplant any funding that in the absence of this chapter would be or has been provided for the community health trust fund or other health initiatives.

23-42-06. Conflict of interest. No member of the advisory committee or of the executive committee who has a direct and substantial personal or pecuniary interest in a matter before them may vote or take any action on that matter.

23-42-07. Audit. At least once a biennium, the executive committee shall provide for an independent review of the comprehensive plan to assure that the comprehensive plan is consistent with the centers for disease control best practices. The executive committee shall report the results of that review to the governor and to the state health officer on or before September first in each odd-numbered year.

54-27-25. Tobacco settlement trust fund - Interest on fund - Uses.

1. There is created in the state treasury a tobacco settlement trust fund. The fund consists of the tobacco settlement dollars obtained by the state under subsection IX(c)(1) of the master settlement agreement and consent agreement adopted by the east central judicial district court in its judgment entered December 28, 1998 [Civil No. 98-3778] in State of North Dakota, ex rel. Heidi Heitkamp v. Philip Morris, Inc. Except as provided in subsection 2, moneys received by the state under subsection IX(c)(1) must be deposited in the fund. Interest earned on the fund must be credited to the fund and deposited in the fund. The principal and interest of the fund must be allocated as follows:
   a. Transfers to a community health trust fund to be administered by the state department of health. The state department of health may use funds as appropriated for community-based public health programs and other public health programs, including programs with emphasis on preventing or reducing tobacco usage in this state. Transfers under this subsection must equal ten percent of total annual transfers from the tobacco settlement trust fund of which a minimum of eighty precent must be used for tobacco prevention and control.
   b. Transfers to the common schools trust fund to become a part of the principal of that fund. Transfers under this subsection must equal forty-five percent of total annual transfers from the tobacco settlement trust fund.
   c. Transfers to the water development trust fund to be used to address the long-term water development and management needs of the state. Transfers under this subsection must equal forty-five percent of the total annual transfers from the tobacco settlement trust fund.
2. There is created in the state treasury a tobacco prevention and control trust fund. The fund consists of the tobacco settlement dollars obtained by the state under section IX(c)(2) of the agreement adopted by the east central judicial district court in its judgment entered December 28, 1998 [Civil No. 98-3778] in State of North Dakota, ex rel. Heidi Heitkamp v. Philip Morris, Inc. Interest earned on the fund must be credited to the fund and deposited in the fund. Moneys received into the fund are to be administered by the executive committee for the purpose of creating and implementing the comprehensive plan. If in any biennium, the tobacco prevention and control trust fund does not have adequate dollars to fund a comprehensive plan, the treasurer shall transfer money from the water development trust fund to the tobacco prevention and control trust fund in an amount equal to the amount determined necessary by the executive committee to fund a comprehensive plan.
3. Transfers to the funds under this section must be made within thirty days of receipt by the state.

My name is Melany Jenkins. I am the Associate Director of Program Services for the North Dakota Chapter and the lead Public Affairs staff.

The mission of the March of Dimes is to improve the health of babies by preventing birth defects, premature birth and infant mortality. I writing at this time to testify to you about a very important item related to our mission that directly affects the health of our tiniest North Dakotans, the bill SB 2063, which allocates how funds for tobacco control and prevention will be appropriated.

SB2063 exists to use tobacco settlement dollars for tobacco prevention and control in the state of North Dakota. This bill is important to North Dakotans as our most precious resources, our tiniest North Dakotans will be protected. **The March of Dimes asks that bill SB 2063 appropriate the state Tobacco Settlement payments to fully fund a CDC-based, comprehensive tobacco prevention and cessation program statewide that will; 1) commit funds to cover smoking prevention/cessation programs for pregnant women (Quitline, and Medicaid programs, etc.), 2) commit funds to cover costs of health warning signs, 3) earmark funds to cover training for physicians for 5A counseling for women of childbearing age.**

North Dakota's preterm birth rate at 11.5% is more than 50% higher than the Healthy People 2010 objective of 7.6% and has increased by nearly 14% between 1995 and 2005. While research continues as to the causes of preterm births and low birthweight babies, the state of North Dakota can address one of the known contributing factors of smoking and take measures toward prevention.

The first step in preventing preterm births and low birth weight babies is to identify the causes. **For 50% of preterm births the causes are unknown.** However, studies have shown that women who smoke have a higher risk of having a premature baby or a low birhtweight baby. Cigarette smoking during pregnancy poses many risks for pregnant women and their children, including increased risk of premature delivery. Smoking directly affects fetal growth, and as a result, increases the risk of a baby being born smaller or low birthweight. The harmful effects are directly linked to the amount and duration of smoking during pregnancy. Studies show that women who stop smoking before or early in pregnancy decrease their risk of having a low birthweight baby to nearly that of women who have never smoked. Women who stop smoking later in pregnancy can still significantly increase their chances of a healthy birth outcome.

Environmental exposure to tobacco products, passive or second-hand smoke, is also unhealthy for pregnant women and their newborns. Exposure to second-hand smoke during pregnancy and after birth increases the risk of sudden infant death syndrome (SIDS), which is a key contributor to infant mortality. In addition to perinatal effects, smoking is detrimental to the overall health of women and has been shown to cause lung disease, heart disease, and various cancers including cervical and lung cancer. According to the March of Dimes Prematurity Report card released November 2008, about 24.4% of women of childbearing age in North Dakota smoke that is 1 in 4. A fully funded, smoking prevention and cessation program plays a vital role in reducing the rate of preterm births and low birthweight babies in North Dakota and protecting a women's health.

March of Dimes believes in doing its part. The March of Dimes promotes the health benefits of smoking prevention and cessation by providing educational materials for consumers, promoting evidence-based smoking cessation methods, and encouraging research related to smoking cessation during pregnancy. However, this is far from enough to compensate for the growing need of maintaining a strong tobacco prevention and cessation program in the state to offset the increasing number of women of child bearing age who are smoking in North Dakota. Again, **March of Dimes asks that this committee support SB 2063 and appropriate Tobacco Settlement funds to fully fund the CDC-based, comprehensive tobacco prevention and cessation program that will; 1) cover smoking prevention and cessation programs for pregnant women, 2) cover costs of health warning signs, 3) cover training for physicians for a 5A counseling for women of childbearing age.**

On behalf of the March of Dimes, thank you for the opportunity to comment on the need for state tobacco Settlement dollars to be appropriated to fund tobacco prevention and cessation programs in North Dakota. We thank you for all that you do to protect and improve maternal and child health in North Dakota.

march of dimes

march of dimes

2008 Premature Birth Report Card

North Dakota
Preterm Birth Rate: **11.5%**
U.S. Rank: **16th**
Grade: **D***

North Dakota's preterm birth rate is more than 50% higher than the Healthy People 2010 objective of 7.6% and increased by nearly 14% between 1995 and 2005. Disparities exist among population subgroups. While research continues on the causes of preterm birth, the nation can address some contributing factors and prevention opportunities. Three of these are below.

Selected Contributing Factors	Rate (%)	Comments
Uninsured Women	**13.3%**	About 1 in 8 women of childbearing age in North Dakota has no health insurance coverage. Health care access before and during pregnancy can help identify and manage conditions that contribute to premature birth.
Women Smoking	**24.4%**	About 1 in 4 women of childbearing age in North Dakota is a smoker. Smoking cessation programs can reduce the risk of premature birth.
Late Preterm Births	**8.3%**	About 1 in 12 live births in North Dakota is late preterm (34-36 weeks gestation). The rise in late preterm births has been linked to rising rates of early induction of labor and c-sections.

March of Dimes Call for Action

1. We urge the federal government to increase support for prematurity-related research and data collection as recommended by the Institute of Medicine and the Surgeon General's Conference on the Prevention of Preterm Birth, to: (a) identify the causes of premature birth; (b) test strategies for prevention; (c) improve the care, treatment and outcomes of preterm infants; and (d) better define and track the problem of premature birth.
2. We urge federal and state policymakers to expand access to health coverage for women of childbearing age and to support smoking cessation programs as part of maternity care.
3. We call on hospitals and health care professionals to voluntarily assess c-sections and inductions which occur prior to 39 weeks gestation to ensure consistency with professional guidelines.
4. We call on the business community to create workplaces that support maternal and infant health.
5. We invite all concerned citizens to sign the 2008 "Petition for Preemies" at marchofdimes.com/petition and learn how you can help.

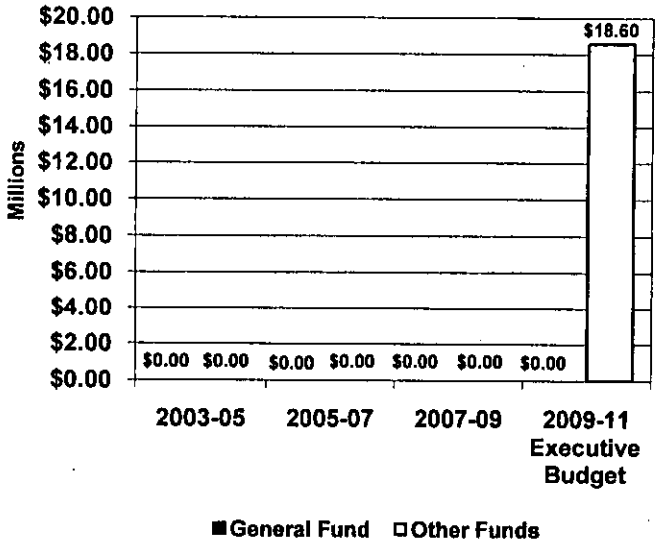
* Grade based solely on preterm birth rate, not on rates of contributing factors.

Prepared by the North Dakota Legislative Council staff for House Appropriations
March 4, 2009

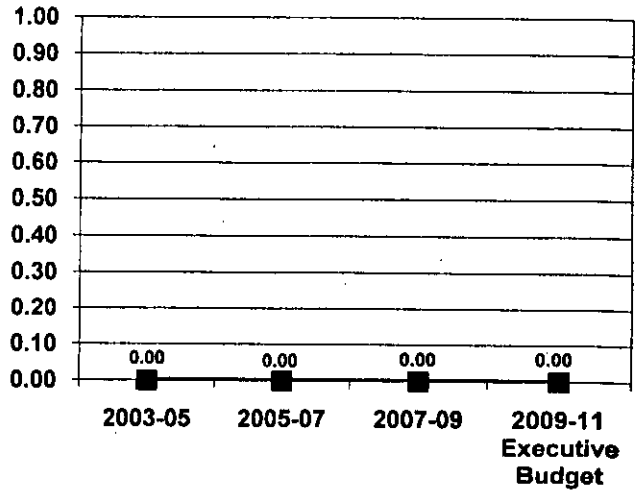
Department 305 - Tobacco Prevention and Control Committee
Senate Bill No. 2063

	FTE Positions	General Fund	Other Funds	Total
2009-11 Executive Budget	0.00	$0	$18,600,000	$18,600,000
2007-09 Legislative Appropriations	0.00	0	0	0
Increase (Decrease)	0.00	$0	$18,600,000	$18,600,000

Agency Funding



FTE Positions



First House Action

Attached is a summary of first house changes.

Executive Budget Highlights

The following is an analysis of the tobacco prevention and control trust fund for the 2007-09 and 2009-11 bienniums reflecting the 2009-11 biennium executive budget recommendation:

	2007-09 Biennium		2009-11 Biennium	
Beginning balance		$0[1]		$13,797,729
Add estimated revenues				
Tobacco settlement revenues collected to date	$0		$0	
Projected tobacco settlement revenues	13,797,729[1]		27,595,458[1]	
Total estimated revenues		13,797,729		27,595,458
Total available		$13,797,729		$41,393,187
Less estimated expenditures and transfers				
Appropriated expenditures	$0[2]		$18,600,000[2]	
Total estimated expenditures and transfers		0		18,600,000
Estimated ending balance		$13,797,729		$22,793,187

[1]Revenue - In the November 2008 general election voters approved initiated measure No. 3 that amends North Dakota Century Code (NDCC) Section 54-27-25 to create a tobacco prevention and control trust fund to receive tobacco settlement funds under subsection IX(c)(2) of the Master Settlement Agreement, which began in April 2008 and continues through 2017. The strategic contribution amount received under subsection IX(c)(2) of the Master Settlement Agreement consists of a base amount to which the Master Settlement Agreement provides adjustments. Remaining strategic contribution payments have been estimated based on the amount received in 2008 of $13,797,729.

The measure provides that interest earned on the balance in this fund be deposited in the fund, and if in any biennium the tobacco prevention and control trust fund does not have adequate funding for the comprehensive plan, money may be transferred from the water development trust fund to the tobacco prevention and control trust fund in an amount determined necessary by the executive committee to adequately provide for the comprehensive plan.

[2]Because the tobacco prevention and control trust fund was established in December 2008, no expenditures or transfers were appropriated from the fund for the 2007-09 biennium. Section 1 of Senate Bill No. 2063 (2009) appropriates $18,600,000 from the tobacco prevention and control trust fund for the purpose of providing a level of funding that will meet the annual level recommend- by the Centers for Disease Control and Prevention for North Dakota as published in its *Best Practices for Comprehensive Tot Control*.

Senate Action

The following is an analysis of the tobacco prevention and control trust fund for the 2007-09 and 2009-11 bienniums reflecting Senate action:

	2007-09 Biennium		2009-11 Biennium	
Beginning balance		$0[1]		$13,735,326
Add estimated revenues				
Tobacco settlement revenues collected to date	$0		$0	
Projected tobacco settlement revenues	13,797,729[1]		27,595,458[1]	
Total estimated revenues		13,797,729		27,595,458
Total available		$13,797,729		$41,330,784
Less estimated expenditures and transfers				
Appropriated expenditures	$62,403[2]		$12,882,000[2]	
Total estimated expenditures and transfers		0		12,882,000
Estimated ending balance		$13,735,326		$28,448,784

[1]Revenue - In the November 2008 general election voters approved initiated measure No. 3 that amends NDCC Section 54-27-25 to create a tobacco prevention and control trust fund to receive tobacco settlement funds under subsection IX(c)(2) of the Master Settlement Agreement, which began in April 2008 and continues through 2017. The strategic contribution amount received under subsection IX(c)(2) of the Master Settlement Agreement consists of a base amount to which the Master Settlement Agreement provides adjustments. Remaining strategic contribution payments have been estimated based on the amount received in 2008 of $13,797,729.

The measure provides that interest earned on the balance in this fund be deposited in the fund, and if in any biennium the tobacc- prevention and control trust fund does not have adequate funding for the comprehensive plan, money may be transferred from water development trust fund to the tobacco prevention and control trust fund in an amount determined necessary by the exec committee to adequately provide for the comprehensive plan.

[2]Because the tobacco prevention and control trust fund was established in December 2008, the executive recommendation did not include expenditures or transfers for the 2007-09 biennium. The Senate, in Section 2 of Senate Bill No. 2063 (2009), provided $62,403 from the tobacco prevention and control trust fund to defray the expenses of the Comprehensive Tobacco Control Advisory Committee, for the period beginning January 1, 2009, and ending July 1, 2009. Section 1 of the bill was amended by the Senate to provide $12,882,000 from the tobacco prevention and control trust fund for the purpose of providing a level of funding that will meet the annual level recommended by the Centers for Disease Control and Prevention for North Dakota as published in its *Best Practices for Comprehensive Tobacco Control*, for the period beginning July 1, 2009, and ending June 30, 2011. The Senate also authorized 4 FTE positions in Section 1 of the bill.

Continuing Appropriations

No continuing appropriations for this agency.

Major Related Legislation

No major legislation is currently under consideration affecting this agency.

ATTACH:1

STATEMENT OF PURPOSE OF AMENDMENT:

ate Bill No. 2063 - Funding Summary

	Executive Budget	Senate Changes	Senate Version
Tobacco Control Advisory Committee			
Comprehensive tobacco control	$18,600,000	($5,718,000)	$12,882,000
Total all funds	$18,600,000	($5,718,000)	$12,882,000
Less estimated income	18,600,000	(5,718,000)	12,882,000
General fund	$0	$0	$0
FTE	0.00	4.00	4.00
Bill Total			
Total all funds	$18,600,000	($5,718,000)	$12,882,000
Less estimated income	18,600,000	(5,718,000)	12,882,000
General fund	$0	$0	$0
FTE	0.00	4.00	4.00

Senate Bill No. 2063 - Tobacco Control Advisory Committee - Senate Action

	Executive Budget	Senate Changes	Senate Version
Comprehensive tobacco control	$18,600,000	($5,718,000)	$12,882,000
Total all funds	$18,600,000	($5,718,000)	$12,882,000
Less estimated income	18,600,000	(5,718,000)	12,882,000
General fund	$0	$0	$0
FTE	0.00	4.00	4.00

Department 305 - Tobacco Control Advisory Committee - Detail of Senate Changes

	Reduces Funding for Comprehensive Tobacco Control	Total Senate Changes
Comprehensive tobacco control	(5,718,000)	(5,718,000)
Total all funds	($5,718,000)	($5,718,000)
Less estimated income	(5,718,000)	(5,718,000)
General fund	$0	$0
FTE	4.00	4.00

Testimony
House Appropriations Committee
Statement of Jodi L. Radke
March 10, 2009
SB 2063

Same given to Senate Approps 2-13-09

Good Morning Chairman Pollert and members of the House Appropriations Committee. Thank you for your time to consider my testimony. My name is Jodi Radke. I am the Director of the Rocky Mountain/Great Plains Region for the Campaign for Tobacco Free Kids, which includes the state of North Dakota. Our agency, for those who may not be familiar, is based in Washington DC. As the Regional Director for this region, I am based in Loveland, Colorado. Our agency is considered a leader in the fight to reduce tobacco use and its devastating consequences in the United States and around the world. By changing public attitudes and public policies on tobacco, we strive to prevent kids from smoking, help smokers quit and protect everyone from secondhand smoke. Our agency has the luxury of working strictly and solely on the issue of tobacco control policy at the local, state, national and international level.

My testimony today reflects our agency's support for the Committee to appropriate $9.3 million annually to tobacco control programming in North Dakota, which is the recommendation by the CDC for the state of North Dakota.

What I would like to address in my testimony this morning are two things, **why** states should fund tobacco control programs at CDC levels and to outline what North Dakota can expect if a fully funded tobacco control program at the CDC level is implemented over time.

Why fully fund a program?

The bottom line is this, a fully funded program saves lives and saves taxpayers'money. Tobacco use is the **single** most preventable cause of death and disease in the United States.

In North Dakota, annual health care costs directly caused by smoking total $247 million. Of this amount, $47 million is covered by the state Medicaid program. Taxpayers in North Dakota pay $571/household in state and federal taxes from smoking-caused government expenditures. In uncertain economic times such as these, it is our position that legislators have a responsibility to save lives and taxpayer dollars by recognizing the research and fully funding tobacco control programs at CDC levels.

States should fully fund tobacco control programming at the CDC recommended funding levels because we know that these programs are effective. They work. Evidence-based, statewide tobacco control programs that are comprehensive, sustained and accountable have been shown to reduce smoking rates, tobacco-related deaths, and

diseases caused by smoking. The more a state invests, the **greater** the reduction in smoking, and, the **longer** the state invests, the greater and faster the impact.

In Florida, between 1998-2002, a comprehensive program reduced smoking rates among middle school students by 50% and among high school students by 35%. Other states, such as Maine, New York and Washington, have seen 45% to 60% reductions in youth smoking with sustained comprehensive statewide programs. Between 2000 and 2006, New York reported that the prevalence of adult and youth smoking declined faster than the US as a whole. ***It is also important to note that once Florida achieved these results, they decided to reverse their funding, and, have since seen significant increases in their use rates, a prime example of why it is critical to fully fund these programs each year.***

In California, home of the longest running comprehensive program, smoking rates among adults declined from 22.7 percent in 1998 to 13.3 percent in 2006. Compared with the rest of the country, heart disease deaths and lung cancer incidence in California have declined at accelerated rates. Among women in California, the rate of lung cancer deaths decreased while it continued to increase in other parts of the country. Since 1998, lung cancer incidence in California has been declining four times faster than in the rest of the nation. The tobacco use epidemic can be stopped. We know these programs work.

Earlier studies have found that state tobacco prevention programs can, in their early years, save $3.00 or more just in reduced state health care expenditures for every dollar spent. New research has strengthened those findings, demonstrating that state programs secure even larger returns on investment if tobacco prevention programs are sustained for over ten or more years at adequate levels. In California's tobacco prevention program they found that for every dollar the state spent on its tobacco control program, the state saved $50 in total healthcare costs. This study confirms that the cost-saving benefits from sustained state investments in effective tobacco control programs quickly grow over time to dwarf the state expenditures; producing massive gains for the state not only in terms of improved public health and increased worker productivity but in reduced government, business, and household costs.

States should not linger any longer. The research is clear. And, if we as a nation fully funded and sustained a tobacco control program in each state, we would meet IOM's best-case scenario of reducing adult tobacco prevalence to 10% by 2025.

What can North Dakota expect once the program is fully funded?

Our agency issued a report last September that analyzed what outcomes a fully funded tobacco control program in North Dakota could expect. A fully funded program at CDC recommended levels would accomplish the following:

- ***Reduce youth smoking by 12.7%;***
- ***Stop 4,570 North Dakota kids from becoming addicted adult smokers;***

- ***Save 1,460 kids from dying from smoking;***
- ***Prompt more than 3,480 current adult smokers to quit for good; and***
- ***Save more than 920 North Dakota adults from dying prematurely from smoking.***

Using conservative, research-based estimates, the smoking declines from a comprehensive Best Practice program will lock-in more than $113 million in future smoking-caused health expenditure reductions, including more than $11.9 in future cuts to state Medicaid program expenditures. The projections would grow even larger after the first five years of a fully-funded program.

Research shows that that on average, the impact of a fully-funded program would reduce adult smoking by 1,200 in the first year. These adult smoking reductions would continue to grow each year the program is in place. The 5-year heart-stroke savings would be $1.1 million and 5-year pregnancy savings would be $920,000. North Dakota's health care costs would be reduced by approximately $2.0 million in the first five years just from fewer smoking-caused heart attacks, strokes and fewer smoking-affected births.

I'd like to close by saying...

"If Congress and the states show the political will to implement proven solutions, we will win one of the most significant public health victories in our nation's history. If our leadership fails to do so, it will be a tragic missed opportunity for the nation's health and for North Dakota."

Thank you for your time, consideration and energy to review this critical public health issue.

Please contact me if you have further questions,

Jodi L. Radke
Director, Rocky Mountain/Great Plains Region
Campaign for Tobacco-Free Kids
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Testimony on SB 2063
Human Resources Division of the House Appropriations Committee
March 10, 2009
Wanda Rose PhD, RN, BC
North Dakota Nurses Association

Chairman Pollert and members of the Human Resources Division of the House Appropriations Committee

I am Dr. Wanda Rose, President of the North Dakota Nurses Association and a volunteer lobbyist for the North Dakota Nurses Association. I stand before you in support of SB 2063.

As nurses, we see daily the damage and devastation that tobacco has caused many human beings.

In North Dakota we now we have a historical opportunity to invest in a comprehensive tobacco prevention and control program at the level which the Centers of Disease Control recommends. With sustained implementation of such a program, North Dakota can expect a marked reduction in adult and youth tobacco use, lives saved from the ravages of tobacco use; and tremendous cost savings to society. This work is so very important and must begin as swiftly as possible.

In November, the North Dakota citizens chose to use these funds as expediently as possible; and the appropriations for our public-health and tobacco-prevention professionals to make the crucial decisions regarding the specific details of the new program.

NDNA supports the funding in SB 2063 for tobacco prevention and control.

Thank you, for your consideration of SB 2063.

MEMORANDUM

To: Representative Chet Pollert, Chair, and Members of the House Appropriations Committee, Human Resources Division

From: Kathleen Mangskau, Chair, Tobacco Prevention and Control Advisory Committee

Date: March 10, 2009

Subject: SB 2063 Additional Information Requested

Per the request of the Committees, attached are the following:

1) Codified version of Measure 3
2) State Funding Recommendation Formulations – this document compares the 1999 and 2007 funding recommendations in answer to the question of how CDC came up with the funding recommendation and the question of how these funding recommendations have changed over time
3) North Dakota funding recommendations 1999
4) North Dakota funding recommendations 2007
5) Projected time frames for North Dakota health and economic benefits based on the Campaign for Tobacco Free Kids Report-2008.

In addition a question was asked regarding how much money is currently in the Tobacco Prevention and Control Trust Fund. The first transfer of funds is expected to occur in April of 2009 when the state receives the Strategic Contribution Fund payment. The amount is expected to be approximately $13.8 million per year.

If you need additional information I can be reached at 701-258-7919 or kmconsult@btinet.net

SEE NOTE RE ONLINE AVAILABLITY

Best Practices for Comprehensive Tobacco Control Programs

Suggested Citation

Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs—2007.* Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; October 2007.

Ordering Information

To download or order copies of this book,
go to www.cdc.gov/tobacco
or
to order single copies, call toll-free
1 (800) CDC-INFO
1 (800) 232-4636

Selected Pages

Best Practices

for Comprehensive Tobacco Control Programs

October 2007

Funding Recommendation Formulations

In *Best Practices for Comprehensive Tobacco Control Programs—August 1999*, funding formulas were provided for the nine specific elements of a comprehensive program. These formulas were based on evidence from scientific literature and the experience of large-scale and sustained efforts of state programs in California and Massachusetts.[1]

In December 2006, technical consultation was sought from a panel of experts regarding the best available evidence to determine updated cost parameters and metrics for major components of a comprehensive tobacco control program. The panel reviewed data relevant to potential changes in the 1999 funding recommendations, including state experience and findings on program effectiveness that have emerged since the release of *Best Practices—1999*. The panel generally agreed that the published funding formulas remained sound but that technical updates were necessary.[2] A listing of participants in the expert panel is provided in Appendix A.

Funding recommendations in this publication are based on the funding formulas presented in 1999, with adjustments to specific variables to account for changes in the total population (2006), population of persons aged 18 years and older (2006), public (2006) and private (2003) school enrollment, and smoking prevalence (2006), as well as an increase to keep pace with the national cost of living (June 2007).[3-7]

The original basis for budget recommendations is as follows:[1]

- Community Programs: $850,000-$1,200,000 (statewide training and infrastructure) + $0.70-$2.00 per capita
- Tobacco-Related Disease Programs: Average of $2.8 million - $4.1 million per year
- School Programs: $500,000-$750,000 (statewide training and infrastructure) + $4-$6 per student (K-12)
- Enforcement: $150,000-$300,000 estimated range for youth access and smoke-free air enforcement + $0.43-$0.80 per capita
- Statewide Programs: $0.40-$1.00 per capita
- Counter-Marketing: $1.00-$3.00 per capita
- Cessation
  - Minimum: $1 per adult (screening) + $2 per smoker (brief counseling)
  - Maximum: $1 per adult (screening) + $2 per smoker (brief counseling) + $13.75 per smoker (50% of quitline cost for 10% of smokers) + $27.50 per smoker for NRT (assumes approximately 25% of smokers treated are covered by state-financed programs)
- Surveillance and Evaluation: 10% of program total
- Administration and Management: 5% of program total

As with the funding guidance first published in 1999, recommended annual costs can vary within the lower and upper estimates provided for each state. Therefore, to better assist states, specific guidance is now provided regarding each state's recommended level of investment within its range. These recommended levels of annual investment factor in state-specific variables, such as the overall population; smoking prevalence; the proportion of the population uninsured or receiving publicly financed insurance or living at or near the poverty level; infrastructure costs; the number of local health units; geographic size; the targeted reach for quitline services; and the cost and complexity of conducting mass media campaigns to reach targeted audiences, such as youth, racial/ethnic minorities, or people of low socioeconomic status.[3,6,8-14]

Per capita formula adjustments for 2007 include:

- Community Programs: Upper and lower limits were adjusted for inflation. Specific state estimates within these limits took into account smoking prevalence, proportion of the population living at or below 200% of the poverty level, average wage rates for implementing public health programs, the number of local health units, and geographic size.
- Tobacco-Related Disease Programs: Total budget numbers were adjusted for inflation and distributed to each state on a per capita basis.
- School Programs: Budget numbers were adjusted for inflation and applied to state school enrollment.
- Enforcement: Budget numbers were adjusted for inflation.
- Statewide Programs: Upper and lower limits were adjusted for inflation. Specific state estimates within these limits took into account smoking prevalence, proportion of the population living at or below 200% of the poverty level, average wage rates for implementing public health programs, the number of local health units, and geographic size.
- Counter-Marketing: Upper and lower limits were adjusted for inflation. Specific state estimates within these limits took into account relative media costs and the complexity of the media market.
- Cessation:
  - Health care systems (screening and brief counseling) budget numbers were adjusted for inflation.
  - Quitline support: (number of callers enrolled in quitline) x (per person cost for counseling) + (per person cost for NRT). Formula assumes 6% of adult smokers in the state receive treatment each year.
- Surveillance and Evaluation: 10% of program total.
- Administration and Management: 5% of program total.

Funding Recommendation Formulations

Multiplying state per capita funding recommendations by state population will provide the total funding recommendations presented in the total funding summary table and the state-specific pages. Because total funding recommendations are rounded to the nearest hundred thousand, the reverse calculation might produce slightly different per capita estimates. The recommended levels of investment (per capita and total) are presented in 2007 dollars using 2006 population rates. These should be updated annually according to the U.S. Department of Labor Consumer Price Index and U.S. Census Bureau.[3,7]

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CDC Recommended Annual Total Funding Levels for State Programs, 2007

State	Total Recommended Program Costs			State and Community Interventions			Health Communication Interventions		
	Recommended (millions)	Lower (millions)	Upper (millions)	Recommended (millions)	Lower (millions)	Upper (millions)	Recommended (millions)	Lower (millions)	Upper (millions)
United States	**3,696.6**	2,524.0	5,473.8	**1,461.3**	1,194.1	2,022.4	**706.7**	389.4	1,167.6
Alabama	**58.7**	40.3	89.2	**23.2**	18.7	31.6	**7.8**	6.0	17.9
Alaska	**10.7**	7.9	16.0	**5.3**	4.5	7.2	**1.4**	0.9	2.6
Arizona	**68.1**	51.2	110.5	**29.0**	24.7	41.7	**10.1**	8.0	24.0
Arkansas	**36.4**	25.5	55.9	**15.3**	12.1	20.3	**5.0**	3.7	11.0
California	**441.9**	286.2	610.4	**170.6**	137.8	234.8	**110.0**	47.4	142.2
Colorado	**54.4**	39.8	84.9	**23.2**	19.1	32.4	**8.6**	6.2	18.5
Connecticut	**43.9**	30.2	63.3	**17.8**	14.9	25.1	**9.2**	4.6	13.7
Delaware	**13.9**	9.3	18.7	**5.6**	5.1	8.2	**3.3**	1.1	3.3
District of Columbia	**10.5**	6.9	13.7	**4.8**	4.0	6.5	**2.3**	0.8	2.3
Florida	**210.9**	149.1	332.1	**78.6**	66.7	114.0	**36.2**	23.5	70.6
Georgia	**116.5**	77.3	169.2	**44.4**	36.2	61.6	**24.5**	12.2	36.5
Hawaii	**15.2**	12.4	25.3	**7.1**	6.6	10.9	**1.9**	1.7	5.0
Idaho	**16.9**	13.7	27.9	**7.9**	7.3	12.1	**2.4**	1.9	5.7
Illinois	**157.0**	106.4	232.4	**63.3**	49.2	83.7	**27.4**	16.7	50.0
Indiana	**78.8**	54.7	121.2	**31.5**	25.0	42.4	**11.6**	8.2	24.6
Iowa	**36.7**	26.6	57.0	**16.0**	12.8	21.5	**4.8**	3.9	11.6
Kansas	**32.1**	24.5	52.0	**14.7**	12.1	20.2	**3.6**	3.6	10.8
Kentucky	**57.2**	38.4	87.1	**23.1**	17.2	29.0	**7.0**	5.5	16.4
Louisiana	**53.5**	38.2	84.1	**22.8**	18.1	30.4	**6.8**	5.6	16.7
Maine	**18.5**	13.0	27.5	**7.8**	6.7	11.0	**3.2**	1.7	5.2
Maryland	**63.3**	46.8	99.8	**24.6**	22.5	38.2	**12.2**	7.3	21.9
Massachusetts	**90.0**	53.3	114.5	**31.7**	25.2	42.8	**25.1**	8.4	25.1
Michigan	**121.2**	85.5	188.8	**49.9**	39.2	66.7	**16.8**	13.1	39.4
Minnesota	**58.4**	43.4	92.2	**24.7**	20.8	35.2	**9.1**	6.7	20.2
Mississippi	**39.2**	26.7	59.4	**15.8**	12.7	21.3	**6.2**	3.8	11.4
Missouri	**73.2**	50.5	111.4	**28.9**	23.2	39.3	**11.6**	7.6	22.8
Montana	**13.9**	9.6	19.9	**6.3**	5.3	8.7	**2.5**	1.2	3.7
Nebraska	**21.5**	16.3	34.0	**9.3**	8.4	14.0	**3.5**	2.3	6.9
Nevada	**32.5**	22.6	48.7	**13.5**	11.0	18.5	**5.4**	3.2	9.7
New Hampshire	**19.2**	12.8	26.1	**7.1**	6.7	11.1	**5.1**	1.7	5.1
New Jersey	**119.8**	72.1	154.3	**41.5**	34.2	58.0	**34.0**	11.3	34.0
New Mexico	**23.4**	17.9	38.2	**10.9**	9.0	15.1	**2.6**	2.5	7.6
New York	**254.3**	155.1	339.4	**89.9**	71.3	121.9	**66.1**	25.1	75.3
North Carolina	**106.8**	74.3	165.1	**42.9**	33.8	57.6	**16.2**	11.5	34.5
North Dakota	**9.3**	7.2	14.5	**4.7**	4.2	6.8	**1.2**	0.8	2.5
Ohio	**145.0**	96.7	213.6	**58.7**	43.9	74.6	**23.2**	14.9	44.8
Oklahoma	**45.0**	32.2	71.7	**19.3**	15.0	25.3	**4.8**	4.7	14.0
Oregon	**43.0**	31.5	67.5	**17.8**	15.1	25.5	**7.0**	4.8	14.4
Pennsylvania	**155.5**	103.8	228.0	**55.9**	46.7	79.7	**32.0**	16.2	48.5
Rhode Island	**15.2**	10.8	22.5	**6.7**	5.8	9.6	**2.7**	1.4	4.2
South Carolina	**62.2**	37.7	83.1	**20.5**	17.7	29.8	**16.9**	5.6	16.9
South Dakota	**11.3**	8.5	17.0	**5.5**	4.8	7.7	**1.5**	1.0	3.0
Tennessee	**71.7**	51.8	115.0	**28.2**	23.7	40.2	**10.6**	7.9	23.6
Texas	**266.3**	189.4	411.2	**114.1**	90.2	153.4	**43.1**	30.6	91.7
Utah	**23.6**	21.1	42.0	**11.6**	11.6	19.4	**3.7**	3.3	9.9
Vermont	**10.4**	7.2	14.2	**4.6**	4.2	6.8	**2.3**	0.8	2.4
Virginia	**103.2**	63.5	137.0	**33.4**	29.6	50.3	**29.8**	9.9	29.8
Washington	**67.3**	52.5	111.8	**28.9**	25.0	42.5	**9.2**	8.3	24.9
West Virginia	**27.8**	17.6	38.7	**10.4**	8.4	14.0	**5.7**	2.4	7.1
Wisconsin	**64.3**	47.5	103.1	**27.6**	22.3	37.7	**8.0**	7.2	21.7
Wyoming	**9.0**	6.5	12.7	**4.4**	3.8	6.1	**1.5**	0.7	2.0

CDC Recommended Annual Total Funding Levels for State Programs, 2007

Cessation Interventions			Surveillance and Evaluation			Administration and Management			
Recommended (millions)	Lower (millions)	Upper (millions)	Recommended (millions)	Lower (millions)	Upper (millions)	Recommended (millions)	Lower (millions)	Upper (millions)	2006 Population Estimate (millions)
1,046.2	611.2	1,569.3	**321.4**	219.4	476.3	**161.0**	109.9	238.2	299.403
18.3	10.3	28.0	**4.9**	3.5	7.8	**2.5**	1.8	3.9	4.599
2.6	1.5	4.1	**0.9**	0.7	1.4	**0.5**	0.3	0.7	0.670
20.1	11.8	30.4	**5.9**	4.5	9.6	**3.0**	2.2	4.8	6.166
11.3	6.4	17.3	**3.2**	2.2	4.9	**1.6**	1.1	2.4	2.811
103.7	63.7	153.8	**38.4**	24.9	53.1	**19.2**	12.4	26.5	36.458
15.5	9.3	22.9	**4.7**	3.5	7.4	**2.4**	1.7	3.7	4.753
11.2	6.8	16.2	**3.8**	2.6	5.5	**1.9**	1.3	2.8	3.505
3.2	1.9	4.8	**1.2**	0.8	1.6	**0.6**	0.4	0.8	0.853
2.0	1.2	3.1	**0.9**	0.6	1.2	**0.5**	0.3	0.6	0.582
68.6	39.4	104.2	**18.3**	13.0	28.9	**9.2**	6.5	14.4	18.090
32.4	18.8	49.0	**10.1**	6.7	14.7	**5.1**	3.4	7.4	9.364
4.2	2.5	6.1	**1.3**	1.1	2.2	**0.7**	0.5	1.1	1.285
4.4	2.7	6.5	**1.5**	1.2	2.4	**0.7**	0.6	1.2	1.466
45.8	26.6	68.4	**13.7**	9.3	20.2	**6.8**	4.6	10.1	12.832
25.4	14.3	38.4	**6.9**	4.8	10.5	**3.4**	2.4	5.3	6.314
11.1	6.4	16.4	**3.2**	2.3	5.0	**1.6**	1.2	2.5	2.982
9.6	5.6	14.2	**2.8**	2.1	4.5	**1.4**	1.1	2.3	2.764
19.6	10.7	30.3	**5.0**	3.3	7.6	**2.5**	1.7	3.8	4.206
16.9	9.5	26.0	**4.7**	3.3	7.3	**2.3**	1.7	3.7	4.288
5.1	2.9	7.7	**1.6**	1.1	2.4	**0.8**	0.6	1.2	1.322
18.2	10.9	26.7	**5.5**	4.1	8.7	**2.8**	2.0	4.3	5.616
21.5	12.8	31.6	**7.8**	4.6	10.0	**3.9**	2.3	5.0	6.437
38.7	22.1	58.1	**10.5**	7.4	16.4	**5.3**	3.7	8.2	10.096
17.0	10.2	24.8	**5.1**	3.8	8.0	**2.5**	1.9	4.0	5.167
12.1	6.7	18.9	**3.4**	2.3	5.2	**1.7**	1.2	2.6	2.911
23.1	13.1	34.8	**6.4**	4.4	9.7	**3.2**	2.2	4.8	5.843
3.3	1.9	4.9	**1.2**	0.8	1.7	**0.6**	0.4	0.9	0.945
5.9	3.5	8.6	**1.9**	1.4	3.0	**0.9**	0.7	1.5	1.768
9.4	5.4	14.2	**2.8**	2.0	4.2	**1.4**	1.0	2.1	2.496
4.5	2.7	6.5	**1.7**	1.1	2.3	**0.8**	0.6	1.1	1.315
28.7	17.2	42.2	**10.4**	6.3	13.4	**5.2**	3.1	6.7	8.725
6.9	4.0	10.5	**2.0**	1.6	3.3	**1.0**	0.8	1.7	1.955
65.1	38.5	97.9	**22.1**	13.5	29.5	**11.1**	6.7	14.8	19.306
33.8	19.3	51.4	**9.3**	6.5	14.4	**4.6**	3.2	7.2	8.857
2.2	1.3	3.3	**0.8**	0.6	1.3	**0.4**	0.3	0.6	0.636
44.2	25.3	66.3	**12.6**	8.4	18.6	**6.3**	4.2	9.3	11.478
15.0	8.3	23.1	**3.9**	2.8	6.2	**2.0**	1.4	3.1	3.579
12.6	7.5	18.8	**3.7**	2.7	5.9	**1.9**	1.4	2.9	3.701
47.3	27.4	70.1	**13.5**	9.0	19.8	**6.8**	4.5	9.9	12.441
3.8	2.2	5.7	**1.3**	0.9	2.0	**0.7**	0.5	1.0	1.068
16.7	9.5	25.6	**5.4**	3.3	7.2	**2.7**	1.6	3.6	4.321
2.8	1.6	4.1	**1.0**	0.7	1.5	**0.5**	0.4	0.7	0.782
23.6	13.4	36.2	**6.2**	4.5	10.0	**3.1**	2.3	5.0	6.039
74.3	43.9	112.4	**23.2**	16.5	35.8	**11.6**	8.2	17.9	23.508
5.2	3.5	7.2	**2.1**	1.8	3.7	**1.0**	0.9	1.8	2.550
2.1	1.3	3.2	**0.9**	0.6	1.2	**0.5**	0.3	0.6	0.624
26.5	15.7	39.0	**9.0**	5.5	11.9	**4.5**	2.8	6.0	7.643
20.4	12.3	29.8	**5.9**	4.6	9.7	**2.9**	2.3	4.9	6.396
8.1	4.5	12.5	**2.4**	1.5	3.4	**1.2**	0.8	1.7	1.818
20.3	11.8	30.2	**5.6**	4.1	9.0	**2.8**	2.1	4.5	5.557
1.9	1.1	2.9	**0.8**	0.6	1.1	**0.4**	0.3	0.6	0.515

North Dakota

Recommended Program Element Budgets

August 1999

NOTE: A justification for each program element and the rationale for the budget estimates are provided in Section A.

An upper and a lower estimate are presented for each budget category.

The funding required for implementing programs will vary depending on state characteristics, such as sociodemographic factors, tobacco use prevalence, and other factors. Therefore, the funding ranges presented here are illustrative.

I. Community Programs to Reduce Tobacco Use

Upper Estimate	**$2,482,000**	Formula: $1,200,000 (statewide training and infrastructure) + $2.00 per capita
Lower Estimate	**$1,299,000**	Formula: $850,000 (statewide training and infrastructure) + $0.70 per capita

II. Chronic Disease Programs to Reduce the Burden of Tobacco-Related Diseases

Upper Estimate	**$4,162,000**	Formula: See section A-II
Lower Estimate	**$2,787,000**	Formula: See section A-II

III. School Programs

Upper Estimate	**$1,498,000**	Formula: $750,000 (statewide training and infrastructure) + $6 per student (K-12)
Lower Estimate	**$999,000**	Formula: $500,000 (statewide training and infrastructure) + $4 per student (K-12)

IV. Enforcement

Upper Estimate	**$817,000**	Formula: $300,000 (inter-agency coordination) + $0.80 per capita
Lower Estimate	**$426,000**	Formula: $150,000 (inter-agency coordination) + $0.43 per capita

V. Statewide Programs

Upper Estimate	**$641,000**	Formula: $1.00 per capita
Lower Estimate	**$257,000**	Formula: $.40 per capita

VI. Counter-Marketing

Upper Estimate	**$1,923,000**	Formula: $3.00 per capita
Lower Estimate	**$641,000**	Formula: $1.00 per capita

VII. Cessation Programs

Upper Estimate	**$2,865,000**	Formula: $1 per adult (screening) + $2 per smoker (brief counseling) + $137.50 per served smoker (50% of program cost for 10% of smokers) + $275 per served smoker (100% of program cost for 10% of publicly financed smokers)
Lower Estimate	**$687,000**	Formula: $1 per adult (screening) + $2 per smoker (brief counseling)

Subtotal (I to VII above)

Upper Estimate	**$14,388,000**
Lower Estimate	**$7,096,000**

VIII. Surveillance and Evaluation

Upper Estimate	**$1,439,000**	Formula: 10% High Estimates Subtotal
Lower Estimate	**$710,000**	Formula: 10% Low Estimates Subtotal

IX. Administration and Management

Upper Estimate	**$720,000**	Formula: 5% High Estimates Subtotal
Lower Estimate	**$355,000**	Formula: 5% Low Estimates Subtotal

Total Program Annual Cost

Upper Estimate	**$16,547,000**
Lower Estimate	**$8,161,000**

Per Capita Funding Ranges

Upper Estimate	**$25.82**
Lower Estimate	**$12.73**

Office on Smoking and Health
Centers for Disease Control and Prevention
Telephone Number: 770-488-5705
http://www.cdc.gov/tobacco
E-Mail Address: tobaccoinfo@cdc.gov

FUNDING MODEL FOR STATE AWARDS

			Program Area Funding Estimates									
		FY 1998	Community Programs		Tobacco-Related Disease Programs		School Programs		Enforcement		Statewide Programs	
STATE	1997 Population Level	Estimated Federal Funding Level	Lower Estimate (000,000)	Upper Estimate (000,000)	Lower Estimate (000,000)	Upper Estimate (000,000)	Lower Estimate (000,000)	Upper Estimate (000,000)	Lower Estimate (000,000)	Upper Estimate (000,000)	Lower Estimate (000,000)	Upper Estimate (000,000)
[redacted]	4,319,154	$400,313	$3.87	$9.84	$2.85	$4.23	$3.62	$5.42	$2.01	$3.78	$1.73	$4.32
AK	609,311	$388,012	$1.28	$2.42	$2.79	$4.16	$1.06	$1.58	$0.41	$0.79	$0.24	$0.61
AZ	4,554,966	$256,614	$4.04	$10.31	$2.86	$4.23	$4.12	$6.18	$2.11	$3.97	$1.82	$4.56
AR	2,522,819	$303,275	$2.62	$6.25	$2.82	$4.20	$2.44	$3.67	$1.24	$2.33	$1.01	$2.52
CA	32,268,301	$0	$23.44	$65.74	$3.35	$4.73	$25.66	$38.49	$14.04	$26.28	$12.91	$32.27
CO	3,892,644	$1,266,108	$3.58	$8.99	$2.85	$4.22	$3.47	$5.20	$1.83	$3.44	$1.56	$3.89
CT	3,269,858	$265,000	$3.14	$7.74	$2.83	$4.21	$2.80	$4.20	$1.56	$2.93	$1.31	$3.27
DE	731,581	$295,000	$1.36	$2.66	$2.79	$4.16	$1.01	$1.52	$0.47	$0.89	$0.29	$0.73
DC	528,964	$231,000	$1.22	$2.26	$2.79	$4.16	$0.80	$1.19	$0.38	$0.73	$0.21	$0.53
FL	14,653,945	$400,000	$11.11	$30.51	$3.04	$4.41	$10.58	$15.87	$6.46	$12.10	$5.86	$14.65
GA	7,486,242	$428,000	$6.09	$16.17	$2.91	$4.28	$6.22	$9.33	$3.37	$6.33	$3.00	$7.49
HI	1,186,602	$392,300	$1.68	$3.57	$2.80	$4.17	$1.36	$2.04	$0.66	$1.26	$0.48	$1.19
ID	1,210,232	$300,000	$1.70	$3.62	$2.80	$4.17	$1.54	$2.31	$0.67	$1.28	$0.49	$1.21
IL	11,895,849	$574,000	$9.18	$24.99	$2.99	$4.36	$9.58	$14.37	$5.27	$9.88	$4.76	$11.90
IN	5,864,108	$1,200,164	$4.96	$12.93	$2.88	$4.26	$4.86	$7.29	$2.67	$5.02	$2.35	$5.87
IA	2,852,423	$275,000	$2.85	$6.91	$2.83	$4.20	$2.67	$4.00	$1.38	$2.60	$1.14	$2.85
KS	2,594,840	$337,500	$2.67	$6.39	$2.82	$4.20	$2.54	$3.80	$1.27	$2.39	$1.04	$2.60
KY	3,908,124	$426,158	$3.59	$9.02	$2.85	$4.22	$3.32	$4.98	$1.83	$3.45	$1.56	$3.91
LA	4,351,769	$250,000	$3.90	$9.90	$2.85	$4.23	$4.01	$6.01	$2.02	$3.81	$1.74	$4.35
ME	1,242,051	$850,126	$1.72	$3.69	$2.80	$4.17	$1.41	$2.12	$0.69	$1.30	$0.50	$1.24
MD	5,094,289	$382,500	$4.42	$11.39	$2.87	$4.24	$4.19	$6.28	$2.34	$4.40	$2.04	$5.10
MA	6,117,520	$2,133,855	$5.13	$13.44	$2.89	$4.26	$4.71	$7.06	$2.78	$5.23	$2.45	$6.12
MI	9,773,892	$1,634,072	$7.69	$20.75	$2.95	$4.33	$7.91	$11.86	$4.36	$8.17	$3.91	$9.77
MN	4,685,549	$1,117,504	$4.13	$10.57	$2.86	$4.23	$4.24	$6.36	$2.17	$4.07	$1.88	$4.69
MS	2,730,501	$350,000	$2.76	$6.66	$2.82	$4.20	$2.71	$4.06	$1.33	$2.50	$1.09	$2.73
MO	5,402,058	$1,131,719	$4.63	$12.01	$2.87	$4.25	$4.66	$6.99	$2.48	$4.65	$2.16	$5.40
MT	878,810	$375,000	$1.47	$2.96	$2.79	$4.17	$1.20	$1.80	$0.53	$1.01	$0.35	$0.88
[redacted]	1,656,870	$381,698	$2.01	$4.51	$2.81	$4.18	$1.82	$2.73	$0.86	$1.64	$0.66	$1.66
[redacted]	1,676,809	$294,000	$2.02	$4.55	$2.81	$4.18	$1.75	$2.63	$0.87	$1.65	$0.67	$1.68
[redacted]	1,172,709	$355,000	$1.67	$3.55	$2.80	$4.17	$1.39	$2.09	$0.66	$1.25	$0.47	$1.17
NJ	8,052,849	$1,250,824	$6.49	$17.31	$2.92	$4.29	$6.22	$9.33	$3.62	$6.79	$3.22	$8.05
NM	1,729,751	$909,252	$2.06	$4.66	$2.81	$4.18	$1.96	$2.94	$0.90	$1.69	$0.69	$1.73
NY	18,137,226	$1,945,676	$13.55	$37.48	$3.10	$4.47	$13.49	$20.23	$7.96	$14.91	$7.26	$18.14
NC	7,425,183	$1,655,544	$6.05	$16.05	$2.91	$4.28	$5.92	$8.88	$3.35	$6.28	$2.97	$7.43
ND	640,883	$358,000	$1.30	$2.48	$2.79	$4.16	$1.00	$1.50	$0.43	$0.82	$0.26	$0.64
OH	11,186,331	$599,326	$8.68	$23.57	$2.98	$4.35	$8.86	$13.29	$4.96	$9.31	$4.48	$11.19
OK	3,317,091	$411,162	$3.17	$7.84	$2.84	$4.21	$3.11	$4.66	$1.58	$2.97	$1.33	$3.32
OR	3,243,487	$376,308	$3.12	$7.69	$2.83	$4.21	$2.89	$4.34	$1.55	$2.91	$1.30	$3.24
PA	12,019,661	$570,000	$9.26	$25.24	$2.99	$4.37	$9.00	$13.51	$5.32	$9.98	$4.81	$12.02
RI	987,429	$819,089	$1.54	$3.18	$2.79	$4.17	$1.19	$1.78	$0.58	$1.10	$0.40	$0.99
SC	3,760,181	$1,012,935	$3.48	$8.72	$2.84	$4.22	$3.31	$4.96	$1.77	$3.33	$1.51	$3.76
SD	737,973	$294,000	$1.37	$2.68	$2.79	$4.16	$1.09	$1.64	$0.47	$0.90	$0.30	$0.74
TN	5,368,198	$285,000	$4.61	$11.94	$2.87	$4.25	$4.35	$6.53	$2.46	$4.62	$2.15	$5.37
TX	19,439,337	$627,478	$14.46	$40.08	$3.12	$4.50	$16.38	$24.56	$8.52	$15.95	$7.78	$19.44
UT	2,059,148	$300,000	$2.29	$5.32	$2.81	$4.19	$2.47	$3.70	$1.04	$1.96	$0.82	$2.06
VT	588,978	$337,500	$1.26	$2.38	$2.79	$4.16	$0.95	$1.42	$0.40	$0.78	$0.24	$0.59
VA	6,733,996	$1,113,868	$5.56	$14.67	$2.90	$4.27	$5.27	$7.90	$3.05	$5.72	$2.69	$6.73
WA	5,610,362	$1,254,572	$4.78	$12.42	$2.88	$4.25	$4.77	$7.16	$2.57	$4.82	$2.25	$5.61
WV	1,815,787	$765,411	$2.12	$4.83	$2.81	$4.18	$1.73	$2.60	$0.93	$1.76	$0.73	$1.82
WI	5,169,677	$1,100,851	$4.47	$11.54	$2.87	$4.24	$4.55	$6.82	$2.38	$4.46	$2.07	$5.17
WY	479,743	$250,000	$1.19	$2.16	$2.78	$4.16	$0.90	$1.36	$0.36	$0.69	$0.19	$0.48
US TOTAL	267,636,061	$33,230,714	$230.72	$596.50	$146.32	$216.45	$227.04	$340.54	$122.84	$230.83	$107.08	$267.66
US Average			$4.52	$11.70	$2.87	$4.24	$4.45	$6.68	$2.41	$4.53	$2.10	$5.25

FUNDING FORMULA	
Community Programs	$850,000–$1,200,000 (statewide training and infrastructure) + $0.70–$2.00 per capita.
[redacted]bacco-Related [redacted] Programs	$2.8 million–$4.1 million per year. See section A-II for details.
[redacted] Programs	$500,000–$750,000 (statewide training and infrastructure) + $4–$6 per student (K–12).
[redacted]ment	$150,000–$300,000 estimated range for youth access and clean indoor air enforcement + $0.43–$0.80 per capita.
Statewide Programs	$0.40–$1.00 per capita.

FUNDING MODEL FOR STATE AWARDS

Program Area Funding Estimates										Total Estimates			
Counter-Marketing		Cessation Programs		**Program Area Subtotal**		Surveillance and Evaluation (10%)		Administration and Management (5%)		**Total Program Costs**		**Per-Capita Costs**	
Lower Estimate (000,000)	Upper Estimate (000,000)	Lower Estimate (000,000)	Upper Estimate (000,000)	Lower Estimate (000,000)	Upper Estimate (000,000)	Lower Estimate (000,000)	Upper Estimate (000,000)	Lower Estimate (000,000)	Upper Estimate (000,000)	Lower Estimate (000,000)	Upper Estimate (000,000)	Lower Estimate	Upper Estimate
[redacted]2	$12.96	$4.85	$21.40	$23.25	$61.94	$2.33	$6.20	$1.16	$3.10	$26.74	$71.24	$6.19	$16.49
[redacted]61	$1.83	$0.65	$2.97	$7.03	$14.36	$0.70	$1.44	$0.35	$0.72	$8.09	$16.51	$13.27	$27.10
$4.56	$13.67	$4.66	$18.92	$24.16	$61.83	$2.42	$6.18	$1.21	$3.09	$27.79	$71.10	$6.10	$15.61
$2.52	$7.57	$2.92	$13.86	$15.57	$40.39	$1.56	$4.04	$0.78	$2.02	$17.91	$46.45	$7.10	$18.41
$32.27	$96.81	$31.90	$120.38	$143.56	$384.70	$14.36	$38.47	$7.18	$19.24	$165.10	$442.40	$5.12	$13.71
$3.89	$11.68	$4.18	$17.59	$21.34	$55.00	$2.14	$5.50	$1.07	$2.75	$24.55	$63.26	$6.31	$16.25
$3.27	$9.81	$3.56	$14.70	$18.47	$46.86	$1.85	$4.69	$0.92	$2.34	$21.24	$53.90	$6.50	$16.48
$0.73	$2.20	$0.85	$3.89	$7.50	$16.06	$0.75	$1.61	$0.38	$0.80	$8.63	$18.46	$11.80	$25.24
$0.53	$1.59	$0.58	$2.22	$6.50	$12.67	$0.65	$1.27	$0.33	$0.63	$7.48	$14.57	$14.14	$27.55
$14.65	$43.96	$16.46	$70.89	$68.16	$192.40	$6.82	$19.24	$3.41	$9.62	$78.38	$221.26	$5.35	$15.10
$7.49	$22.46	$7.96	$33.37	$37.04	$99.43	$3.70	$9.94	$1.85	$4.97	$42.59	$114.34	$5.69	$15.27
$1.19	$3.56	$1.21	$4.61	$9.37	$20.39	$0.94	$2.04	$0.47	$1.02	$10.78	$23.45	$9.08	$19.76
$1.21	$3.63	$1.20	$4.73	$9.60	$20.94	$0.96	$2.10	$0.48	$1.05	$11.04	$24.09	$9.13	$19.90
$11.90	$35.69	$12.77	$54.50	$56.44	$155.69	$5.65	$15.57	$2.82	$7.79	$64.91	$179.05	$5.46	$15.05
$5.87	$17.59	$6.66	$30.35	$30.25	$83.31	$3.03	$8.33	$1.51	$4.17	$34.78	$95.80	$5.93	$16.34
$2.85	$8.56	$3.11	$13.25	$16.82	$42.36	$1.68	$4.24	$0.84	$2.12	$19.35	$48.71	$6.78	$17.08
$2.60	$7.79	$2.77	$11.70	$15.70	$38.86	$1.57	$3.89	$0.79	$1.94	$18.05	$44.69	$6.96	$17.22
$3.91	$11.73	$4.76	$23.48	$21.82	$60.78	$2.18	$6.08	$1.09	$3.04	$25.09	$69.90	$6.42	$17.88
$4.35	$13.06	$4.72	$20.75	$23.59	$62.11	$2.36	$6.21	$1.18	$3.11	$27.13	$71.43	$6.23	$16.41
$1.24	$3.73	$1.37	$5.80	$9.73	$22.05	$0.97	$2.21	$0.49	$1.10	$11.19	$25.35	$9.01	$20.41
$5.10	$15.28	$5.40	$21.66	$26.35	$68.35	$2.64	$6.84	$1.32	$3.42	$30.30	$78.60	$5.95	$15.43
$6.12	$18.35	$6.57	$26.20	$30.65	$80.66	$3.07	$8.07	$1.53	$4.03	$35.24	$92.76	$5.76	$15.16
$9.77	$29.32	$11.06	$50.20	$47.66	$134.40	$4.77	$13.44	$2.38	$6.72	$54.80	$154.56	$5.61	$15.81
$4.69	$14.06	$4.93	$20.38	$24.89	$64.36	$2.49	$6.44	$1.25	$3.22	$28.62	$74.01	$6.11	$15.80
$2.73	$8.19	$2.90	$12.36	$16.34	$40.70	$1.63	$4.07	$0.82	$2.04	$18.79	$46.80	$6.88	$17.14
$5.40	$16.21	$6.29	$29.94	$28.49	$79.44	$2.85	$7.95	$1.43	$3.97	$32.77	$91.36	$6.07	$16.91
$0.88	$2.64	$0.92	$3.66	$8.13	$17.11	$0.81	$1.71	$0.41	$0.86	$9.36	$19.68	$10.65	$22.39
$1.66	$4.97	$1.75	$7.30	$11.57	$26.99	$1.16	$2.70	$0.58	$1.35	$13.31	$31.04	$8.03	$18.73
$1.68	$5.03	$1.92	$8.97	$11.72	$28.69	$1.17	$2.87	$0.59	$1.44	$13.48	$32.99	$8.04	$19.68
[redacted]7	$3.52	$1.31	$5.80	$9.47	$21.54	$0.95	$2.15	$0.47	$1.08	$10.89	$24.77	$9.28	$21.12
[redacted]5	$24.16	$8.67	$35.57	$39.19	$105.50	$3.92	$10.55	$1.96	$5.28	$45.07	$121.33	$5.60	$15.07
$1.73	$5.19	$1.78	$7.38	$11.92	$27.78	$1.19	$2.78	$0.60	$1.39	$13.71	$31.95	$7.93	$18.47
$18.14	$54.41	$19.85	$84.54	$83.33	$234.17	$8.33	$23.42	$4.17	$11.71	$95.83	$269.30	$5.28	$14.85
$7.43	$22.28	$8.42	$37.96	$37.04	$103.15	$3.70	$10.32	$1.85	$5.16	$42.59	$118.63	$5.74	$15.98
$0.64	$1.92	$0.69	$2.87	$7.10	$14.39	$0.71	$1.44	$0.36	$0.72	$8.16	$16.55	$12.73	$25.82
$11.19	$33.56	$12.54	$55.75	$53.68	$151.02	$5.37	$15.10	$2.69	$7.55	$61.74	$173.68	$5.52	$15.53
$3.32	$9.95	$3.64	$16.01	$18.98	$48.96	$1.90	$4.90	$0.95	$2.45	$21.83	$56.31	$6.58	$16.98
$3.24	$9.73	$3.44	$13.83	$18.37	$45.95	$1.84	$4.60	$0.92	$2.30	$21.13	$52.84	$6.51	$16.29
$12.02	$36.06	$13.61	$59.49	$57.02	$160.66	$5.70	$16.07	$2.85	$8.03	$65.57	$184.76	$5.46	$15.37
$0.99	$2.96	$1.12	$4.88	$8.60	$19.05	$0.86	$1.91	$0.43	$0.95	$9.89	$21.91	$10.01	$22.19
$3.76	$11.28	$4.12	$17.65	$20.79	$53.92	$2.08	$5.39	$1.04	$2.70	$23.91	$62.01	$6.36	$16.49
$0.74	$2.21	$0.80	$3.51	$7.55	$15.84	$0.76	$1.58	$0.38	$0.79	$8.69	$18.21	$11.77	$24.68
$5.37	$16.11	$6.22	$28.65	$28.03	$77.46	$2.80	$7.75	$1.40	$3.87	$32.23	$89.08	$6.00	$16.59
$19.44	$58.32	$20.13	$84.74	$89.82	$247.60	$8.98	$24.76	$4.49	$12.38	$103.29	$284.74	$5.31	$14.65
$2.06	$6.18	$1.75	$5.62	$13.24	$29.03	$1.33	$2.90	$0.66	$1.45	$15.23	$33.38	$7.40	$16.21
$0.59	$1.77	$0.65	$2.77	$6.87	$13.86	$0.69	$1.39	$0.34	$0.69	$7.91	$15.94	$13.42	$27.06
$6.73	$20.20	$7.59	$33.42	$33.80	$92.92	$3.38	$9.29	$1.69	$4.65	$38.87	$106.85	$5.77	$15.87
$5.61	$16.83	$6.14	$26.63	$28.99	$77.72	$2.90	$7.77	$1.45	$3.89	$33.34	$89.38	$5.94	$15.93
$1.82	$5.45	$2.17	$10.11	$12.31	$30.75	$1.23	$3.08	$0.62	$1.54	$14.16	$35.37	$7.80	$19.48
$5.17	$15.51	$5.60	$23.89	$27.09	$71.64	$2.71	$7.16	$1.36	$3.58	$31.16	$82.38	$6.03	$15.94
$0.48	$1.44	$0.52	$2.24	$6.42	$12.52	$0.64	$1.25	$0.32	$0.63	$7.38	$14.40	$15.39	$30.01
$267.66	$802.93	$289.64	$1,233.32	$1,391.29	$3,688.23	$139.16	$368.84	$69.59	$184.43	$1,600.04	$4,241.50	$5.98	$15.85
$5.25	$15.74	$5.68	$24.18	$27.28	$72.32	$2.73	$7.23	$1.36	$3.62	$31.37	$83.17		

FUNDING FORMULA	
Counter-Marketing	$1.00–$3.00 per capita.
Cessation (Minimum)	$1 per adult (screening) + $2 per smoker (brief counseling).
Cessation (Covered Programs)	$1 per adult (screening) + $2 per smoker (brief counseling) + $13.75 per smoker (50% of program cost for
[redacted]	10% of smokers) + $27.50 per smoker (approximately 25% of smokers covered by state financed programs).
[redacted] Program Costs	Program Area Subtotal + 10% for Surveillance and Evaluation + 5% for Administration and Management.

MEASURE 3: COMPREHENSIVE TOBACCO PREVENTION AND CESSATION FOR NORTH DAKOTA

A WIN-WIN SOLUTION FOR NORTH DAKOTA'S HEALTH AND ECONOMY

Selected Pages

A Special Report by the Campaign for Tobacco-Free Kids

September 22, 2008

The Campaign for Tobacco-Free Kids is an independent, non-partisan, nonprofit organization dedicated to preventing and reducing tobacco use and its harms, especially among youth. The Campaign does not receive or accept any government funding, nor does it receive or accept any funding from the tobacco industry. The Campaign works nationwide to support cost-effective state measures to reduce smoking and other tobacco use, save lives, and reduce smoking-caused harms and costs. For more information, see www.tobaccofreekids.org.

Fully Funding the North Dakota Tobacco Prevention Programs Will Reduce Smoking, Save Lives and Protect Kids

Directing the new revenue from the tobacco settlement "bonus payments" to expand the state's efforts to prevent and reduce tobacco use would dramatically improve the health of North Dakota residents. Significant and health and economic benefits would begin almost immediately and would quickly continue to grow much larger every year the program is in place.*

Reducing Youth Smoking and Related Harms. Recent research on the impact of state tobacco prevention program funding on reductions to youth smoking levels indicates that fully funding North Dakota's tobacco prevention program at the CDC-recommended level would work to reduce the number of youth smokers by approximately 12.7 percent, stopping at least 4,570 North Dakota kids alive today from growing up to become addicted adult smokers – thereby saving at least 1,460 North Dakota kids from ultimately dying prematurely from smoking.[16] The youth smoking reductions would start immediately and grow each year so long as the programs funding level was maintained at the new level.

	Decline in Youth Smoking	Kids Alive Today Stopped From Smoking	Kids Saved From Dying From Smoking
Fully-Funded Prevention Program	12.7%	4,570	1,460

These estimates are conservative, however, because additional funding for the state's tobacco control program would have an impact on the use of other tobacco products besides cigarettes, such as smokeless tobacco and cigars.

Currently, 11.7 percent of high schoolers in North Dakota use smokeless tobacco. The habit is more popular among boys than girls, with 19.8 percent of high school boys using smokeless tobacco compared to 3.2 percent of high school girls.[17] The use of smokeless tobacco among high school boys in North Dakota is among the highest in the country. Clearly, more must be done to prevent this destructive activity. Increasing funding for the state's prevention and cessation program would help to prevent the death, disease, costs and other harms caused by these tobacco products.

Cigar smoking is also increasing among kids, and is just as deadly and addictive as cigarettes. In North Dakota, 11.4 percent of high school students smoke cigars.[18] Fully funding the state tobacco prevention program through Measure 3 would help to prevent youth from becoming addicted to smoking through trying cigars, which often come in kid-friendly flavors such as grape, cherry, and chocolate.

Reducing Adult Smoking and Related Harms. Recent research on the average impact of state tobacco prevention program funding on adult smoking levels shows that fully funding the North Dakota would, in the first year reduce adult smoking by 1,200. But these adults smoking reductions would continue to grow each year the fully funded program was in place. After just the first five years, the program would be reducing the total number of adult smokers in the state by 3,480, thereby saving 920 from dying prematurely from smoking and extending the lives of many of the others. With Measure 3 in place, these adult smoking declines would be maintained and continue to grow after the first five years, saving and improving even more lives.[19]

* For more detail on the benefits and savings from each percentage point decline in North Dakota smoking rates, See Appendix B.

	Fewer Adult Smokers	Adults Saved From Dying From Smoking
Fully-Funded Prevention Program	3,480	920

But these projected results are based on the assumption that the North Dakota program has only average results. If, instead, North Dakota follows the CDC program guidelines and establishes and runs an above-average program it would shrink adult, and youth, smoking even more sharply and secure even larger public health benefits – as well as larger amounts of related healthcare and other cost savings.

In addition, these adult and youth smoking declines, and the related benefits, could be accelerated and expanded if North Dakota also increased its tobacco tax rates and implemented a comprehensive smoke-free law.

Fully Funding the North Dakota Tobacco Prevention Program Would Reduce Government, Private Sector, and Household Smoking-Caused Health Costs Throughout the State

Extra healthcare expenditures in North Dakota caused by smoking add up to $247 million annually. That includes $47 million a year in state Medicaid program costs, much of it paid by the state and North Dakota taxpayers.* Increasing funding for the state's efforts to prevent and reduce smoking and other tobacco use is a cost-effective method to reduce these costs to North Dakota's government, businesses, and taxpayers.†

As the table below shows, given the conservative youth and adult smoking declines outlined above, in the first five after fully funding its tobacco prevention program, North Dakota health care costs would be reduced by approximately $2.0 million just from fewer smoking-caused heart attacks, strokes and fewer smoking-affected births.[20]

	5-Year Heart-Stroke Savings	5-Year Pregnancy Savings
Fully-Funded Prevention Program	$1.1 million	$920,000

These short-term healthcare savings from heart-stroke and pregnancy cost reductions, which would begin to accrue immediately, represent only the tip of the savings iceberg for North Dakota, as the smoking declines from a fully funded program would immediately begin to reduce numerous other smoking-caused health costs as well. But available data and research is not currently adequate to make reliable estimates of the actual dollar amounts.

Fully funding North Dakota's tobacco prevention program would quickly lock-in more than $113 million in total future healthcare cost savings in the state, with at least $11.9 million of those savings in the state Medicaid program. By prompting current adult and youth smokers to quit, helping former smokers from relapsing, and getting thousands of kids to never start smoking, state tobacco-prevention programs lock in enormous savings over the lifetimes of each person stopped from future smoking. Put simply, the lifetime healthcare costs of smokers total at least $17,500 more than nonsmokers, on average, despite the fact that smokers do not live as long, with

* For more detail on the economic toll of tobacco use in North Dakota, see Appendix A.

† For more detail on how comprehensive tobacco prevention and cessation programs save money, See TFK Factsheet, *Comprehensive Tobacco Prevention and Cessation Programs Reduce Tobacco Use*, http://www.tobaccofreekids.org/research/factsheets/pdf/0168.pdf

a somewhat smaller difference between smokers and former smokers.[21] That means that for every thousand kids kept from smoking by a state program, future healthcare costs in the state decline by roughly $17.5 million (in current dollars), and for every thousand adults prompted to quit future health costs drop by roughly $9.5 million.[22]

The long-term savings from state tobacco-prevention programs -- as well as the immediate and short-term savings outlined above – also directly reduce state Medicaid program expenditures. More than 10% of all smoking-caused healthcare expenditures In North Dakota are paid for by the state's Medicaid program.[23]

Accordingly, the previously described declines in adult and youth smoking that would be secured through passing Measure 3 and fully funding North Dakota's tobacco prevention program at the CDC-recommended level –if the program obtained only average results – would, after just five years, reduce future healthcare costs in the state by an estimated $113 million, including $11.9 in reduced state Medicaid Program expenditures. And with every passing year, even more savings would be secured.

	Total Future Health Savings	Medicaid Share of Total Savings
Fully-Funded Prevention Program	$113 million	$11.9 million

As noted above, these savings would be even larger if North Dakota's tobacco prevention program, when fully funded through Measure 3, followed the CDC program guidelines and other best practices to make sure it obtained above-average results. California, for example, which has run an exemplary tobacco prevention program focusing on reducing adult smoking, as well as youth tobacco use declines, has been found to have saved, in its first fifteen years, tens of dollars for every single dollar it invested in the tobacco prevention program.[24] And California spent somewhat less than the CDC-recommended amounts during that time period; and would have reaped even larger savings if it had.

Supplementing North Dakota's tobacco program's efforts with an increase to the state's tobacco tax rates and by implementing a strong smoke-free law would also secure even larger smoking reductions and related cost savings.

But even without above-average or additional efforts, the projections here would continue to grow even larger after the first five years of the fully-funded program's efforts – locking in even larger future healthcare savings and state Medicaid Program expenditure reductions.

The above projections of overall healthcare savings to public, private sector, and household healthcare costs throughout the state would occur over the lifetimes of the smokers who quit or kids who never start smoking because of a fully-funded tobacco program. Besides Medicaid, North Dakota would also see reductions to the smoking-caused health costs in other state or state-funded programs because of the smoking declines prompted by the program – and private sector and individual smoking-caused health costs would also decline. Most notably, decreasing smoking rates among workers would also lower public and private sector employers' health care and health insurance costs.

Businesses pay a large share of smoking-related healthcare costs. Studies have indicated that 30 to 85 percent of medical costs to employers are unnecessarily excessive and could be reduced if the health status of their employees was improved.[25] Each smoking employee costs their employer an estimated $1,000 to $4,600 per year in excess medical costs.[26] Studies show that smoking and other tobacco use decrease business productivity through high rates of absenteeism and reduced concentration and drive up businesses' health and non-health costs. With adequate

APPENDIX B

BENEFITS & SAVINGS FROM EACH ONE PERCENTAGE POINT DECLINE IN NORTH DAKOTA'S SMOKING RATES

The following estimates show the benefits and savings that are obtained in North Dakota for each one percentage point decline in adult and youth smoking rates in the state (e.g., from new state investments in tobacco prevention or increased statetobacco tax rates). These estimates can also be switched around to show what harms and costs North Dakota would suffer from each one percentage point increase to its smoking rates or from each one percentage point reduction the State fails to obtain (e.g., because it fails to sustain adequate state tobacco prevention funding or lets its tobacco tax rates erode over time).

Fewer Smokers

Fewer current adult smokers: 4,900

Fewer current pregnant smokers: 90

Fewer current high school smokers: 400

North Dakota kids alive today who will not become addicted adult smokers: 1,400

Public Health Benefits

Today's adults saved from dying prematurely from smoking: 1,300

Today's high school smokers saved from dying prematurely from smoking: 130

North Dakota kids alive today who will not die prematurely from smoking: 450

	First Year	Over 5 Years
Fewer smoking-affected births:	**90**	**430**
Fewer smoking-caused heart attacks:	**2**	**32**
Fewer smoking-caused strokes:	**1**	**17**

[The number of heart attacks and strokes prevented each year by a one-time decline in adult smoking rates of one percentage point starts out small but grows sharply until it peaks and stabilizes after about ten years.]

Monetary Benefits (Reduced Public, Private, and Individual Smoking-Caused Costs)

	First Year	Over 5 Years
Savings from smoking-affected birth reductions	**$0.1 million**	**$0.7 million**
Savings from heart attack & stroke reductions	**$0.2 million**	**$2.3 million**

[Annual savings from fewer smoking-caused heart attacks and strokes grows substantially each year as more and more are prevented by the initial one percentage point smoking decline. Savings from prevented smoking-caused cancer are even larger, but do not begin to accrue until several years after the initial smoking decline.]

Reduction to future health costs from adult smoking declines: **$46.6 million**

Reduction to future health costs from youth smoking declines: **$24.5 million**

[These savings accrue over the lifetimes of the adults who quit and the youth who do not become adult smokers. Roughly 10.6% of smoking-caused healthcare expenditures in North Dakota are paid by its Medicaid program.]

At the same time that they reduce public and private smoking-caused costs, state smoking declines also increase public and private sector worker productivity and strengthen the state's economy.

Prepared by Rosellen Sand
March 11, 2009

Non-exhaustive Inventory
of Other State Entities with Statutory Authority Similar
to the Tobacco Prevention and Control Advisory Committee.

This document provides a non-exhaustive inventory of several statutory references that authorize other state entities to take action, or exercise an authority, that the Tobacco Prevention and Control Advisory Committee and Executive Committee is also authorized to take or exercise by Measure 3 (now codified as N.D.C.C. ch. 23-42).

Section 23-42-04 sets out the duties of the advisory board, including setting its compensation. The pertinent portion of that statute that allows the committee to set its own compensation states: here:

> **23-42-02. Tobacco prevention and control advisory committee - Membership - Terms - Duties - Removal.**
> . . .
> 5. The advisory board shall:
> . . .
> b. Fix the compensation of the advisory committee and the executive committee. However, compensation may not exceed compensation allowed to the legislature. Advisory and executive committee members are entitled to reimbursement for mileage and expenses as provided for state officers in addition to any compensation provided;
> . . .

The authority of a board to fix the compensation of its members subject to a cap is found in several places in the Century Code. Examples are the Dry Bean Council (N.D.C.C. § 4-10.3-05), the Wheat Commission (N.D.C.C. § 4-28-05), the Dairy Promotion Commission (N.D.C.C. § 4-27-05), the Beef Commission (N.D.C.C. § 4-34-07).

Section 23-42-04 sets out the powers of the executive committee. That statute states:

> **23-42-04. Powers of the executive committee.** To implement the purpose of this chapter and, in addition to any other authority granted elsewhere in this chapter, to support its efforts and implement the comprehensive plan, the executive committee may employ staff and fix their compensation[1], accept grants[2], property[3], and gifts[4], enter contracts[5], make loans[6], provide grants[7], borrow money[8], lease property[9], provide direction to the state investment board for investment of the tobacco prevention and control fund[10], and take any action that any private individual, corporation, or limited liability company lawfully may do except as restricted by the provisions of this chapter[11].

References to other state statutes that authorize other state entities to exercise these same powers are contained the respectively numbered paragraphs on the following 2 pages. If the Committee or individual Legislators need more information or have further questions, my e-mail address is sandlaw@bis.midco.net

1. The power to employ staff and fix compensation is found in several places in the Century Code including authorizing legislation for the Dry Bean Council (N.D.C.C. § 4-10.3-07); the Wheat Commission (N.D.C.C. § 4-28-06); Department of Commerce Division of Economic Development and Finance (N.D.C.C. § 54-34.3-04); the State Health Department (N.D.C.C. § 23-01-08); Superintendant of Public Instruction (N.D.C.C. § 15.1-02-03); Council on the Arts (N.D.C.C. § 54-54-04).

2. The power to accept and make grants can be found in many places in the Century Code including: the Governor's prevention and advisory council (N.D.C.C. § 54-07-07); Department of Commerce Division of Economic Development and Finance (N.D.C.C. § 54-34.3-13); Oil and Gas Research Council (N.D.C.C. § 54-17.6-04); the State Health Council (N.D.C.C. § 23-01-3.3).

3. The power to accept property can be found in general legislation in N.D.C.C. § 1-08-07 as well as in legislation authorizing specific entities, for example the Dry Bean Council (N.D.C.C. § 4-10.3-07).

4. The power of state entities to accept gifts can be found in general legislation in N.D.C.C. § 1-08-07 as well as in legislation specific to a particular agency. Examples of specific legislation are the Governor's prevention and advisory council (N.D.C.C. § 54-07-07); the Dry Bean Council (N.D.C.C. § 4-10.3-07); the Industrial Commission controlling the Oil and Gas Research Council (N.D.C.C. § 54-17.6-04); and the Legislature (N.D.C.C. § 54-03-29).

5. The power to enter contracts is ubiquitous because the state must interact with others to provide service and receive goods and services. It does so through contracts. Specific examples of statutes authorizing a state entity to contract include: Dry Bean Council (N.D.C.C. § 4-10.3-07); Wheat Commission (N.D.C.C. § 4-28-6); State Water Commission (N.D.C.C. § 65-02-09) ND Pipeline Authority (N.D.C.C. § 54-17.7); State Health Department (N.D.C.C. § 23-01-24); Department of Commerce Division of Economic Development and Finance (N.D.C.C. § 54-34.3-04); The Industrial Commission controlling the Oil and Gas Research Council (N.D.C.C. § 54-17.6-04); Superintendent of Public Instruction (N.D.C.C. § 15.1-02-03); Council on the Arts (N.D.C.C. § 54-54-06).

6. The power to make loans can be found in legislation authorizing the North Dakota Pipeline Authority (N.D.C.C. § 54-17.7-04); the State Water Commission (N.D.C.C. ch. 61-02); the State Health Council (N.D.C.C. § 23-01-3.3); Department of Commerce Division of Economic Development (N.D.C.C. § 54-34.3-13).

7. See paragraph 2 above.

8. The power to borrow money can be found in specific legislation including that authorizing the North Dakota Pipeline Authority (N.D.C.C. § 54-17.7-04); the State Water Commission (N.D.C.C. ch. 61-02); the Attorney General (N.D.C.C. § 54-12-14.1); Office of Management and Budget (N.D.C.C. § 54-27-23)

9. The authority to lease property can be found in legislation including that authorizing the Wheat Commission (N.D.C.C. § 4-28-06); the State Water Commission (N.D.C.C. § 65-02); and the Superintendent of Public Instruction (N.D.C.C. § 15.1-02-07).

10. A list of those with authority to provide direction to the state investment board is found in 21-10-06 and includes the state bonding fund, TFFR, the state fire and tornado fund, the National Guard tuition trust fund, workforce safety and insurance, PERS, and the state risk management fund.

11. The authority to take actions a private individual, corporation or limited liability company can take is also found in legislation authorizing the state mill and elevator (N.D.C.C. § 54-18-02). The State Fair Association also has "all the rights, privileges, and liabilities pertaining to corporations." (N.D.C.C. § 4-02.1-16)